“Being treated like a human being”: Attitudes and behaviours of reproductive and maternal health care providers

Mother and baby in the marketplace in Lagos

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<td>FGD</td>
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<td>HIV</td>
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<td>IMMPACT</td>
<td>Initiative for Maternal Mortality Programme assessment</td>
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<td>MHCP</td>
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<td>UN</td>
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Executive summary

Introduction

Although there has been significant progress in reducing preventable maternal deaths and disability, the pace is too slow to achieve the Millennium Development Goal 5 target of reducing maternal deaths by three-quarters by 2015, especially in low or middle income countries. There has also been a growing appreciation of the importance of improving the quality, as well as the coverage, of health care more generally in developing countries. Consideration of the attitudes and behaviour of maternal health care providers (MHCPs) is central to a human rights based approach to reproductive and maternal health. We also need to consider the rights of health care workers, the majority of whom are women, including their right to a healthy and safe working environment.

That the attitudes and behaviour of health care workers can affect patient care has long been recognised and there are increasingly calls for more attention to be given to assessing and improving interpersonal skills as part of addressing the quality of care. We undertook a scoping review of evidence and experiences in relation to the attitudes and behaviours of MHCPs, their impact, influences, and how we might intervene effectively to foster positive attitudes and improve provider-patient relationships. We reviewed and synthesised a wide range of published evidence and experiences from the peer-reviewed and grey literature.

The range of maternal health care providers’ attitudes and behaviours

Although we found few studies that set out specifically to document health care worker attitudes and behaviours, a wide range of studies were able to contribute useful information. These included studies of the influences on access and uptake of reproductive and maternal health services; quality of care studies; program evaluation studies; studies of maternal death audits, and studies of the impact of HIV-related stigma and discrimination.

While there were some reports of kind and friendly staff, there were also many reports of poor attitudes and behaviours, from both patients and from MHCPs themselves. These included lack of sympathy and empathy, reports of neglect, rude and verbally abusive behaviour, physical abuse, lack of respect, humiliating behaviour and lack of control, judgemental and punishing behaviour, and lack of attention to privacy and confidentiality.
Influences on the attitudes and behaviour of maternal health care providers

Our review suggests that a range of interrelated reasons contribute to attitudes and behaviours that prevent MHCPs working effectively, and that these vary greatly in different contexts. We need to understand these in order to plan effective strategies.

There is often a great difference in the way women and MHCPs view and know about pregnancy and childbirth with tensions between traditional cultural expectations and rituals, and the practices required for modern maternal health care. Lack of an enabling working environment, including heavy workloads, poor remuneration, lack of supportive supervision, weak management and lack of equipment and supplies are especially common causes of stress and frustration that affect interactions with patients. The HIV epidemic has increased the workload for many MHCPs and given them new tasks, and they may fear occupational exposure to infection.

Lack of knowledge may combine with class prejudice resulting in stereotyping and discriminatory attitudes, especially towards those judged to be too old, too young, unmarried or having too many children. Attitudes and behaviours of MHCPs often reflect the broader societal prejudices, for example in relation to poor people, people living with HIV, and to migrants or minority ethnic groups. Some MHCPs believe that patients are inferior and aim to maintain their own middle-class, educated identity; treating patients rudely can enable them to feel more powerful. MHCPs may also neglect poor patients because they believe they will not be able to pay unofficial charges. Communication styles with patients may reflect how much value is placed on courtesy in the wider society.

MHCPs sometimes report that their frustration when women arrive late for antenatal or delivery care, or without money, causes them to be harsh. Within maternal health care facilities norms of behaviour and attitudes develop and influence new staff. In many societies, women have low status and are seen as needing discipline and control, a belief that may legitimise use of violence by staff to control female patients. Gender discrimination and sexual harassment towards MHCPs from managers, co-workers, patients and the public themselves can result in MHCPs taking out their frustration on their patients or inhibit communication. MHCPs themselves may have sexist attitudes that negatively affect the way that they treat women patients.
Impact of maternal health care provider attitudes and behaviour

Despite methodological challenges there is clear evidence that poor provider attitudes have a variety of adverse impacts on patient care and health outcomes. Just as a friendly, informative and reassuring manner can help to reduce the existing fears of a patient, so an uncaring, judgemental or hostile attitude can exacerbate fears and inhibit people from seeking reproductive and maternal health care services, or from benefitting when they do. This is especially important in relation to delivery care when women are especially vulnerable and failure to deliver with a skilled birth attendant or seek emergency obstetric care can result in death or disability. Many studies of the determinants of access to and use of reproductive and maternal health care services report quality of care to be an important issue, and poor staff attitudes are often emphasised. These concerns interact with other barriers, such as availability of supplies, waiting times, distance and cost. The poorest in the population tend to suffer most from abuses of power and lack of responsiveness from MHCPs.

Poor inter-personal relationships create a communication barrier that prevents MHCPs giving women the information they need about family planning, nutrition, preparation for labour and skilled attendance at delivery, smoking cessation during pregnancy, newborn care, and infant feeding. Poor treatment from MHCPs during labour, especially being neglected, can cause women to experience a loss of sense of control which can result in later emotional and psychological problems.

MHCPs are often a cadre of workers, predominantly female, that have relatively low status in the health system hierarchy, are poorly paid, often overworked and inadequately trained and supervised, and have little autonomy, yet great responsibilities. Looking after women in labour is inherently stressful. Obstetric complications are unforgiving of even short delays. Deaths of mothers and infants are often blamed on the midwife by the family, the community, and by senior health staff. When things go wrong MHCPs may blame themselves and suffer secondary traumatic stress. When MHCPs display poor attitudes or behaviour towards their patients they may lose the respect and gratitude from their patients that they deserve with adverse effects on their own morale, confidence, motivation and job satisfaction. Combined with poor remuneration and heavy workloads this contributes to low retention rates and, in turn, greater stress. The potential for positive attitudes and behaviours to improve outcomes requires more attention.

What can be done to improve the relationship between MHCPs and patients? There is no single
intervention, or ‘package’ of interventions that will solve the problems described in this review. Different approaches will be needed in different settings. But MHCPs everywhere need an ‘enabling environment’ to be able to apply their skills, with improvements in training, management practices, infrastructure, availability of equipment and supplies, and infection control.

Human rights principles need to be incorporated into national policy making, health services management, and clinical management. Human rights education equips MHCPs with the knowledge and tools to empower them to promote and protect the rights of their patients, and to defend their own rights. Partnerships between international or developed country professional associations and those in developing countries can help. Advocacy with government and non-government organizations is essential, but messages should not inadvertently blame MHCPs. The White Ribbon Alliance, with the Policy Project and USAID, is raising awareness through a Respectful Maternity Care advocacy campaign.

There is a danger that MHCP skills assessment may focus on technical clinical skills and neglect interpersonal skills. Experience shows that training efforts to improve communication and counselling skills should be participatory, with role plays, and ongoing in-service training with supportive supervision. Exchanges of senior midwives to centres with norms of respectful care can result in effective role models. Training should include discussions about traditional beliefs and practices and how they can be respected and accommodated in antenatal, delivery and postnatal care. Traditional birth attendants could be invited to share their knowledge and understanding about cultural beliefs and practices in relation to pregnancy, childbirth, newborn care and infant feeding. There are some useful resources to support training in communication and counselling skills that can be downloaded free from the internet (Appendix 1). These include an excellent manual from WHO’s Department of Making Pregnancy Safer: ‘Counselling for maternal and newborn health care: a handbook for building skills.’ Counselling should also be specifically included in care protocols.

The 2010 UN Global Strategy for Women's and Children's health highlighted the importance of motivation. Motivation is a key factor in encouraging supportive attitudes, and in turn motivation is increased by better relationships between providers and patients – their work is more interesting and fulfilling when they have good communication and counselling skills. Most MHCPs have strong professional ethics. Community appreciation, perceived government and development partner support, and on-the-job learning are sources of encouragement. It is
important that rural health centre managers, especially, receive support from higher levels of the health system. A mix of financial and non-financial incentives are needed.

It is important to communicate with the community about the subject of quality of care at maternal health facilities. Women’s impressions of how they are likely to be treated by MHCPs are influenced by the experiences of others. Decisions about whether to deliver with a skilled birth attendant, and whether and when to go to a referral hospital, are often taken by men or other family members rather than by the woman herself. The attitudes and behaviours of MHCPs are often influenced by wider cultural norms, and also by the expectations of their patients. Trials of community women’s groups have shown positive effects on maternal and perinatal health and survival.

There have been many calls for mechanisms to improve accountability. Suggestions include introducing a Patients’ Charter or Code of Ethics for health workers, although these must be backed by investment and institutional processes, such as an ombudswoman, to apply and enforce them. Similarly, complaint mechanisms systems require quality assurance officers to receive and address the complaints, and should be discussed with MHCPs. Poor staff behaviour often stems from work-related stress and poor conditions so it makes more sense to work on improving these before introducing penalties for MHCPs. There are now useful evaluations of maternal and perinatal death (and ‘near miss’) audits which can promote accountability by health providers and policy makers. Processes of formal accreditation of health care facilities can improve quality of care and contribute to accountability but are expensive, and have proved difficult to evaluate.

There is good evidence from randomised controlled trials that continuous support during labour can enable labouring women to feel in control, relieve MHCPs, and improve health outcomes. Such support can be provided by a family member, friend or community volunteer. Partnerships between traditional midwives and skilled birth attendants with shared care during antenatal, delivery and postnatal care have also been successful in several settings.

Most of the studies that provide insights into the attitudes and behaviours of MHCPs and their influences and impacts have used qualitative methods to explore the perspectives of women, men, TBAs and health care providers. These are appropriate methods for studying a topic which is complex, sensitive, context-specific and has inter-related influences and impacts. With these methods it is possible to learn things that the researchers might not have known to ask about, and to understand the range of different attitudes and behaviours. Qualitative findings can be
used to develop better quantitative research and evaluation tools, such as explicit observation checklists.

It was notable that there were far more relevant studies from sub-Saharan African countries than from other parts of the world. While many of the influences on MHCPs’ attitudes and behaviours are likely to be common in resource constrained settings, the cultural and societal context in which MHCPs work clearly has a significant influence and will vary greatly between countries. There is a need for more studies in low and lower middle income Asian and Pacific countries, especially where maternal mortality remains high.

**Conclusions**

Most MCHPs are caring, respectful and supportive to their patients and clients. But poor provider attitudes and behaviours have been frequently documented in many parts of the world and have significant impacts on health–care seeking behaviour, on the physical, psychological and emotional health of women and their babies, and on the job satisfaction, motivation and retention of MHCPs themselves. These impacts are greatest on the poorest in the population and so add to inequalities in health outcomes.

In addition to encouraging a new focus on patient-centred care we also need to pay attention to the well-being and rights of MHCPs who too often work in poor and stressful conditions, lacking the effective management, training, supervision, equipment, and supplies that they need to do their jobs. It has been said that we know what works to improve maternal health. But if the evidence-based interventions are to be implemented effectively and at scale then greater attention to the attitudes and behaviours of MHCPs must be part of efforts to improve quality of care. There have been successful efforts and there are useful resources available. But much greater investment is needed. As Rosemary Kumwenda from Zambia has noted, we need services that are not only baby-friendly but mother-friendly as well.
Introduction

An estimated 284,000 pregnant women lose their lives each year\(^1\), there are nearly 3 million stillbirths,\(^2\) and 4 million newborns die in the first month of life.\(^3\) Although there has been significant progress in reducing preventable maternal deaths, the pace is too slow to achieve the Millennium Development Goal 5 target of reducing maternal deaths by three-quarters by 2015.\(^1\) Almost all these deaths were in low or middle income countries, and about 45% of maternal deaths occur in Asia and the Pacific, with the largest burden in the region in South Asia. Another ten million women a year suffer significant pregnancy-related disease, disability, or depression.\(^4\) Direct causes of maternal deaths are post-partum haemorrhage, eclampsia, obstructed labour and unsafe abortion; indirect causes include HIV, malaria, heart disease, anaemia and suicide.\(^5\) But the road to maternal death is a long one\(^6\), and there are many underlying factors that contribute to the immediate causes of maternal and newborn death and disability. Pregnancy-related and post-partum mental and emotional health problems are common in developing countries and also have significant consequences for the health and survival of mothers and their babies.\(^7\) In 2010, the United Nations’ Global Strategy for Women’s and Children’s Health was launched and a Commission on Information and Accountability for Women’s and Children’s Health was established to develop a reporting and accountability framework to track whether international financial pledges are delivered on time, are spent wisely and transparently, and are achieving the desired results.

In 1997, the 10\(^{th}\) anniversary of the Safe Motherhood Initiative, new action messages included: “Improve access to quality maternal health services”, which emphasised the importance of both clinical and interpersonal aspects of care. There has also been a growing appreciation of the importance of improving the quality, as well as the coverage, of health care more generally in developing countries. The World Bank publication “Disease Control Priorities in Developing Countries (2006)” includes a chapter on “Improving the quality of care in developing

countries.” One of the Institute of Medicine’s six ‘elements of quality’ is “Patent centeredness – Is patient care being provided in a way that is respectful and responsive to a patient's preferences, needs, and values?”

Consideration of the attitudes and behaviour of maternal health care providers (MHCPs) is central to a human rights based approach to reproductive health. The significance of respect, privacy, dignity, freedom from discrimination, and confidentiality in health care settings as basic human rights was emphasised at the 1994 International Conference on Population and Development. A recent report from South Africa also notes that failures in maternity care and lack of accountability undermine the right to a remedy, and contribute to violations of the right to life, health, and the right to freedom from cruel, inhuman and degrading treatment. We also need to consider the rights of health care workers, the majority of whom are women, including their right to a healthy and safe working environment. In September 2012 the report “Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality” was presented to the UN Human Rights Council at its twenty-first session in Geneva by the Office of the High Commissioner for Human Rights.

Significant improvements in maternal and newborn health and survival depend on women (and couples) being able and willing to access family planning and other reproductive health services, and antenatal, delivery, postnatal and newborn care. That the attitudes and behaviour of health care workers can affect patient care has long been recognised. For example, Aubel et al found in a study aimed at improving management of diarrhoea in Sudan that negative health care worker attitudes towards mothers, traditional healers and home interventions created communication barriers that affected care. And Thompson, in her 1996 paper, ‘Safe motherhood at risk?’, emphasised the importance of midwives’ attitudes and urged midwives to treat childbirth traditions with respect and to offer women dignity. More recently, Freedman et al, and van

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14 Thompson A. Safe Motherhood at risk? Midwifery 1996; 12: 159-164
den Broek and Graham\textsuperscript{16}, have called for as much attention to be given to assessing the quality of implementation as to evaluating the efficacy of maternal and newborn health interventions. Van den Broek and Graham point out that two components of care are important: the quality of the provision of care – the service and the system; and quality of care as experienced by users. They note “The use of services and maternal health outcomes are the result not only of the provision of care but also of women’s experience of that care. Provision of care may be deemed of high quality against recognised standards of care but unacceptable to the woman, her family and the community.” Despite this recognition, there have been relatively few studies or reviews that focus on health care workers’ attitudes and behaviour, the influences on these, and their impact.*


* It was only after completing this review that we found and read the review report: Exploring evidence for disrespect and abuse in facility-based childbirth. Report of a landscape analysis by Diana Bowser and Kathleen Hill, undertaken for USAID-TRAAction project. September 20, 2010. This review, like ours, includes available evidence on the scope, contributors, impact and promising intervention approaches, but focuses on facility-based childbirth. Both reviews find that poor provider attitudes and behaviours have an important but neglected impact on health care seeking behaviour and on health outcomes, and provide an overview of strategies. \url{http://www.tractionproject.org/content/respectful-care-during-childbirth}. Although there is overlap the two reviews highlight some different points, and there have been further relevant publication in the two years since the USAID review was undertaken, so it is worth reading both.
Figure 1 sets out the theoretical framework that underpins this review. The relationship between MHCPs and their patients or clients may influence maternal and newborn heath outcomes through a number of pathways. A good relationship between a patient and health care provider has been described as one in which there is mutual respect, openness and a balance in their respective roles in decision-making. Negative attitudes, or fear of negative attitudes from MHCPs, have the potential to influence the decision to seek family planning, antenatal, delivery and post-natal health care. A poor relationship is also likely to affect process elements of quality of care. History-taking and problem assessment, the appropriateness and effectiveness of management, the patient’s compliance with treatment and health promotion advice, the

likelihood of appropriate referral, and of return for follow up care will all be influenced by poor communication resulting from a poor inter-personal relationship.\textsuperscript{18}

Bruce, in her analysis of quality of care in relation to family planning services, identifies interpersonal relations as one of six elements of quality of care, the others being choice of methods; information given to clients; technical competence; follow-up and continuity mechanisms; and the appropriate constellation of services.\textsuperscript{19} The composite nature of quality is increasingly acknowledged. Van den Broek and Graham identify the following elements: “effectiveness, safety, timeliness, efficiency, equity and responsiveness to the preferences, needs and values of mothers and their families – as individuals and populations.”\textsuperscript{16}

Peabody et al describe three elements of quality of care\textsuperscript{8}:

- \textit{Structure} referring to infrastructure, tools, and technology; the resources of the organizations that provide care; and the financing of care, including levels of funding, staffing, payment schemes and incentives.
- \textit{Process} referring to the interaction between caregivers and patients during which structural inputs from the health care system are transformed into health outcomes
- \textit{Outcomes} measured as health status, deaths, or disability-adjusted life years, as well as patient satisfaction or patient responsiveness to the health care system.

We argue that interpersonal relationships between MHCPs and patients can also influence these other elements of quality of care, as well as being influenced by them.

The quality of the relationship is also likely to affect the satisfaction of MHCPs, influencing their self-esteem, motivation and confidence, the likelihood that they will stay in the job, and their desire to learn. The relationship between the MHCP and the patient is influenced by the attitudes and behaviours of both the patient and the MHCP. The attitudes and behaviour of the patient may be affected by their previous experiences with MHCPs, by social, cultural or ethnic differences, and by personal characteristics such as shyness, level of autonomy, and self-confidence. Determinants of the attitudes and behaviour of the MHCPs may include factors such as their working conditions, including workload, stress, lack of privacy, and fear of


infection, their level of training and communication skills, norms in the workplace including the influence of role models, their personal characteristics, including gender, culture, ethnicity, and class, and personality attributes such as self-confidence, caring, courtesy, and charisma. Because pregnancy and child care are common reasons for contact with health care services, MHCPs, if well trained and supported, are well placed to identify and address factors that increase the likelihood of depression and anxiety, such as lack of spousal and family support, and gender violence.

We undertook a review of evidence and experiences in relation to the attitudes and interpersonal skills of maternal health care providers, their impact, influences, and how we might intervene to foster positive attitudes and improve interpersonal skills.

**Methods**

This was a scoping review rather than a formal systematic review, which was not possible or appropriate because of the nature of the broadness of the topic, context-specificity, lack of comprehensive index terms and variety of studies with relevant data. As Gabrysch and Campbell have noted “Systematic reviews of observational data are useful when trying to estimate an effect of interest that can be assumed to be independent of context (which is true for most biological effects) or when trying to explore heterogeneity that is thought to be due to a limited range of factors.” Integrating quantitative and qualitative studies in a single review can give valuable insights into the social and cultural factors identified.

The theoretical framework for our review is shown in Figure 1. The diagram indicates that the relationship between maternal health care providers and their patients or clients is central to the quality of a consultation, and influences both health care seeking behaviour and job satisfaction. Such relationships are thereby crucial to good health outcomes for mothers and babies. The relationship depends on the attitudes and behaviours of both the health care providers and the patients or clients, which are influenced by a range of factors. We aimed to review and synthesise published evidence and experiences from the peer-reviewed and grey literature of both quantitative and qualitative studies to answer the questions:

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• What are the attitudes and behaviours of MHCPs towards their patients and clients?
• What influences the attitudes and behaviours of MHCPs?
• What is the impact of the attitudes and behaviours of MHCPs?
• What can be done to improve the attitudes and behaviours of MHCPs?

Preliminary scoping indicated that a wide range of maternal health and health systems studies and policy papers include findings relevant to these questions.

PubMed, POPLINE, EMBASE and Cochrane databases, were systematically searched using a combination of the following search terms, entered as separate phrases and in various combinations of these phrases and keywords:

• ‘maternal healthcare workers attitudes respect privacy confidentiality developing countries’
• ‘counselling maternal newborn health care attitudes’
• ‘community satisfaction with primary health care services’
• ‘health care workers attitudes towards expectant mothers respect privacy confidentiality developing countries’
• ‘patient provider attitude developed/developing countries’
• ‘patient satisfaction’
• ‘safe motherhood’
• ‘the first delay barriers to health seeking behaviour’
• ‘the first delay obstetric care developing countries’
• ‘quality of care developing countries’

Abstracts were scanned for relevance and full copies of the papers obtained and read. The reference lists of retrieved articles were checked and any relevant new articles obtained and read.

Grey literature was identified through UN agency sites (WHO, UNICEF, UNFPA), Engenderhealth, Family Health International, IMMPACT, other relevant government and non-government organisations, and general web searches using similar search terms. The criteria for inclusion in the review were that the literature must:

• be available in English
• be published between 1990 and 2012
• address the issues of the review
• be available to read as a full article

Findings from the review have been organised and illustrated with quotes.

Findings

1. Health care workers’ attitudes and behaviours

Although we found few studies that set out to document health care worker attitudes and behaviours, a wide range of studies were able to contribute useful information. These included studies of the influences on access and uptake of reproductive and maternal health services; quality of care studies; program evaluation studies; studies of maternal death audits, and studies of the impact of HIV-related stigma and discrimination.

Most of the studies used qualitative methods or combinations of quantitative and qualitative methods, and were observational. There were few intervention studies. There were more relevant studies from sub-Saharan African countries than from other parts of the world. It is notable that studies are more likely to report negative attitudes and behaviours; positive attitudes and behaviours are less often mentioned. However, this does not necessarily mean that positive attitudes and behaviours are rare, because few studies have tried to quantify the frequency of different types of attitudes and behaviours. The views of patients about the attitudes and behaviours of MHCPs have been documented more frequently than the views of the MHCPs. It was noticeable that there has been a great increase in the number of relevant study reports and policy papers in the past five years.

A wide range of attitudes and behaviours have been documented, including neglect, and verbal, physical and sexual abuse. An important review and advocacy paper in the Lancet by d’Oliveira et al described various forms of violence taking place against women within health care services, ranging from threats, scolding, shouting and neglect, to denial of pain relief, sexual violence and over-medicalisation\(^{22}\).

Many qualitative studies of women’s experiences of maternal health care describe evidence of MHCPs showing a lack of sympathy and empathy, often pointed out in contrast to the caring

and kind attitude of traditional birth attendants (TBAs). In Kiwanuka et al’s systematic review of socio-economic differences in morbidity and access to health care in Uganda, women described that it was impossible to receive ‘an appropriate sympathetic response’ from MCHPs while in the labour suite in hospital.23 D’Ambruoso et al conducted in-depth interviews with 21 women in the Greater Accra region of Ghana who had delivered with a health professional within the previous five years to explore their accounts of interactions with health care providers during labour and delivery.24 The women interviewed complained of impatient and unkind behaviour, with some so distressed they cried when recounting their experiences: “…the attendants were angry with me when I was in labour. They were impatient with me.”[Mother, Great Accra Region, Ghana].24

Reports of neglect are also frequent. In a qualitative Tanzanian study, several of the women reported that they had been neglected, sometimes resulting in fatal consequences: “[In a lonely voice] one mother said that [because the Maternal and Child Health Aide did not come] her child was born outside the dispensary and died after one day. The child ‘sucked the dust’ and although the RMA (rural medical aside) came and gave some help, it was too late.” [Rural woman, southern Tanzania].25 In the 2011 Human Rights Watch study in South Africa, women described “being turned away from clinics without examination while in labour, being ignored by nurses when they called for help, waiting hours or even days for care, being denied referrals to specialized care, and being told to walk with their newborns between wards immediately after delivery while weak and bleeding heavily.”26

Belay et al’s qualitative study to evaluate the efficacy of the Making Pregnancy Safer Initiative in four Ethiopian areas found that poor provider attitude, in the form of harassment and in particular the absence of adequate attention, was cited as the main reason for dissatisfaction with maternal health services: “Labouring mother is just left alone. Alone in the labouring room and service providers are not supportive during delivery.” [Woman, Ethiopia].27 Others note being treated as unimportant or a nuisance. Mohammed-Alizadeh et al’s study of perceptions of

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Iranian family planning services reported instances where women were belittled or humiliated: “The provider [in the public clinic] sat and talked on the phone and laughed...Believe me, she was on the phone about 10 minutes and then repeated what she had talked about to her colleague while I and others were waiting.” [Woman, Iran].  

In a qualitative study in West Java, Indonesia, exploring the reasons why women choose either the trained village midlife or the traditional birth attendant (TBA), the researchers did not hear stories of abuse or rudeness, but there were complaints of absenteeism and being left alone during labour by trained midwives: “They say the traditional birth attendants are more patient. They gently touch your stomach and do not easily feel upset. This attitude is different from midwives. Sometimes after the physical examination, the midwife leaves if she thinks it is not the time for delivery yet. In contrast, the traditional birth attendant will wait patiently and accompany the woman all along.” [TBA, Sukabumi].  

An evaluation study was conducted in Bangladesh using interviews with women who gave birth in a health centre or at home, and with staff, as well as observation of provider-patient relations. The researchers reported that female paramedics who attended normal deliveries were praised for being caring, but made women deliver lying down, did not always use aseptic procedures and were too busy to give information, making birth a passive experience.  

**Rude and verbally abusive behaviour** is also often described. In a Zimbabwean study, women described how contributing reasons for not wanting to be referred to hospitals related to the rude, unfriendly, and abusive behaviour of the nurses: “Ah! Those ones at the referral hospital, they are very rough, they take their time to give you any assistance and they shout at patients. It is very bad.” [Mother, Gutu District, Zimbabwe]. In a quantitative community survey in Lusaka, Zambia, while 89% of women reported their care as "good" or "very good", 21% remembered someone who had treated them badly during labour, principally by shouting

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or scolding.\textsuperscript{32}

In 2010-11 Human Rights Watch researchers interviewed 157 women who received maternal health services, or accompanied other women seeking such services, at public health facilities in Eastern Cape, South Africa, over the past five years.\textsuperscript{26} They also made observations, interviewed 30 nurses, managers and other key informants and reviewed laws, policies, official health strategies, and reports by academics, national and international organizations, and United Nations agencies. Their comprehensive report documented abuse and other risky practices by health workers during maternity care that compromised the quality of care offered to women.\textsuperscript{26}

In a careful qualitative study using FGDs with women, men and health staff to determine perceptions of delivery care in Nigeria, Asuquo et al report that “The majority of women in the four groups in the two communities abhorred the attitude of hospital staff towards patients.”, with examples of rudeness, shouting and scolding.\textsuperscript{33} Grossman-Kendall et al in their qualitative quality of care study of 19 women who had recently given birth in a referral hospital in Benin, found that many complained about not being able to ask questions or get any explanations, and being mistreated and humiliated by health personnel.\textsuperscript{34} Studies in Uganda and Bangladesh also reported women’s concerns about rude behaviour from MHCPs.\textsuperscript{35, 36}

Tanzania has a high maternal mortality ratio and a shortage of health care staff. There have been several studies of quality of health care and of patient’s satisfaction with services. In one evaluation of community satisfaction with primary health services in the Morogoro region of Tanzania in 1992, the poor attitudes of health staff were cited as major criticisms of local health services: “Mothers used to go to the clinic but the MCHA (maternal and child health aide) was not polite to them. For example, when you put you card on the table, the nurse used to say, ‘Look! Your card is very dirty and it has got a bad smell. She would throw down the card and say ‘I cannot examine you!’ Sometimes we mothers face a lot of problems.” [Woman, southern Tanzania].\textsuperscript{18} In a 2007 combined quantitative and qualitative study of the factors that influence


home delivery in Tanzania, poor staff attitude was perceived to exist in most health facilities; including abusive language, denying women service, lacking compassion and refusing to assist.\(^{37}\)

On the other hand there are other studies from Tanzania that have showed a better picture, showing that poor attitudes are not inevitable. In rural southern Tanzania, Mrisho et al found in a 2009 study that nearly all women expressed complete trust in MHCPs and the care they receive at antenatal clinics.\(^{38}\) Another study using FGDs to examine perspectives of health care providers, Maasai and Watemi women, community members, and TBAs on antenatal, delivery, and post-natal care in Ngorongoro, Northern Tanzania, in 2009, found that women described health care providers at the clinics and hospitals as well trained, competent, and compassionate:

"I delivered my second child at Wasso hospital and the care was very good. I'm sure most women here have the same opinion [most women nod to show that they agree with her]. My husband sent me there because I had some problems. I was weak and my lower abdomen was painful. I tell you I'll never forget the courteous welcome and care I got. I vowed that my subsequent deliveries will all be at this hospital. My husband did not allow me to go there for delivery in my third pregnancy because I had no problem. I felt disappointed." [pregnant Maasai woman FGD].\(^{39}\)

Another recent study in Dar es Salaam, Tanzania, comparing the competence of MHCPs in ANC in the private and public sectors, also found that inter-personal skills were generally good.\(^{40}\) They undertook a quantitative survey, interviewing and observing consultations with 166 women in public services and 188 in private facilities. In a rare attempt to quantify inter-personal skills they used an observation checklist which included: ‘Making women comfortable’: Seat offered; ‘Health worker-woman interaction’: showing interest, non-interruption of woman’s speech, politeness, asking about woman’s concerns; ‘Privacy’: Door closed during consultation; ‘Explaining procedures to the women’: Explaining before examination, explaining of diagnosis, explaining use of prophylactic drugs. Seats were offered


\(^{40}\) Boller C, Wyss K, Mtasiwa D, Tanner M. Quality and comparison of antenatal care in public and private providers in the United Republic of Tanzania. BMC Health Serv Res. 2010; 10: 319.
to 89% of the women attending public facilities and to 93% in private ones. The door of the examination room was closed in 81% of consultations in the public sector and in 99% in the private sector. Women were invited to talk about their medical concerns in 71% of consultations in public facilities and 81% in private ones. The median summary score for interpersonal aspects was 11 out of a possible 16 (range 4–16) for the public sector and 13 (range 5–16) for the private sector. The authors did acknowledge the possibility of observation bias, although fieldworkers were discrete and staff did not know in advance that the fieldworkers would visit.\textsuperscript{40} In a similar quality of care study MHCPs were observed “usually interacting with their clients in a friendly and joking manner.”

**Physical abuse** appears to be a worryingly common experience for many women.\textsuperscript{41} The problem was mentioned in the WHO World Report on violence and health in 2002, which noted that it has been a much neglected issue.\textsuperscript{42} For example, one woman in Benin described how: “They asked why I could not stay still to give birth, and they started to beat me. That’s when I got mad and I left to give birth in the Maternité X (another facility).”\textsuperscript{34} In the South African Human Rights Watch report physical and verbal abuse by MHCPs was reported by more than half of the women interviewed.\textsuperscript{12} At least 30 women reported that nurses pinched, slapped, and handled them roughly during labor. Physical abuse can also take the form of refusing treatment, such as pain medicine for abortion care\textsuperscript{43} or over-medicalisation, such as undertaking unnecessary Caesarean section, noted in Latin America\textsuperscript{44}, and in Africa.\textsuperscript{34,45,46}

**Lack of respect, humiliating behaviour and lack of control** are also frequent complaints in these studies. For example, one woman in the Ugandan study said: “Once you go to deliver in a hospital you are treated like a child or a fool, in total disregard of your age, experience or status. Imagine a young nurse, old enough to be your granddaughter telling you how to lie down or when and how to push…Why should I be treated as a helpless and passive patient? After all, the pregnancy and its consequences are my personal concern and not anyone else’s.” [Mother with both traditional and hospital birth experiences, Hoima, Uganda].\textsuperscript{23}

\textsuperscript{45} Kyomuhendo G. B. Low use of rural maternity services in Uganda: Impact of women’s status, traditional beliefs and limited resources. Reprod Health Matters. 2003; 11(21): 16-26
Studies in Benin\textsuperscript{34} and Tanzania\textsuperscript{46,18,37} also found that the young age of health care workers and their lack of respect for age hierarchy were given as reasons for avoiding hospital or clinic delivery: "...the health care workers are very young compared to us, so I can never be naked in front of those child-health workers, I will just deliver at home." [Rural woman, Tanzania].\textsuperscript{46}

Jaffre et al in a study in Niger heard that some women were forced to clean the room after delivery for not acting ‘appropriately’ during labour.\textsuperscript{47} Similar humiliating experiences were described in D’Ambruoso et al’s Ghana study: “She (the midwife) said because of the pushing I had a soiled pad and so she ordered that I should go and dispose of it myself. In fact this was difficult, but I had to crawl to the disposal bin.”\textsuperscript{24} and from Zimbabwe: “I vomited during the night and I was in labour. The nurses asked me to clean the mess. I could not do it because I was in pain.” [Mother, Zimbabwe].\textsuperscript{31}

There are also reports of MHCPs showing disrespectful attitudes towards TBAs as well as to their patients. Izigburo et al, in their qualitative study of TBAs’ views, heard that when escorting their clients to the hospitals they had been humiliated by nurses and doctors who called them names and referred to them as quacks.\textsuperscript{48}

There are similar reports from other regions of the world. Mohammad-Alizadeh S et al., in their study in Iran, found the desire to be treated with dignity and respect emerged as the most important theme for women attending family planning services.\textsuperscript{28} Similarly, in a quantitative study in Bogra District in northern Bangladesh investigating client satisfaction with a number of health services, including family planning and maternal services, multivariate analysis revealed respect and politeness from the service provider to be the most powerful predictor of satisfaction, above competency.\textsuperscript{49} A prospective quantitative study to understand the care seeking responses to intrapartum morbidities was conducted in Karnataka, India. Questionnaires were administered to 388 women both during pregnancy and immediately after delivery. The attitudes and behaviours of MHCPs were not asked about specifically but the authors did note that the insensitivity with which women are treated makes them averse to institutional, or medically attended deliveries.\textsuperscript{50} Whittaker, in a detailed case study based on ethnographic work


in Northern Vietnam illustrating women's perspectives of reproductive human rights also found repeated instances of mocking and scolding behaviour by health care providers “They scold us saying ‘Why don’t you wash – why do you let it (the genital region) become so dirty and very smelly…’ The health workers say harsh words which make the women lose their self respect.” [Woman, Viet Nam].

Whittaker noted that such behaviour feeds women’s fear and erodes their dignity, contributing to a ‘horrible experience’ where ‘women feel scared and afraid’. Another Vietnamese study examining both quantitatively and qualitatively the quality of abortion services in the main maternity hospital in Hải Phòng noted similar scolding and disrespect for the patients. In 2002, a qualitative study was undertaken to identify perceptions, beliefs, barriers and strengths relevant to the utilization of ANC by women in the urban, periurban and rural communities of Goroka, Papua New Guinea. Although there was a high level of satisfaction with services, the attitude of health care workers was one of the most significant concerns raised by the women. Shaming or condescending attitudes of health care workers were described, for example, in relation to the women not having washed before attending for their visit, not wearing convenient clothing, having too many children or missing a visit: “If a nurse is angry at me she should talk to me quietly inside the room on my own. This practice of theirs to get angry at me when I am outside with all the other women is not a good one.” [Pregnant woman, PNG]. Garner et al in an earlier study also reported similar problems.

In a small quantitative survey of 220 women with childbirth experience in Yemen, the researchers reported that while personal empowerment at birth is very important to Yemeni women, the women’s perceptions are that skilled birth attendants worked against their personal authority, did not give them emotional support, and did not answer their questions or requests. Most chose to deliver at home because of fear of bad experiences or prior bad experiences of institutional deliveries.

Miller et al undertook observations and reviewed records at 14 facilities in the Dominican republic in the Caribbean. They found evidence of ‘compassion fatigue’ among busy MHCPs

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and that the birthing process was ‘dehumanized’. Foster et al, in their participatory research in the Dominican republic, also found that women and their families feared hospital care and felt disrespected.

But in the study in Indonesia the trained village midwives were perceived as diligent, kind, friendly, responsive, alert and willing to provide health services. And in a combined quantitative and qualitative study in Vietnam the researchers noted that, in general, interpersonal communication skills and conduct of health personnel at commune health centres were highly appreciated. However, there were some descriptions of humiliating and disrespectful behaviour: “Once an assistant doctor examined my pregnancy. She asked me whether I had a bath before going to clinic that really made me embarrass. After examination, I asked her to explain further my pregnant status and why I had to take so many drugs. She did not answer me as if she did not hear what I said. When I asked her again, she shouted at me ‘why do you talk too much’ and repeated ‘you have to take a bath before going to a commune health centre. [Woman, aged 19, delivered at home]. This was in contrast to the care provided by TBAs: “She was a very kind person. She assisted many women in the village to give birth but never asked for money. Her hands were so skilful and she always encouraged me as my mother.” [Woman, aged 25, delivered at home].

Sometimes MHCPs are reported to display judgemental and punishing behaviour. In a qualitative study in Tanzania of community satisfaction with primary health care services, MHCPs in family planning units were criticized by the women attending the clinic for appearing to disapprove of their behaviour. One woman noted: “When I go to the clinic I am asked, ‘why are you giving birth so soon after your last child?’...” [Woman, Tanzania] Another woman described how she was made to pay money for (normally free) vaccinations by the nurse at the local clinic as punishment for delivering her baby at home. Women who appear to violate perceived social or moral conventions, such as having sex at a young age or choosing an abortion may be treated badly. Women who have had an illegally induced abortion are in some instances refused pain relief when they seek care at health facilities as a method of

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punishment. One doctor in Kenya was reported as saying: “I don’t spare these young girls who become pregnant. They should be made to feel the worst pain so that they can fear having sex aimlessly.” Stories of midwives telling women that they enjoyed making the baby and should not complain about labour pains were frequent. For example, the South African Human Rights watch study reported a 20-year-old woman saying that when she was in labour at a community health centre: “The nurse pinched me really hard on the thighs as she was abusing me. She told me, ‘it was very good when you were making the baby. Open up.’”, and a Peruvian mother interviewed in a study by the Center for Reproductive Rights reported: “The nurses and technicians yelled at me, ‘Who forced you to have kids? What were you expecting? You should have thought about it before you did it. If you open your legs to your husband, get ready to give birth’.”

In the Vietnamese study mentioned above, women having a third child or more, or becoming pregnant soon after a previous delivery, reported being criticized or discriminated against by the health workers, who were responsible for keeping population growth under control: “I was so ashamed during the pregnancy when some neighbours and health workers criticized me. When I went for antenatal care at the commune health centre, everybody pointed at my belly and laughed at my face. My husband recommended me to deliver at the commune health centre, as I was not young anymore. But I did not want to go there. I chose to deliver at home because it was a lot easier.” [Mother of 3, aged 38].

The Center for Reproductive Rights and Federation of Women Lawyers gathered the experiences of over 120 women through a combination of in-depth interviews, FGDs, and questionnaires in 2006-2007. There were reports of women being detained within health facilities if they were unable to pay their bills. As a result of this newly delivered women were obliged to sleep on the floor, were underfed, and abused by staff for their failure to pay. As the authors note: “For women whose babies have died, there is a particular psychological cruelty to being detained in a maternity ward, surrounded by other mothers and their infants.” Field research for a human rights and accountability enquiry into maternal deaths in Nigeria also

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found that detention after childbirth for mothers who cannot pay user fees is common.  

**Lack of attention to privacy and confidentiality** is also often cause for concern. In the Bangladesh study mentioned above, the second most powerful predictor of client satisfaction was attention to privacy.  

Women visiting the clinic for maternal or reproductive issues were especially likely to report privacy as important. However, privacy was achieved for less than half of these individuals. In the Iran study mentioned above, lack of privacy was also noted as a key issue for the women attending the clinics in both low and high income areas. Study participants acknowledged structural issues such as lack of space, but also noted instances of thoughtlessness: “In the midst of all the people and from a distance of some metres, she asks me: ‘What’s your problem?’ Nobody would reply: ‘I have a (vaginal) infection’ in front of all those people...I wanted to tell this lady: ‘Go and sit in your room so that I can come and tell you my problems!’” [Woman, Tabriz, Iran]. Whittaker also found that women in Vietnam found lack of privacy upsetting, although they might not reveal this: “Many women think that the reproductive organ is a secret organ. So we don’t want to show others - to let them see it. We are very shy and ashamed when we have an examination ... Maybe we show a normal attitude on the outside but in fact we are very shy and ashamed on the inside.” [Woman, Viet Nam]. Breaches of confidentiality were also found to be common in this study: “After the mobile clinic, the chairman of the Commune People’s Committee (male) and the President of the Commune Women’s Union were in the health station staff room. They were checking the records of the clinic, noting who had visited the clinic and what service they had received”.  

Lack of privacy in some of the health facilities was also mentioned as a contributing factor for home delivery in Mrisho et al’s large qualitative and quantitative study in southern Tanzania, and some young women avoided delivering at health facilities because of the presence of male health workers during delivery: “Some health facilities have no special room for delivery; the room is small and all treatment for both men and women are taking place in the same room; you can easily be seen while giving birth.” [Mother, Kilimaheawa village].  

Issues of privacy and confidentiality are especially important in relation to HIV infection.

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prevention and care. There are now many studies that have highlighted that, although many HIV positive women are satisfied with their care, problems in relation to breaches of confidentiality and discrimination are common, especially within reproductive and maternal health care services. For example, in a qualitative study from Karnataka, India, recently delivered positive women reported experiences of lack of confidentiality by staff, refusal for treatment, abusive behaviour, and moral judgment: “During the delivery, there were two nurses and they did not even touch me during delivery even when I was suffering from pain... Even when I was bleeding they did not come to my help. They scolded my grandmother to wipe the blood, and they even did not touch my child.” [26 year old].

In 2011, the Women’s Program of the Asia Pacific Network of People Living with HIV with the Regional Treatment Working Group conducted a study on HIV positive women’s access to reproductive and maternal health care and services in six Asian countries: Bangladesh, Cambodia, India, Indonesia, Nepal, and Viet Nam. The study assessed the experience of accessing reproductive and maternal health services as reported by HIV positive women over 16 years of age and pregnant in the past 18 months. The study used quantitative and qualitative methods: a survey among 757 women, 17 interviews and 10 FGDs. Overall 37.8% of the women who received maternal health care said they were dissatisfied with the treatment they received and 18.0% stated they were dissatisfied with the confidentiality afforded to them. The researchers reported that many women were coerced into an abortion and they faced considerable discrimination when they went for the procedure.

There were many reports of discrimination during ANC: "We are offered the same services as negative women but we are treated differently. The healthcare worker won’t sit on the same chair that I have sat on or use the same pen. When they look into my mouth to examine my throat they stand far away and won’t touch me. The doctor also has a security guard with her because she’s afraid that positive people might harm her though she has never been attacked. We want to be treated the same as everybody else." [Positive woman, Viet Nam].

There were also accounts of discrimination at the time of the delivery from the HIV positive women in all the countries except Bangladesh. Their stories included being neglected by staff before, during and after their delivery, and staff abusing the woman when she was in labour for getting pregnant. Women were sometimes left alone in labour, with stories of staff refusing to touch them. Some of the women reported that they were coerced into being sterilized against their wishes.


63 Asia Pacific Network of People Living with HIV. Positive and pregnant: How dare you. March 2012. Available at: www.womenandaids.net/.../Positive-and-Pregnant--How-Dare-You
However, there is some evidence that over time problems of breaches of confidentiality and poor health care provider attitudes have diminished. In a mixed methods study of a purposive sample of positive women in Burkina Faso, Kenya, Malawi and Uganda in 2011, 25% reported that they were ‘made to feel bad’, but only one woman said that health workers had ignored or avoided treating them. Most (85%) felt that the health workers and counsellors respected their desire for confidentiality by protecting their results. In 2011, Winestone et al undertook qualitative interviews with 36 healthcare providers in Nyanza Province, Kenya to explore their views on integrating antiretroviral therapy for HIV with ANC. One of the points made by the MHCPs was that integration would lead to closer provider-patient relationships and increased patient satisfaction, although they had concerns about increased workloads.

2. Influences on the attitudes and behaviour of maternal health care providers

Why do health care providers so often seem to demonstrate attitudes and behaviours that prevent them working effectively? Review of the literature suggests a range of interrelated reasons. It is important to understand these reasons in order to plan effective strategies to overcome these attitudes and behaviours. Jewkes et al in a significant qualitative study of this question in the South African context make the point that “Nurse-patient relationships are a substantially neglected area of empirical research.”

2.1 Differences in knowledge and understanding of childbirth

One of the reasons that some MHCPs display negative attitudes and behaviours, and that their patients fear this when they attend health care services, is because there is often a great difference in the way each side views and knows about pregnancy and childbirth. There has long been discussion about the adverse consequences of the medicalisation of childbirth. Childbirth is a natural physiological process, of great cultural and gender significance, but also one in which unexpected and life-threatening complications occur in a substantial proportion of women without risk factors. To reduce deaths of women and infants skilled attendance at delivery within reach of emergency obstetric care is vital. It has been estimated that the presence of

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skilled birth attendants at delivery could reduce between 13 and 33% of maternal deaths. But this produces an inevitable tension between traditional cultural expectations and rituals, and the requirements and rituals of the health care services. In developed countries in recent decades there has been a gradual transformation of normal birth in hospitals with home-like birthing rooms and more emphasis on informal, friendly, supportive care by midwives. Unnecessary and often harmful routines such as enemas, shaving, infusions, continuous monitoring, delivery lying down, episiotomies, separation from husbands and family members, and separation of mothers and babies after birth have been abandoned. But in many developing countries the shift from homebirths to facility births is relatively new, or still underway, and it is understandable that there are conflicts between the different knowledge of the MHCPs and the women they care for.

Differences in cultural understandings between MHCPs and their patients may also underlie judgemental attitudes and behaviour. Concern that traditional practices might have dangerous consequences, and result in blame on the midwife, may adversely affect the caring relationship. For example, Kyomuhendo et al found that rural Ugandan women in labour were distressed when they were not allowed to give birth in their traditional kneeling position: “There is no way I am going to deliver women in that position. What if the baby dies? Who will be responsible?” [Maternal Health Worker, Hoima, Uganda]. In a small qualitative study in rural Nigeria, Gazali et al found that modern midwives have little tolerance for traditional beliefs about childbirth such as delivering in a squatting position, not crying out during delivery, and burying the placenta to ward off evil spirits, and as a result there are frequent conflicts in health centres. Jaffre et al, in their report of a qualitative study in Niger, refer to the mutual relationship between women and midwives. They make the point that both women and midwives are constrained by the same cultural and social norms, such as the need to show respect, language taboos about naming body parts, and shame. But midwives explained that in order to provide modern clinical care during labour and delivery they are required to break these norms which damages the relationship with their patients, which often degenerates into an open

confrontation’. In Kwazulu, South Africa, many of the midwives said that they themselves suffered abuse from patients who did not understand the patho-physiology of labour. One nurse complained ‘they don't care about us...the community is having a bad attitude towards nurses’. A qualitative study of women’s and health-care providers’ views of maternal practices and services in rural Nigeria also highlighted this conflict between traditional and modern maternal health care perspectives, the impact on care and the consequences for health outcomes.

The gulf in cultural understandings that can exist between MHCPs and patients or clients is also illustrated by a study of the perceived quality of emergency obstetric care by indigenous Maya in Guatemala. Through detailed observations of interactions between Mayan patients and the medical staff treating them at an emergency hospital department in Sololá, in the highlands of western Guatemala, the author highlighted the problem of discordance between local expectations of care (including expectations by the Mayan community that they will not receive good care) and modern medical care. For example, expectations by indigenous Mayans that they will ‘not be attended’ meant that even a short waiting time was seen as neglect. Fasting before surgery goes against Mayan traditional beliefs that food provides strength and nourishment, especially during pregnancy. In a qualitative study in the Gambia to inform strategies to avoid exposure to harmful medicines in early pregnancy, Stokes et al conducted 41 interviews and 16 FGDs with women, adolescents, men and TBAs. They found that for a variety of cultural reasons women were often reluctant to tell others about a pregnancy. They feared that gossip about their pregnancy may attract evil spirits resulting in abortion, or that they would be judged for becoming pregnant while single or still breastfeeding. It was also important to them that they be the first to tell their husband. These fears resulted in pregnant women delaying their first antenatal visit and not disclosing pregnancy to health workers. Frustration at this behaviour led to breaches in confidentiality by MHCPs. For example, upon discovering his patient was pregnant, one male health worker reportedly refused treatment until the woman registered for ANC, forcing her to disclose her pregnancy.

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71 Okafor CB, Rizzuto RR. Women's and health-care providers' views of maternal practices and services in rural Nigeria. Stud Fam Plann. 1994;Nov-Dec;25(6 Pt 1):353-61.
2.2 Lack of an enabling environment

Poor working conditions including heavy workloads, poor remuneration, lack of supportive supervision, weak management, and lack of equipment and supplies are especially common causes of stress that affect interactions with patients. A descriptive, qualitative study assessed the quality of care of MHCPs in the labour ward of a Palestinian public referral hospital in the Occupied Palestinian Territory. The in-depth interviews with 31 MHCPs uncovered that the factors influencing the poor quality of care poor service were high workloads, low pay, poor supervision, lack of supportive guidance, and being humiliated at work. The study found the responsibilities and duties of midwives greatly exceeded those of both doctors and nurses. Despite their high level of education, they also reported the lowest salary. Some of the midwives described themselves as ‘machines’: “They give us workloads that are extremely exceeding our abilities as individuals and humans. It’s insane!” [Midwife, Occupied Palestinian Territory]. Many of the midwives acknowledged that this stress makes it difficult to communicate with patients and their families; they also admitted feeling exhausted and ‘displaying harshness’ while providing care. In addition, humiliation and abuse by doctors, other staff and the patients themselves contributed to the stress of these MHCPs. They reported that being shouted at caused them to feel insecure and devalued. In South Africa, too, researchers heard from several nurses and facility managers that systemic problems such as understaffing, poor pay, heavy workloads, and lack of equipment and medical supplies contribute to negative attitudes, abuses and poor quality of care. One midwife said: “I know we are not always right, but the department forgets our problems. You work so hard and there is no appreciation. At the end of the month you earn peanuts.” Some managers were aware that poor behaviour often results from excessive stress: “The nurse asked the client about her HIV status and an argument ensued. The sister slapped the client. It was a busy time and we had gross shortage of staff on that day. We had many complicated cases and were preparing women for theater. So everybody was stressed.”

In the study of care at the Calabar Hospital in Nigeria, doctors and nurses explained that they find their jobs frustrating, they lack equipment and supplies, receive poor pay and as a result have no job satisfaction. A qualitative study among MHCPs in a number of hospitals in Tehsil Pindi Gheb, District Attock, Pakistan, found that heavy workloads, absence of managerial

\[74\] Hassan-Bitar S, Narrainen S. ‘Shedding light’ on the challenges faced by Palestinian maternal health-care providers. *Midwifery* 2009; doi:10.1016/j.midw.2009.05.007
support and poor remuneration often led to high rates of absenteeism and malpractice. Many health care providers undertake private practice to make ends meet, which can result in conflicts of interest, competition, and poor behaviour towards patients in public facilities. In South Africa there have been reports of MHCPs asking for bribes, and some of the hospital midwives interviewed admitted that nurses accept money or lunch offers, especially from migrants. Where corruption is common in society and pay is low it is not surprising to find that it occurs in health care facilities. Van Lerbergher et al have called practices such as moonlighting, asking for unofficial payments, moving to the private or NGO sectors, or abroad, individual “‘coping strategies’” of underpaid staff, and argue that they need to be more openly and honestly discussed. They note that these activities can jeopardize the necessary trust between user and provider.

### 2.3 Class prejudice and stereotyping

Lack of knowledge may combine with class prejudice resulting in stereotyping and discriminatory attitudes. For example, in her case study from Vietnam, Whittaker describes a revealing role-play of a reproductive health consultation when one group decided the role of the women with vaginal discharge should be played by the only woman in the team with traditional commune dress, as the other women in the group were ‘pretty and dressed too well to have a discharge’. Health care providers may make assumptions about their patients. For example, Whittaker noted that some providers rationalised that many Vietnamese women live communally and that privacy is not therefore important to them. However, interviews with the women indicated that this assumption was mistaken. Prejudice and judgemental attitudes were also evident in Jewkes et al study in South Africa. They found that the views some midwives held that certain women should not be having children, for example because they were too old, too young, unmarried or had too many children, resulted in harsh and disrespectful behaviour. Jewkes et al found a general underlying belief among MHCPs in the inferiority of patients that determined their inter-personal relationship with them, in order to maintain their own middle-class, educated identity. They proposed that treating patients in a rude or abusive manner enables MHCPs to feel more powerful themselves, and that this culture is able to persist because of a lack of accountability and lack of good management practices.

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2.4 Feelings of superiority in relation to socio-economic status and ethnicity

Our review suggested that feelings of superiority can result in discriminatory behaviour towards patients. Attitudes and behaviours of MHCPs often reflect the broader societal prejudices, for example in relation to poor people, people living with HIV, and to foreigners or minority ethnic groups. Jewkes et al found race and class differentials between patients and providers in a South African obstetric hospital to be significant explanations for abusive behaviour. Verbal abuse often followed instances where the MHCP’s authority was challenged, and was used as a tool to restore the power hierarchy. The Human Rights Watch study in South Africa on quality of maternal health care also found that migrants and refugees were especially likely to experience lack of sympathy, abuse and neglect by maternal health staff. Another Human Rights Watch report from South Africa in 2009 also noted that: “The most serious barrier to health care access for asylum seekers, refugees and undocumented migrants is discrimination by individual health care providers … simply for being foreign.”

In the Vietnamese case study in reproductive health clinics, one woman noted that health care workers “…will only speak to the poor for one or two sentences. They let us sit, we joke, like a ‘flu go’ (a dog sick and miserable with the flu) sitting in the corner” [Woman, Viet Nam]. A study in Northern Thailand revealed examples of preferential treatment to higher-earners, and in Tanzania rural women described preferential treatment given to people from the town. One woman commented: “…drugs are for those with power, money, rich people…” [Rural woman, Tanzania]. In another qualitative Tanzanian study the women mentioned their belief that knowing the health care providers makes a difference to the way that they are treated: “the distribution of drugs (there) is based on friendship. As we do not belong to that village we do not get proper treatment.” [FGD with a women’s organisation, Tanzania]. Asuquo et al in their qualitative study of obstetric care in Calabar, Nigeria, similarly heard: “Doctors and nurses only pay attention to their friends and relatives or those ‘who have seen them privately’. Lack of ability to pay unofficial charges is another reason that MHCPs may neglect patients they perceive to be poor: “There are two doors – the front door and the back door. Those who use the back door are known to the RMA (rural medical aside) or they are those people who pay

something. When you go there they tell you there are no drugs but those known to them or those who gave them money get treatment.” [Schoolchild Tanzania].

In many countries the social status of nurses and other health care providers may be viewed as higher than that of patients by both the health care providers and the patients. In hierarchical societies, especially, this may influence the respect and dignity that MHCPs display towards their patients. A study using qualitative and quantitative methods assessing the quality of abortion care in the main maternity ward in Hai Phong, Viet Nam, found that almost all the women surveyed (92%) reported being treated respectfully by staff. However, long waiting periods did upset some women and they felt unable to question this because of their lower status: “I am fretting from having to wait too long but I just didn’t dare to ask her at that moment because I was afraid that she would blame me for disturbing her. I though it was better to wait until she came back.” [Woman, maternity hospital, Hai Phong, Viet Nam].

Doctors, nurses and midwives may find opportunities to demonstrate the power they have in relation to patients. For example, in this study, one doctor frankly admitted: “...I sometimes disappear for a quarter or half an hour. Indeed, I have nothing to do, but that is the way we (health staff) let them know who is superior here.” [Doctor, maternity hospital, Hai Phong, Viet Nam]. The qualitative study in hospitals in the Punjab, Pakistan, found managerial power assertion was a common concern among MHCPs, as did the study of Palestinian health care workers. A study in Sao Paolo, Brazil, found that labour was sometimes induced or unnecessary caesarean sections were performed so that the delivery did not interfere with the HCWs social or work schedules. Indeed in Uganda, southern Tanzania, and Benin the women interviewed reported feeling that they were hurried into unnecessary surgery: “…I hadn’t even pushed for a long time, and was still feeling strong. Yet they took me to the theatre and cut me. I feel they just wanted me out of the labour ward…Even now I am suffering with the incision scar.” [Women, Mparangasi village, rural Uganda] and “…they never wait to see whether you can deliver normally, but they hurry in doing an operation on you.” [Rural woman, southern Tanzania].

2.5 Frustration at patients’ behaviour

In their study to determine perceptions of delivery care in Calabar Hospital in Nigeria, Asuquo et al reported that the hospital staff acknowledged that their attitudes were negative ‘most of the time’, and ascribed it to their frustration at women coming too late to the hospital, for example,

79 Diniz SG, Chacham AS. The cut above” and “the cut below”: the abuse of caesareans and episiotomy in São Paulo, Brazil. Reprod Health Matters. 2004 May;12(23):100-10.
coming for an elective Caesarean only after hours in labour at home. They also complained that patients came without funds to pay for ‘consumables’. At a quality improvement workshop in Uganda an MHCP explained: “Despite all of the problems women face, health workers are often frustrated when women come at a late point in their illness to the dispensary. When this happens, health workers sometimes see women as negligent and incapable of dealing with their problems, and this causes them to be scornful of the patient.”

### 2.6 Gender inequality

Gender inequality and discrimination shape the interaction between patients and health care providers in a number of ways. Gender also interacts with class and ethnicity in influencing the relationship. Govender and Penn-Kekana undertook a thorough review of this issue for a background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health. D’Oliveira et al in their review of violence in health care settings make the point that in many societies, women have a low status and are seen as needing discipline and control for their own good. They suggest that these ideas can be interpreted in health-care settings as legitimising use of violence by staff to control female patients’ behaviour. Gender discrimination towards MHCPs from managers, coworkers, patients and the public themselves can result in MHCPs taking out their frustration on their patients. In the study in Pakistan, the women MHCPs repeatedly expressed their discomfort at sexual advances and abuse from senior (male) staff, and from the public. One woman described the effect this in turn had on her work: “When I leave home to come to the Basic Health Unit. I need to travel by local transport, and there are men who offer a lift or pass comments. I feel so bad and insulted that when I reach the Basic Health Unit I misbehave with my patients.” [Lady Health Visitor, Aged 24]. In their study in Palestine, Hassan-Bitar and Narrainen heard that the MHCPs (all women) were at the bottom of the health professional hierarchy and reported abuse from the male doctors. They admitted feeling exhausted and ‘displaying harshness’ when providing care. In a study in two hospitals in Turkey, 62% of 251 nurses surveyed said they had been subjected to sexual harassment in the workplace, and this was severe enough to affect their productivity at work. The harassment included sexual testing,

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jokes, remarks and pressure for dates, and came from both doctors and patients. Sexual harassment of female health care providers by male doctors has also been reported to be a problem in Pakistan.

Cultural restrictions on women’s behaviour can also lead to conflicts in the work of a health care provider. Many of the MHCPs in the Pakistan study described how the fear of judgement affects their interpersonal communication: “People make scandals very quickly. Even if you just smile at a patient, they become suspicious of your character.” [Lady Health Visitor, aged 32]. As a result women admitted adopting a strict attitude towards patients to avoid being labelled as ‘easy’.

MHCPs themselves may have sexist attitudes that negatively affect the way that they treat women patients. For example, in the case study of Vietnamese reproductive clinics, while role-playing a ‘bad’ consultation a male doctor abruptly finished his consultation as an example of poor provider behaviour, but then said: “Actually with a woman this good looking I would probably spend all day with her”. [Male doctor]. Whittaker reported similar experiences in North-eastern Thailand.

2.7 Cultural and workplace norms

Wider cultural norms influence the degree of courtesy, politeness and respect with which women are treated. Nigenda et al studied pregnant women’s opinions of ANC in four ‘developing countries’ in the context of a randomised controlled trial to test the benefits of a new ANC protocol. They reported that in Thailand, where courtesy is an important cultural value, most women had been treated with respect, as had Saudi women. However, some of the Argentinian women did have complaints of rude treatment.

Within maternal health care facilities norms of behaviour and attitudes develop and influence new staff. Jewkes et al suggest that, while sometimes health care providers are simply reacting to a stressful situation, some adverse behaviours have become ritualised within the health care system.”

service, with new health care workers learning norms of behaviour from others. There is sometimes a view among midwives that it is necessary to be forceful when women are in labour. One South African midwife at a community health centre said, “These days we do not pinch, but truly speaking you cannot get soft in the labor ward because women don’t do what they are told to do.”

2.8 Implications of the HIV epidemic

The HIV epidemic has inevitably had a large influence on the working environment of MHCPs, especially in high prevalence settings. Turan et al have made the point that the new role of midwives in the prevention of mother-to-child transmission of HIV requires significant additional time, energy, and dedication on the part of MHCPs. They interviewed 18 MHCPs in Kisumu, Kenya to learn about the impact of the HIV epidemic on their work. The MHCPs mentioned increased workload and stress as a result of loss of staff and absenteeism, as well as their new additional tasks. They acknowledged that this often makes them tired and irritable and affects their behaviour towards their patients: “So you find that instead of seeing maybe five to seven clients per day, you will attend to more than twenty clients. Obviously you will get burnout so you might find yourself loosing your temper with something very simple. It can be a comment or anything and you might not want a client to ask you so many questions for clarification. You just want to finish quickly with her so she goes on to the next service. So at times nurses or those who are attending to clients become somehow negative in their attitudes towards clients.” [Nurse-midwife, maternity unit, health center]. They were also aware of breaches of confidentiality, attributing these to the overcrowded conditions about which they feel powerless: “I have said that we are offering PMCT services. But still I should say that it is not a good standard yet, in terms of confidentiality. Actually at [name of health facility] the rooms are so squeezed and we don't have enough rooms or enough space. So you find that confidentiality becomes very difficult. [Nurse-midwife, maternity unit]. They also talked of the fear of occupational exposure, despite acknowledging improvements in infection control procedures: “There is that fear that you may contract it. In case there is an accident, for instance, in the operating theatre. It is just that you work with a lot of fear. The problem here is that you can get infected because of the nature of our work, but nobody will understand that you got it because something pricked you. People will only see the promiscuity in you.” [Nurse-midwife, maternity unit].

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private maternity hospital]. Some spoke of their work with pride and mentioned the respect with which they are treated.\textsuperscript{85}

Several other studies of MHCPs’ attitudes in areas with high prevalence of HIV suggest that fear of infection through occupational exposure may underlie discriminatory behaviour.\textsuperscript{86,87,88,89}. For example, in their Kisumu study, Turan et al also interviewed 14 pregnant or postpartum women, four male partners and two TBAs, and made structured observations at 22 births in Kisumu.\textsuperscript{90} They noted that MHCPs were not adequately prepared to handle issues related to consent, confidentiality and disclosure. In this situation, where it is now common to know pregnant women’s HIV status, they found that women of unknown HIV status during labour and delivery seemed to be especially likely to be targets of stigma and discriminatory practices. Many of the MHCPs also expressed frustration towards positive pregnant women who were not willing to disclose their status to their husbands.\textsuperscript{90}

A quantitative survey of 780 health professionals and 840 pregnant women in China, where the prevalence of HIV is much lower than in sub-Saharan African countries, also found evidence of stigma and discriminatory attitudes among some professionals.\textsuperscript{91} It is interesting to note, though, that these attitudes were in fact less common among health professionals than among the pregnant women. For example, 23% of health professionals and 45% of pregnant women thought HIV was a disease of "low class and illegal" people, 48% of health professionals and 59% of pregnant women thought that HIV positive individuals should not be allowed to get married, and 30% of the health professionals were not willing to treat an HIV positive individual.\textsuperscript{91}

\textsuperscript{86} Mavhandu-Mudzusi A, Netshandama V, Davhana-Maselesele M. Nurses’ experiences of delivering voluntary counselling and testing services for peoples with HIV/AIDS in the Vhembe District, Limpopo Province, South Africa. Nursing and Health Sciences 2007; 9: 254-262
\textsuperscript{91} Hesketh T, Duo L, Li H, Tomkins AM. Attitudes to HIV and HIV testing in high prevalence areas of China: informing the introduction of voluntary counselling and testing programmes. Sex Transm Infect. 2005 Apr;81(2):108-12.
Figure 2. Summary of influences on attitudes and behaviours of maternal health care providers

3. Impact of maternal health care provider attitudes and behaviour

Many of the studies that include health care workers’ attitudes and behaviours refer to the various adverse impacts on patient care and health outcomes. Just as a friendly, informative and reassuring manner can help to reduce the existing fears of a patient, so an uncaring, judgemental or hostile attitude can exacerbate fears and inhibit people from seeking reproductive and maternal health care services, or from benefitting when they do. In recent years there have been many efforts in higher income countries to better understand women’s satisfaction with maternal health services, as part of attention to quality of care.\textsuperscript{92} It is recognised that satisfaction is a

\textsuperscript{92} Johnson M, Langdon R, Yong L, et al. Comprehensive measurement of maternal satisfaction: The
multidimensional concept and that ‘quality of the relations and communication between women and staff’ is one factor that influences satisfaction. Patient satisfaction is important because it has been found to influence care seeking, re-attendance, and compliance with treatment. Van Teijlingen et al have pointed out that it is difficult to measure satisfaction, including satisfaction with the attitudes of maternal health care providers, because women may have low expectations, fear that services may be lost if they criticise them, or because they are grateful to have a service at all. These factors are also likely to be relevant in low income countries. Peabody et al, in their chapter on improving the quality of care in developing countries, note that interpersonal relationships, cultural appropriateness, and gender sensitivity are major determinants of patient access and utilization. Gabrysch et al’s comprehensive literature review of the determinants of delivery service use found that ‘nearly all qualitative studies of service use report quality of care to be an important issue, with staff attitudes featuring prominently. They emphasise that many variables overlap. Concerns about quality (including staff friendliness, availability of supplies and waiting times) interact with other barriers, such as distance or cost. Higher maternal age, education, household wealth, urban residence and lower parity increase use.

3.1 Impact on care seeking behaviour for reproductive and maternal health services

Studies of maternal health care seeking behaviour reveal a range of context-specific influences including cost, distance, maternal education, cultural beliefs, and lack of autonomy of women. But it is striking that most studies also mention poor attitudes and behaviour of MHCPs and perceptions of this as significant barriers. This was most evident in studies from sub-Saharan African countries, but was also mentioned in studies of health care seeking behaviour from other parts of the world. In Manus island, Papua New Guinea, a questionnaire survey of MHCPs found that 68% of those interviewed admitted that their attitudes discouraged mothers from attending family planning services. And in Iran, FGDs exploring women’s perceptions of the quality of family planning care found some women, especially in low-income groups, did not return as a result of being verbally mistreated and humiliated: “She shouted at me ‘Why are you late for your childcare control visit’?...It’s now about a year and a half since I went to that centre. I prefer to buy pills from a pharmacy and not go there to be shouted at.” [Woman, Tabriz, Iran].

Simkhada et al undertook a review in 2008 of qualitative and quantitative studies of factors affecting attendance at ANC in developing countries. Significantly, they were able to identify only one study that looked at the effect of quality of services on their uptake. This was a qualitative study exploring women’s perspectives of ANC in Gutu district, rural Zimbabwe, which found that negative attitudes of service providers presented a barrier to care for the women, who described not returning after being scolded for missed antenatal visits. None of the selected studies in the Simkhada review examined women’s satisfaction with ANC. In a quantitative study in Bogra District in northern Bangladesh investigating client satisfaction with a number of health services, including family planning and maternal services, respect and politeness of the service provider was identified as the most powerful predictor of satisfaction, above competency. In a qualitative study of maternal and newborn health care seeking practices in Bangladesh, Nepal and Pakistan, however, the researchers only mention ‘staff attitudes’ as a barrier to seeking ANC in Pakistan.

In their systematic review of evidence in relation to access to and use of health services for the poor in Uganda, Kiwanuka et al also identified health worker attitudes as a significant barrier to use of health care services. In a cross-sectional survey of community satisfaction with the quality of maternal and child health services in 405 households in southeast Nigeria in 1999, long waiting queues, providers' behaviours and lack of doctors were found to reduce use of maternal and child health services. Vera, in a participatory research project in Santiago in Childe explored the meaning of quality of care among women receiving reproductive health services at a family planning and maternal and infant care clinic. The women defined high quality of care as “being treated like a human being.” Cleanliness, promptness and availability of service, time made available for consultation, learning opportunities for themselves and their partners, and cordial treatment were all of importance to them.

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The choice to deliver with a skilled birth attendant

Many women attend for ANC but choose not to deliver at a health care facility or to be referred when they suffer complications. Skilled attendance at birth is recognised as the single most important factor in preventing maternal deaths and disability, so this has significant implications for maternal and perinatal health outcomes.99 In an important editorial, Buttien et al urged that “Unless the two major challenges of health staff attitude and of availability of adequately skilled providers are addressed, skilled attendance will not move beyond rhetorics.”100

Mwaniki et al found, in rural Kenya, that, although more than 90% of women attended for ANC, only about half attended for delivery care, and lack of commitment by staff was one of several reasons given.101 Similarly, Grace Kyomuhendo aimed, in a qualitative study, to explore the reasons why many rural women in Uganda do not seek care when they experience complications during pregnancy or labour. She found that complaints of abuse, neglect and poor treatment in hospital, and health workers' views that women were ignorant were important reasons, among others, such as cost, distance, time away from home, and lack of autonomy. One mother remarked that despite the shortfalls of TBAs and family members, at least with them: “Nobody will restrain/rebuke you and sometimes the attendant will sympathetically cry along with you.” Many of the women said that they would therefore only visit a hospital as a last resort.45 Similarly, in a study from Ghana that interviewed trained TBAs, the TBAs reported that they often had to undertake high risk deliveries because patients did not want to be referred for fear of disrespectful or painful treatment from medical personnel.102 In the Benin study, too, women said they would avoid hospital care because of the condescending and disrespectful nature of the midwives.34 A mixed methods study of maternal health care seeking behaviour in a rural community in Edo State, Nigeria in 2004, also found that irregular availability of health care providers and their poor interpersonal relationships were a factor influencing pregnant women in choosing where they would deliver.103 And in a cross-sectional questionnaire survey of a random sample of 1,500 women who had delivered within the previous three months in Enugu

state in Nigeria in 2004, ‘promptness of care’ and ‘friendliness of staff’ were significant factors affecting use of maternity services.\textsuperscript{104} The Human Rights Watch study in South Africa was another that reported that women’s experiences influence them to avoid delivery care, illustrated by one woman who had given birth in a large hospital in 2009: “The nurses were shouting and pinching us on the thighs telling us to open up. After delivery, I was feeling very weak but the nurse told me to leave the bed [and to] carry the child to another ward. She was very rude and said I was lazy. After this experience I told myself I will never again go to government hospitals. If I have no money to go to a private hospital, I will deliver at home.”\textsuperscript{112}

In a study of maternal death audits with verbal autopsies in the Gambia, Cham et al found that poor provider attitude and fear of punishment by health care providers based on previous experiences can lead to delays in the decision to seek care when there is a complication: "She was vomiting throughout the night, the following morning the husband decided to take her to the health centre but she refused... ... ...she has not yet get an antenatal care card. She feared the nurses because if she goes to complain about the vomiting she will be asked the card and without it they [nurses] will tell her all salty words. She may be insulted or may even not be given medicine".[Midwife].\textsuperscript{105}

There have been several studies in Tanzania exploring the reasons that, although attendance for ANC is high, only about one third of rural women deliver with a skilled birth attendant. A 2000 study in southern Tanzania including semi-structured interviews with 60 pregnant women, 26 health workers and six key-informants, found that an important reason why rural women avoid the hospital is because they fear discrimination.\textsuperscript{46} In a mixed methods Tanzanian study in which women with obstetric fistula were interviewed, fear of humiliation from staff at the health facility had been an important factor influencing their decision to deliver at home.\textsuperscript{106} Kruk et al undertook an interesting quantitative study using the ‘discrete choice experiment’ method with a random sample of rural Tanzanian women to explore the relative importance of health service characteristics when selecting a health facility for childbirth.\textsuperscript{107} 1,203 women were presented with a choice of several competing hypothetical health-service scenarios, each characterized by

several attributes (distance, cost, provider attitude, availability of drugs and equipment, type of provider, and transport.). The women were then asked to select their preferred scenario. Of all the attributes in the study, ‘provider attitude’ (‘smiles and listens carefully’) had the greatest influence on women's decisions about which facility to attend. Availability of drugs and equipment was also very important.\textsuperscript{107} The same research team, reporting in a separate paper, found that mothers who had obtained their ANC at higher level government facilities or mission facilities, which offered better quality of care, were more likely to have delivered in a health care facility.\textsuperscript{108} The authors concluded that improving the quality of ANC may improve the health of mothers through encouraging women to return to facilities for delivery.\textsuperscript{108} In 2007 the same team undertook a study to assess women's satisfaction with home delivery attended by TBAs compared with facility delivery in dispensaries, health centres, and hospitals in rural western Tanzania.\textsuperscript{109} In their representative rural cluster sample of households from Kasulu District only 36.6\% of 1,205 women in the study gave birth to their last child at a facility; 37.0\% gave birth at home with a TBA; 23.7\% gave birth at home without a TBA (84\% of the women had delivered their last child within the previous 2 years). Interestingly, two-thirds of women who gave birth in a facility were very satisfied with their experience, compared to 21\% of women who gave birth at home with a TBA and 25\% who gave birth at home without a TBA.\textsuperscript{107} The authors noted that these positive experiences may have reflected earlier effective efforts to reduce maternal mortality in the region.\textsuperscript{110} The study did not include qualitative methods to explore the reasons for these levels of satisfaction with delivery care, and the authors noted that it is possible that the respondents may have been influenced by the socially desirable thing to say.\textsuperscript{107}

Sometimes patients will seek health care, but concerns about poor attitudes and behaviour by health staff result in them by-passing their nearest health facility to attend a government or mission hospital. Such bypassing is costly, time consuming and inefficient both for the women and their families, and for the health system.\textsuperscript{111} In a quantitative, questionnaire survey in rural Tanzania more than 40\% of poor women who chose to deliver in a health facility preferred to


travel to a government hospital or mission facility to deliver rather than deliver at their nearest primary care facility, and one of the reasons given was greater trust in the MHCPs at the distant facility.\footnote{111}

In the Ghana study of mothers’ perceptions, women expressed their wish to be treated with patience, encouragement and tolerance. They also said that they would seek alternative care if they experienced poor treatment, and recommend facilities when they receive good treatment:

“I wanted to deliver in (health facility C) but while attending antenatal clinic, a nurse was rude to me, so I changed my mind and delivered in another facility.” and “Compared with my previous delivery attendant this one was very good, polite, patient and reassuring. Therefore, I will recommend her.”.\footnote{24}

In a rare study seeking the views of TBAs, Izugbara et al heard in FGDs that the major reason given by TBAs for why women seek their services rather than deliver at a health facility is because of the inconsiderate and sometimes abusive way the women are treated at clinics and hospitals: ‘‘The nurses even tell them [women] that they were not part of making the pregnancy. Statements like ‘you are not the only patient here for me to handle’, ‘push for yourself’, ‘that’s not my problem’, are used. They so abuse woman and only listen to the heartbeat of the baby and don’t care about the mothers. But when they come to us, apart from being patient with them, listening to them, we will also give her a cup of tea after delivery to give her energy . . . I know what happens in the hospital, I used to work there.’’ [TBA, poor urban community, Kenya] and ‘‘The doctors and nurses are normally very abusive towards women. When a woman goes through this abuse and maltreatment she gets discouraged to go for the next visit. I myself was told (in the hospital) that I was giving birth to children carelessly without planning so I decided to be having my children at home.’’\footnote{48}

Studies of barriers to skilled attendance at delivery from Asian countries seem less likely to identify provider attitudes and behaviours as an important factor.\footnote{112} But in Cambodia, where maternal mortality is very high and few women deliver in health facilities, perceptions of poor staff attitudes have been identified as a barrier.\footnote{113}


\footnote{113} Ir Por, Horeman, D. Narin, S. Van Damme, W. Title: Improving access to safe delivery for poor pregnant women: a case study of vouchers plus health equity funds in three health districts in
Another important consequence of a poor experience with MHCPs during delivery is that women may be less likely to attend for post-natal care. Nabukera et al identified poor attitudes of health service providers as one of the barriers to use of postpartum care service among rural communities in Uganda.\textsuperscript{114} Post-natal care remains uncommon in many developing country settings, but its importance is increasingly emphasised.\textsuperscript{115,116,117}

Pregnant women may be deterred from attending for antenatal, delivery or postnatal care because of discrimination and breaches of confidentiality in relation to HIV, or their fear of these.\textsuperscript{118} For example, Turan’s study investigating the effect of the HIV epidemic on the uptake and quality of maternal health care services in Kisumu, Kenya found that fear of forced HIV testing, involuntary disclosure, and associated stigma resulted in active avoidance of hospital or clinic environments by pregnant mothers.\textsuperscript{85} Many public hospitals routinely test for HIV and the result may be recorded on the mother’s health record. As a result, many women choose to avoid clinics and visit TBAs instead.\textsuperscript{85} Turan’s further, mixed methods study in Migori, Nyanza province, Kenya, concluded that by working to reduce HIV-related stigma in communities, families, couples, and health facilities, programs may increase pregnant women’s health care utilization in high HIV prevalence settings.\textsuperscript{119} The quantitative data indicated that women with more negative attitudes about HIV-positive people at baseline were about half as likely to deliver in a health facility with a skilled attendant as women with more positive attitudes about people living with HIV. It may be that community communication campaigns to increase use of services to prevent mother to child transmission of HIV may have led to the idea that women who give birth in health facilities are likely to be HIV positive. Turan et al advise that messages...
should emphasise that all women, not just HIV-positive women or those with pregnancy complications, should deliver in health facilities.

Just as experiences of poor provider attitudes may cause women to avoid a health care facility, so good experiences result in willingness to re-attend and recommendations to others: "I will recommend that facility because the providers were caring...the Nurse asked me to pray and the doctor said what he would do was going to be painful; but he reassured me." [Mother, Ghana].

Positive experiences can have a greater impact on a woman’s decision to return to a facility than negative ones: "I will go there again because even though one of the nurses was unfriendly and impatient, the other was very accommodating and I pray I will meet someone like her anytime I have to go there." [Mother, Ghana].

3.2 Impact on process aspects of quality of care resulting in poor outcomes

Because complications during pregnancy, delivery and post-partum can quickly cause death, neglect by MHCPs can have very serious consequences for the health and survival of women and newborns. In South Africa, the National Committee on Confidential Enquiries into Maternal deaths reported instances of women being left unobserved for long periods of time in a large number of maternal deaths they had reviewed, noting in some cases lack of monitoring of women with serious complications for up to five hours. They recorded a number of instances where women were found dead in their beds with no indication that they had been monitored after birth.

Poor inter-personal relationships create a communication barrier that prevents MHCPs giving women the information they need. This includes health promotion messages about family planning, nutrition, preparation for labour and skilled attendance at labour, smoking cessation during pregnancy, newborn care, and infant feeding.

It is important to recognise that family planning workers have their own cultural attitudes and beliefs about the role of family planning in people’s lives. They have the potential to be agents of change in the communities they serve, but can also prevent fair access to the most appropriate

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family planning services for individuals.\textsuperscript{121} There has been relatively little research on the attitudes and behaviours of family planning workers, and their implications.\textsuperscript{121} A quantitative survey in Chiri, India, aimed at determining the extent of pregnant and lactating mothers’ participation in the Integrated Child Development Services project (ICDS) (a program addressing the improvement of many aspects of maternal health), reported that low uptake of the service could be attributed to the fact that 15\% of target women were either never approached by anganwadi (government supported child and maternal health) workers, and so therefore had no knowledge of the service, or were actively discouraged by the workers’ unfriendly and discouraging attitude\textsuperscript{122}. Fear of being scolded or shouted at can prevent women from describing their symptoms or complaining of pain, resulting in lack of treatment, delayed treatment, or the wrong treatment, despite having attended a health care facility.\textsuperscript{41}

3.3 Psychological and emotional impacts

A questionnaire study in England found that caregivers have the potential to make a significant difference to a woman's experience of childbirth, and that feeling in control, treated with respect and consideration during labour is associated with positive emotional well-being post-partum.\textsuperscript{123} A study in Sweden also found that feeling a lack of control and lack of support during labour contributed to poor birth experiences which were associated with worse self-rated health at 2 and 12 months post-partum.\textsuperscript{124} Research indicates that the likelihood of experiencing post traumatic stress disorder (PTSD) after birth relates to how women felt they were treated during labour, whether they felt in control, whether they panicked or felt angry, whether they dissociated, and whether they felt overwhelmed and hopeless, rather than simply to experiencing pain.\textsuperscript{125,126} In the first study of PTSD following childbirth in a non-western country, Adewuya et al found that 52 of 876 women (5.9\%) at 6 weeks post-partum fulfilled the criteria for a

\begin{thebibliography}{99}
\bibitem{121} Sebikali B. How health workers influence attitudes and decisions about Family Planning Feb 18\textsuperscript{th} 2011. http://maternalhealthtaskforce.org/discuss/wpblog/2011/02/18/how-health-workers-influence-attitudes-and-decisions-about-family-planning/
\end{thebibliography}
diagnosis of PTSD. This was higher than the rate found in most developed countries. They noted that this is likely to be an underestimate because they obtained their sample at infant vaccination clinics, which depressed mothers may be less likely to attend. They also found poor maternal experience of control during childbirth to be significantly associated with PTSD after childbirth.

There is a high prevalence of post-partum depression in developing countries. But little research has been conducted in developing countries on the psychological consequences of poor personal experiences during pregnancy and childbirth. In a quantitative study researchers in Bangladesh compared the effect of pregnancy and childbirth experiences on self-rated health at 6 weeks post-partum in groups of women that had experienced delivery complications and those that had not. The experiences during pregnancy and childbirth were assessed in terms of a five-point self rating scale from ‘severely uncomfortable=1’ to ‘not uncomfortable at all=5’. After controlling for the background characteristics, postpartum depression was significantly associated with women reporting a negative childbirth experience.

In a useful discussion article Simpkin points out that there is a difference between pain and suffering and that if women are given attention, support and respect they may feel more in control during labour and less likely to suffer psychological problems. She offers useful guidance for helping women to cope during a difficult delivery.

3.4 Impact on job satisfaction and mental health of MHCPs

Few studies have explored the perspective of the MHCPs in relation to their attitudes and behaviour. Some have recommended such studies in order to help identify mechanisms to better respond to the needs of patients and increase quality of care, rather than for the sake of the MHCPs themselves. Yet MHCPs are often a cadre of workers, predominantly female, that have relatively low status in the health system hierarchy, are poorly paid, often overworked and inadequately trained and supervised, and have little autonomy, yet great responsibilities. Looking after women in labour is inherently stressful. Obstetric complications are unforgiving.

of even short delays. Deaths of mothers and infants are often blamed on the midwife by the family, the community, and by senior health staff.\textsuperscript{24} When things go wrong MHCPs may blame themselves and suffer secondary traumatic stress.\textsuperscript{130} When MHCPs display poor attitudes or behaviour towards their patients this is likely to have adverse effects on their own morale, confidence, motivation and job satisfaction. Combined with poor remuneration and heavy workloads this contributes to low retention rates. As Davis-Floyd has observed, trained midwives are often trapped in the biomedical healthcare system.\textsuperscript{131}

There are some illustrations in some of the qualitative studies described of the negative impact of poor provider attitudes and behaviours on MHCPs themselves. When they have behaved negligently or badly they may feel guilty and anxious: “\textit{A lady came here yesterday with obstructed labor. I forgot to insert a catheter as the guidelines say because it was an emergency and I was alone. I was running all over the place calling the [referral] hospital and trying to get the ambulance. I remembered this when I went home and I got so worried, that maybe the woman or her family will complain about me. If we were two, maybe my colleague could have remembered.”} [Midwife, South Africa].\textsuperscript{12}

The Women’s Health Project and WHO Tropical Diseases Research department conducted quality improvement workshops in sub-Saharan African countries in the early 1990s.\textsuperscript{132} An MHCP said, at a workshop in South Africa: “\textit{Yes, there are problems here. Some we can do nothing about, but some we can change. It may be good for the people who come to our clinic, but mostly it will make my job feel better.}” [workshop participant] and another said: “\textit{The situation can easily change, because nobody really enjoys being indifferent or harsh to patients. Someone just has to listen to our problems.”} [workshop participant, Uganda].\textsuperscript{132}

In a qualitative study with 20 nurses in Vhembe district in Limpopo province in South Africa Mavhandu-Mudzusi et al heard about the experiences of the nurses providing voluntary counseling and HIV testing.\textsuperscript{133} The nurses talked about challenges related to inadequate resources; the emotional drain associated with stress and burnout; and frustration related to

\textsuperscript{130} Leinweber J, Rowe HJ. The costs of 'being with the woman': secondary traumatic stress in midwifery. Midwifery. 2010 Feb;26(1):76-87.
certain behaviors and practices of clients and community members. The researchers concluded that nurses are continuously exposed to emotionally draining activities with very little support from their supervisors, which makes them prone to experiencing burnout.

A descriptive, qualitative study assessed the quality of care of MHCWs in the labour ward of a Palestinian public referral hospital in the Occupied Palestinian Territory. The in-depth interviews with 31 MHCWs uncovered that the factors influencing the poor quality of care were high workloads, low pay, poor supervision, lacking in supportive guidance, and being humiliated at work. The study found the responsibilities and duties of midwives greatly exceeded those of both doctors and nurses. Despite their high level of education, they also reported the lowest salary. Some of the midwives described themselves as ‘machines’: “They give us workloads that are extremely exceeding our abilities as individuals and humans. It’s insane!” [Midwife, Occupied Palestinian Territory]. Many of the midwives acknowledged that this stress makes it difficult to communicate with patients and their families; they also admitted feeling exhausted and ‘displaying harshness’ while providing care. In addition, humiliation and abuse by doctors, other staff and the patients themselves contributed to the stress of these MHCWs. They reported that being shouted at caused them to feel insecure and devalued. In South Africa, too, researchers heard from several nurses and facility managers that systemic problems such as understaffing, poor pay, heavy workloads, and lack of equipment and medical supplies contribute to negative attitudes, abuses and poor quality of care. One midwife said: “I know we are not always right, but the department forgets our problems. You work so hard and there is no appreciation. At the end of the month you earn peanuts.” Some managers were aware that poor behaviour often results from excessive stress: “The nurse asked the client about her HIV status and an argument ensued. The sister slapped the client. It was a busy time and we had gross shortage of staff on that day. We had many complicated cases and were preparing women for theater. So everybody was stressed.”

A qualitative study among MHCPs in a number of hospitals in Tehsil Pindi Gheb, Attock District, Punjab, Pakistan, revealed that heavy workloads, absence of managerial support and poor remuneration often led to high rates of absenteeism and malpractice. Many health care providers undertake private practice to make ends meet, which can result in conflicts of interest, competition, and poor behaviour towards patients in public facilities. In South Africa there have been reports of MHCPs asking for bribes, and some of the hospital midwives interviewed admitted that nurses accept money or lunch offers, especially from migrants. Where corruption is common in society it is not surprising to find that it occurs in health care facilities.
In the study of care at the Calabar Hospital in Nigeria doctors and nurses explained that they find their jobs frustrating, they lack equipment and supplies, receive poor pay and as a result have no job satisfaction.33

It is natural for new staff to learn from more experienced role-models, so that a culture of for example, shouting at and pinching women in labour, is seen as necessary and normal. D’Ambruoso et al found that when they fed back their study findings to the MHCPs many expressed surprise and lack of awareness of the perceptions of their women patients revealed by the study.24 In the Human Rights Watch study the head of the South Africa Nursing Council defended health care providers, noting that while changing the way nurses are trained is important to address some of the quality care problems, it is also essential to address other health system challenges: “The Council cannot continue punishing nurses when the root causes are not improving. These problems are in the system itself. We need to make the nursing environment conducive and safe for nurses. Before judging a nurse’s behaviour you need to ask, “How is the labor ward, how many midwives are there?” and think about the equipment that go for repair and never come back.”12 Supratikto et al also note in their evaluation of maternal death audits that village midwives have enormous responsibility placed on them to avoid maternal deaths.134

4. What needs to be done to improve the relationship between MHCPs and patients?

“Please, remind all health workers, especially nurses, that they deal with fellow women; we can’t respect them unless they treat us well too; if they love us we will respect them.”

[In-depth interview, Nahukahuka village, Tanzania]37

There is no single intervention, or ‘package’ of interventions that will solve the problems described in this review. The attitudes and behaviours of MHCPs vary greatly depending on the context. Different approaches will be needed in different settings. Nevertheless, in the desire to reach the MDGs there is currently greater investment in a number of fields that could help to contribute to better health worker attitudes and behaviours. These include quality of care; patient satisfaction; health systems strengthening; human resources management; and staff retention.

The UN Millennium Project Task Force on Child Health and Maternal Health has argued that health systems play a central role in democratic development, poverty reduction and fulfillment of human rights: “But development planners and government authorities have often failed to grasp the extent to which abusive, marginalizing, or exclusionary treatment by the health system has come to define the very experience of being poor. Moreover, they have often failed to grasp that the converse is also true: the health system as a core social institution, part of the very fabric of social and civic life, has enormous potential to contribute to democratic development. Health claims – claims of entitlement to healthcare and enabling conditions – are assets of citizenship. Their effective assertion and vindication through the operation of the health system helps build a human rights culture and a stronger, more democratic society.”

In 2007, Deborah Maine, in a myth-busting Lancet Viewpoint article, called for “actions that can actually help to reduce maternal deaths, such as to improve the retention and functioning of staff at rural health facilities.” She highlighted the problems of ‘One component programmes’ pointing out that “even the best-trained providers cannot effectively use their skills in a setting where equipment, lighting, supplies, and infection control are inadequate. In fact, poor management practices often undermine the potential of many other activities, including training, upgrading of equipment, renovation, and community mobilisation. She discussed the importance of thinking in terms of an ‘enabling environment’ which allows MHCPs to apply their skills. In their review of violence perpetrated by health-care workers against patients, d’Oliveira et al suggest that responses are needed in recruitment, training, socialisation processes in professions and working environments, and improvements in working conditions.

Rosemary Kumwenda, who founded Lusaka Women-friendly Services Project, has said that maternal services should be of high quality, accessible, affordable, culturally acceptable, and satisfy the needs of women, particularly poor women who are at greater risk and have fewer communication skills than women in higher income brackets. She urges that we need services that are not only baby-friendly but mother-friendly as well.

The team conducted a pilot survey in Lusaka's clinics and produced a practical guide, with a six-step "diagnosis and change" cycle, based on the experiences and responses of expectant mothers. The guide, which aims to provide low-cost tools for improving services in poor settings, begins with the premise that both technical and emotional care are essential to good maternal health. Among other things, the guide recommends that women be addressed in their native language and that a more professional and respectful relationship develop between TBAs and medical staff. "For us, it is not so much more resources, but a more positive attitude of health care providers to clients and vice versa," said Kumwenda. "We want a more cordial and mutually rewarding relationship."

Mamdani and Bangser advocate that in planning strategies it is important to consider how they might affect the poorest in the population, since they tend to suffer most from abuses of power and lack of responsiveness from health care staff.  

There are reports of progress. A strategy to improve emergency obstetric care through attention to the structure and process elements of quality of care in three district hospitals in Nepal was able to increase greatly the motivation of MHCPs and the overall functioning of the hospitals. Family Care International undertook a major Skilled Care Initiative in more than 100 health facilities in four poor rural districts of Burkina Faso, Kenya, and Tanzania. They undertook a rigorous evaluation, using a pre-test/post-test, quasi-experimental design with comparison districts. There were significant improvements in the availability and quality of maternity care in all three settings, especially at mid- and lower-level health facilities, and improvements in women’s use of skilled care, including among the poorest women. The results emphasised the importance of community leadership in encouraging women to seek skilled care.  

A project in the State of Ceará, north-east Brazil succeeded in ‘humanizing’ the culture of childbirth in hospitals between 1997 and 2000. The intervention consisted of a number of participatory training activities including seminars, workshops, in-service training, training for trainers, and exchanges of midwives between Brazil and Japan. An evaluation using a Rapid Anthropological Assessment Procedure with both qualitative and quantitative methods, and observations, was conducted before and after the intervention in five municipalities. ‘Humanized’ maternity care was defined as having the following attributes:

- is fulfilling and empowering both to women and to their care providers;
- promotes the active participation and decision making of women in all aspects of their own care;
- is provided by physicians and non-physicians working together as equals;
- is evidence based, including use of evidence based technology;
- is located within a decentralized system of birth attendants and institutions with high priority to community-based primary care;
- is financially feasible (as indicated by a cost-benefit analysis).

The researchers noted that health professionals who received the training showed increased self-esteem, greater commitment, better interpersonal relationships and transformation from the ‘culture of dehumanized childbirth’ to one of ‘humanized childbirth’. More women delivered at the hospitals. Women received continuous support during labour, from a doula or a family member, and delivery room conditions had improved with privacy through the use of curtains.

4.1 Focus on human rights

As this review shows, there are important reasons in terms of health outcomes to seek to improve the attitudes and behaviours of MHCPs. But improving attitudes and behaviours is also necessary from a human rights perspective. The practice of health professionals has a significant bearing on the promotion and protection of human rights, in particular the right to health. As providers of health-care services, health professionals play a vital role in realizing the right to health.

142 UN General Assembly. Promotion and protection of all human rights, civil, political, economic, social and cultural rights. Report of the Special Rapporteur on health workers and human rights education.
Lynn Freedman has written about the ways that human rights principles can be incorporated into national policy making, health services management, and clinical management.\textsuperscript{143} As an example she shows how a human rights 'audit' can help identify ways to encourage respectful, non-discriminatory treatment of patients, providers and staff in the clinical setting. Acknowledging the underlying influence of power imbalances Freedman suggests: “Whether applied to the intricacies of human relationships within a facility or to the impact of international financial institutions on health systems, the ultimate role of human rights is to identify the workings of power that keep unacceptable levels of maternal mortality as they are and to use the human rights vision of dignity and social justice to work for the re-arrangements of power necessary for change.”\textsuperscript{143}

Inadequate compliance by health professionals with human rights standards is often the result of complex and interrelated circumstances, including political pressures and societal influences. However, it is often partly attributable to lack of training in human rights. Human rights education is an essential starting point for equipping health professionals with the knowledge and tools to empower them to promote and protect human rights.\textsuperscript{142} As well as enabling them to defend the rights of their patients, human rights education also has an important role to play in assisting health professionals defend their own human rights.

International and developed country professional associations, such as the International Federation of Gynaecologists and Obstetricians, can play an important role in advocacy for rights-based approaches and partner with professional associations in developing countries. For example, the Canadian Society of Obstetricians and Gynaecologists set up partnership projects with peer associations in Guatemala, Haiti and Uganda, which proved effective at integrating women’s empowerment and reproductive rights into the work of members on both sides.\textsuperscript{144}


health managers’, which offers a session-based and case-based curriculum on how to promote gender equity and reproductive rights through the use of evidence, policy development and service delivery. It is available online and on CD. The Commonwealth Medical Trust also has a training manual to assist in training of health care providers in human rights.

In a recent important paper Cottingham et al describe the development of a tool that uses human rights concepts and methods to improve relevant laws, regulations and policies related to sexual, reproductive, maternal and newborn health. The tool has been tested in Brazil, Indonesia and Mozambique and was found to contribute to improving health. It assists countries to understand their obligations and identify vulnerable groups and encourages a multi-sectoral process, including participation of civil society.

4.2 Advocacy

There has been recognition among international policy makers of the significance of this issue. However, because these problems are context-specific, not easily measured, and cannot be solved with technological interventions that could be subject to randomized controlled trials, they are less likely to receive priority when resources are strained. Advocacy for greater investment is needed.

The first of the ‘Core skills and abilities’ listed in the 2004 joint statement by WHO, ICM and FIGO “Making pregnancy safer: the critical role of the skilled attendant” reflects an understanding of the significance of the attitudes and behaviours of health care providers: “Communicate effectively cross-culturally in order to be able to provide holistic ‘women-centred’ care. To provide such care skilled attendants will need to cultivate effective interpersonal communication skills and an attitude of respect for the woman’s right to be a full partner in the management of her pregnancy, childbirth and the postnatal period.”


The White Ribbon Alliance is raising awareness through a Respectful Maternity Care advocacy campaign, in collaboration with the Policy Project and USAID. They have developed a ‘community of concern’ with online discussions, and have produced advocacy resources, including the Respectful Maternity Care Charter: The Universal Rights of Childbearing Women\textsuperscript{149}, a short video and posters.

It is important that advocacy efforts to raise awareness of women’s rights in relation to reproductive and maternal health care do not inadvertently blame or stigmatise MHCPs. The Health Policy Project supports country-led advocacy initiatives to improve midwives’ working conditions by urging policymakers to support midwives through targeted policy commitments and increased funding and resources. The White Ribbon Alliance in collaboration with the Health Policy Project have produced a short online video film "What I Want is Simple" to improve the public perception of midwives in Tanzania and mobilize support for advocacy targeting improvements in the working conditions of midwives.\textsuperscript{150}

4.3 Planning

The 2010 UN Global Strategy for Women's and Children's health sets out the elements needed to improve women’s and children’s health, beginning with country-led costed national health plans that cover human resources, financing, and delivery and monitoring of an integrated package of interventions. Without attention to strategies to train, retain and deploy health workers, including encouraging good inter-personal skills, evidence-based interventions cannot achieve their potential.\textsuperscript{151} The 2012 UN report sets out the necessary steps in preparing a national public health strategy and plan of action including a sexual, reproductive and maternal health strategy that follows ‘best practices’ as set out by WHO.\textsuperscript{152} The plan should be based on


\textsuperscript{150} Health Policy Project. What I want is simple. April 2012. http://www.healthpolicyproject.com/index.cfm?id=MidwivesVideoTZ


a situation analysis determining which population groups are deprived of access, and determining the reasons behind that deprivation at both the national and subnational levels, and clearly identify those responsible for implementing the plan and establishing accountability mechanisms. Hulton et al have published a very useful guide for evaluating and improving quality of care in maternity services.

4.4 Motivate and retain staff

The desire to make faster progress towards the Millennium Development Goals has resulted in much interest in better understanding and measuring motivation. The 2010 UN Global Strategy for Women's and Children's health highlighted the importance of motivation. Motivation is a key factor in encouraging supportive attitudes, and in turn motivation is increased by better relationships between providers and patients – their work is more interesting and fulfilling when they have good communication and counselling skills. The Lancet South Africa Team have also noted that effective and affordable maternal health interventions are often not implemented well and argued for strategies that will foster health worker motivation and commitment to providing good quality, patient-centered care.

There are WHO guidelines to assist ministries of health to develop appropriate policies to address issues of health worker attraction and retention in underserved areas. The guidelines identify 16 key interventions in relation to health worker education and training, government regulations, financial incentives and personal and professional support programs.

Prytherch et al undertook qualitative in-depth interviews with 25 MHCPs, eight facility and district managers and two policy makers in rural Tanzania to understand better what influences


their motivation, performance and satisfaction.\textsuperscript{157} They found that community appreciation, perceived government and development partner support, and on-the-job learning were sources of encouragement. Discouraging factors were predominantly financial, but also included lack of staff and high workloads, weak management, dysfunctional promotion systems, and health and safety issues. Importantly, the researchers noted that despite these problems, and generally low motivation, the intrinsic nature of their work gave the MHCPs much satisfaction. They recommended that strengthening the skills of rural facility managers, enhancing the status of their role, and increasing the support they receive from higher levels of the health system should be prioritized.\textsuperscript{157} Developing a career structure is also important.

Experience and evidence suggest that a comprehensive strategy to maximize health worker motivation in a developing country context should include a mix of financial and non-financial incentives.\textsuperscript{158}

\textit{Incentives}

Mathauer and Imhoff conducted a qualitative study using semi-structured qualitative interviews with doctors and nurses from public, private and NGO facilities in rural areas in Benin and Kenya to assess the role of non-financial incentives for motivation.\textsuperscript{158} They found that the health workers had strong professional ethics and felt frustrated and demotivated at their inability to do their job well because of lack of equipment and supplies and poor management. They concluded that the aim of human resources management and quality improvement must be to develop the work environment so that health workers are able to meet their personal and organizational goals.\textsuperscript{158}

Discrete choice experiments have been used to determine the job characteristics that are most important to health care providers in order to plan strategies to retain staff in underserved areas. Such studies also provide useful direction in improving the motivation and satisfaction of health care providers and decreasing the likelihood of poor attitudes and behaviours towards patients. Rockers et al investigated preferences for job characteristics among final year medical, nursing,


pharmacy and laboratory students in Uganda. Salary was not the only important factor health workers consider when deciding where to work; better quality health facilities and supportive managers were also very important. They suggested that improving facility quality and training managers to be more supportive of all facility staff may be particularly cost-effective.

There is much interest in improving maternal health through introducing financing mechanisms based on performance, and/or demand side schemes such as distributing vouchers to individuals or families to pay for health services, or providing waivers for user fees. Such schemes have now been trialled in many settings, but evaluation is difficult. This is especially because they are rarely the only change likely to be influencing use of health care services or maternal survival. There is relatively little information related to the effect of financing incentives on maternal health behaviors, including use of services, provider behaviors, and maternal and neonatal health outcomes.

Bellows et al conducted a systematic review on outcomes of reproductive health voucher programs which showed that they can increase use of reproductive health services, improve quality of care and population health outcomes. However, they noted that there is limited evidence on program effectiveness and cost-effectiveness. Abuya et al have published a policy analysis which provides guidance for implementing such voucher programs.

Because of growing interest from policy makers and governments, Witter et al attempted a Cochrane meta-analysis of studies of paying for performance. There were a limited number of studies, and the intervention designs, study methods and contexts were diverse so they presented a narrative synthesis. They found that the evidence base is too weak to draw any conclusions, and acknowledged that performance-based funding is not a single intervention but rather a range of approaches influenced by varied organisational contexts.

In his review of financing mechanisms for USAID, Kinoti also noted that it is difficult to draw conclusions.\textsuperscript{164} There is evidence that performance based financing mechanisms can increase deliveries with skilled attendance, but it is important to recognise that there is also potential for harmful effects and diminishing MHCP satisfaction rather than increasing it.\textsuperscript{164}

Competitive voucher schemes have been trialled which allow recipient patients and clients to choose among a number of different providers. It has been suggested that this choice could increase satisfaction amongst voucher recipients, and create competition among participating providers to improve quality of their services to attract more voucher clients.\textsuperscript{165} Although evaluation has proved difficult, a report from Cambodia provides a useful discussion of the potential of voucher schemes with Health Equity Funds, and incentives such as a delivery payment for midwives, to improve use of skilled attendants at delivery.\textsuperscript{165} Several studies suggest that such demand side financing mechanisms can increase uptake of ANC, skilled attendance at delivery and postnatal care, but in Bangladesh there was little evidence that the mechanism encourages competition and thus improved service quality, because health care services are limited, as is the case in many low income settings.\textsuperscript{166,167,168}

In considering the issue of financial incentives we need to be aware of the political and ideological nature of these proposals.\textsuperscript{169} The UN Millennium Project Task Force on Child Health and Maternal Health pointed out that “the prevailing approach converts healthcare into a marketable commodity, that is, into a product or service to be bought and sold. It encourages the development of a competition-driven private sector to deliver health services on a for-profit basis (and in practice also encourages private, non-profit providers, such as NGOs and church-owned facilities), and tries to expand the choices available to healthcare consumers, who are assumed to make optimal decisions for themselves in seeking healthcare. This basic approach to the health sector, championed largely by donors,…is a strategy that is ideologically opposed to a

\begin{itemize}
\item Kinoti S. Effects of Performance Based Financing on Maternal Care in Developing Countries: Access, Utilization, Coverage, and Health Impact: Rapid Review of the Evidence. USAID-TRAction Project February, 2011. www.tractionproject.org
\item Ahmed S, Khan MM. A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh? Health Policy and Planning. 2010.
\item Agha S. Impact of a maternal health voucher scheme on institutional delivery among low income women in Pakistan. Reprod Health. 2011 May 3;8:10.
\end{itemize}
strong state presence. The strategy minimizes the role and, in practice, the legitimacy of the state.” The new report of the UN High Commissioner for Human Rights makes the point that “Claims for sexual and reproductive health goods, services and information should be understood by health system users, providers and policymakers as fundamental rights, not as commodities to be allocated by the market or matters of charity.”

4.5 Improve communication and counselling skills

Skills assessment

The International Confederation of Midwives have described competencies for MHCPs that include a wide range of interpersonal skills. These include care and counselling, cultural sensitivity, appropriate communication skills, provision of psychological support and involving family members. However, assessments of MHCPs skills have often focused on technical clinical skills and neglected assessment of communication skills and attitudes. Such assessments can result in greater investment in training programs, but there is a danger that if the assessments of MHCP skills do not include inter-personal skills then these may also be omitted in the training. D’Olivera et al also note that communication skills and a caring ethic often have extremely low priority in training curricula.

Communication skills include asking open-ended questions, helping clients express their concerns, engaging in active listening, and handling difficult situations. Murphy, in a review of best practices for client-provider interactions in relation to family planning identified the following key processes:

1. Treat the client well.
2. Provide the client’s preferred method
3. Individualize.
4. Aim for dynamic interaction.
5. Avoid information overload.

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6. Use and provide memory aids.\textsuperscript{174}

The 2008 report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, states that “Health workers’ training must include human rights, including respect for cultural diversity, as well as the importance of treating patients and others with courtesy.”\textsuperscript{175}

\textit{Training}

There are some useful resources to support training in communication and counselling skills that can be downloaded free from the internet. These include an excellent manual from WHO’s Department of Making Pregnancy Safer: ‘Counselling for maternal and newborn health care: a handbook for building skills.’\textsuperscript{176} The Handbook has a self-directed learning approach, and can be used in groups with a facilitator or by an individual. There are practical activities to encourage reflection, provoke discussions, build skills and ensure the local relevance of information.

The EngenderHealth organisation’s ‘Quality Improvement for Emergency Obstetric Care – Leadership Manual’ and “COPE® ("client-oriented, provider-efficient") Handbook: A Process for Improving Quality in Health Services” are also valuable resources.\textsuperscript{177,178}

\textsuperscript{174} Murphy EM. Best practices in client-provider interactions in reproductive health services: A review of the literature. USAID Maximizing Access and Quality (MAQ) Initiative. www.prb.org/pdf/NewPerspQOC-LitRev.pdf

\textsuperscript{175} UN General Assembly. Promotion and protection of all human rights, civil, political, economic, social and cultural rights. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt.A/HRC/7/11 31 January 2008.


Well-designed and conducted training can be effective at improving interpersonal skills. Interpersonal skills are acquired slowly. There is evidence that communication skills develop when they are modeled and role-played frequently, and are less likely to develop with only occasional training interventions. Effective training is based on adult learning principles, and models the behaviors it recommends. Thus, training should be interactive and participatory; responsive to the knowledge level, skills, values and emotions of individual trainees; practice-oriented; and varied to allow for differing learning styles.

A study in Indonesia of five day training for family planning providers in client-centred counselling found that reinforcement following training is important. When training was followed by a process of self-assessment of a counselling session each week, or peer-review, providers' facilitative communication, clients' active communication and clients' ratings of self-expression and satisfaction increased.

Harrowing interviewed 24 Ugandan nurses and nurse-midwives after an HIV education program. She found that the program had positive and synergistic effects on the nurses' professional practice, communication and problem-solving skills, confidence, and engagement in political and social change activities. In a Nigerian intervention study, nurses, doctors and lab technicians were trained by influential role models to try to change knowledge and attitudes about HIV infection. The training included role plays and discussions on discrimination and human rights. One year later, there were significant positive changes in the intervention group with less fear and more sympathy and responsibility towards people living with HIV. There appeared a greater willingness to treat HIV patients, and much less fear of work-related infection.

Ariff et al evaluated health workforce competence in maternal and newborn care in Pakistan. They concluded that counselling skills of all cadres of the healthcare staff had received little

importance in training, and communication skills modules need to be included in all relevant training courses of health care providers.\textsuperscript{183}

In Indonesia in 1997, village midwives participated in a 3-day training course designed to enhance their ability to effectively counsel and communicate with women and community members.\textsuperscript{184} The training included role plays and skills practice. Village midwives who received and who did not receive IPCC training were observed using a checklist in several provider-client interactions after three months and again after a year. Scores were calculated from the results of the observations and exit interviews were conducted among the women observed in the interactions. Scores were constructed from the key skills taught.

<table>
<thead>
<tr>
<th>SKILL</th>
<th>DESCRIPTION OF SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greeting</td>
<td>How the village midwife welcomes her client</td>
</tr>
<tr>
<td>Active listening</td>
<td>Clarification (asking the client to explain the problem), paraphrasing (rewording questions from patients), reflection (using the women’s own words, and summarising the discussion)</td>
</tr>
<tr>
<td>Attitude</td>
<td>Includes patience, avoiding the use of a rude voice or criticism, maintaining eye contact</td>
</tr>
<tr>
<td>Physical exam</td>
<td>Explaining steps and results of physical exam</td>
</tr>
<tr>
<td>Body language</td>
<td>Non-verbal communication</td>
</tr>
<tr>
<td>Conversation style</td>
<td>Ability to use appropriate language</td>
</tr>
<tr>
<td>Next appointment</td>
<td>Explicit communication with woman to set up appointment</td>
</tr>
</tbody>
</table>

The IPCC trained midwives had higher mean scores (78\%) than the untrained (54\%) and women who were seen by an IPCC trained village midwife were more likely to report that they received important or new information, and to have had the purpose of the physical exam explained. Mean score had decreased to 64\% after 15 months after training.\textsuperscript{184}

The Health Workers for Change training intervention was developed in response to complaints about health care provider attitudes and behaviours. The training comprises a series of workshops that encourage reflection of one’s own gender experiences and behaviour. The workshops stimulate reflection on the questions: Why am I a health worker?; How do our clients see us?; Women’s status in society?; Unmet needs?; Overcoming obstacles at work?; Solutions?. Exploring these questions identifies both personal and institutional barriers to quality of care. The intervention was evaluated in a number of countries (six in Africa and one

in Latin America) and found to have a positive impact on the relationship between providers and clients, encouraging teamwork, creating a supportive environment for health facility staff to take more initiative, and increasing demand for responsiveness from the system level.\textsuperscript{185}

Ouma et al evaluated three day health care worker training in WHO recommended Focused ANC (which emphasises the quality rather than the quantity of visits) in western Kenya two years after the training by surveying recently delivered women in an area with the midwives that had been trained compared to an area where the midwives had not.\textsuperscript{186} After the training more women attending ANC thought service providers explained procedures and encouraged questions and rated the quality of the antenatal service as very satisfactory compared to the area without training (17\% vs. 6.5\%, $P < 0.05$). More women were delivered by a skilled assistant in the area where midwives had been trained (30\% vs. 23\%, $P = 0.04$). The authors concluded that training of antenatal staff was associated with improvements in performance but the difference was modest. Overall, services delivered remained sub-optimal, especially with regards to providing key information to pregnant mothers and ordering essential tests.\textsuperscript{186}

The Gender Mainstreaming in Medical Education initiative in India aimed to incorporate gender sensitivity into medical professional training. The project began in 2002 and covered six states in India, reaching around 43\% of the medical students in the country. It was evaluated positively in 2006.\textsuperscript{187} A review of efforts to integrate gender into health professionals training curricula highlighted examples of successful gender-mainstreaming education initiatives in Thailand, Australia, Turkey and Uganda.\textsuperscript{188}

Training should include discussions about traditional beliefs and practices and how they can be respected and accommodated in antenatal, delivery and postnatal care. This is important whether or not the MHCPs have the same cultural background as their patients. Traditional


\textsuperscript{187} Ramanathan M, Khambete A. Case study: The Gender Mainstreaming in Medical Education - the Indian Initiative. Trivandrum, India, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology 2007.

\textsuperscript{188} WHO Department of Gender, Women and Health. Integrating gender into the curricula for health professionals. WHO Meeting Report 4-6\textsuperscript{th} December 2006. http://www.who.int/gender/documents/GWH_curricula_web2.pdf
birth attendants could be invited to share their knowledge and understanding about cultural beliefs and practices in relation to pregnancy, childbirth, newborn care and infant feeding.

The HIV epidemic has necessitated additional training for all MHCPs. In addition to information about transmission, clinical manifestations, natural history, prevention of mother to child transmission and treatment, this should cover issues of informed consent, confidentiality, disclosure, and universal precautions for infection control. To reduce the stigma and discrimination experienced in maternal health care facilities by HIV-positive women and women who are suspected of being HIV positive, stigma reduction interventions for health workers, such as the curriculum developed by EngenderHealth, are needed. Policies and programs should also be developed to meet the needs of HIV positive health workers.\textsuperscript{189} Turan et al recommend that to minimize the negative impact of training programs on service delivery in small health facilities training programs should be short and focused and be conducted at the health facilities in the late afternoon when the workload is lighter. They also suggest that ideally other workers would take over while their colleagues go away to training programs, but acknowledge this is difficult with staff shortages.\textsuperscript{189}

\textit{Include counselling in care protocols}

A quantitative study into the effectiveness of a new comprehensive postnatal package of care in four health facilities in a rural district of eastern Kenya where three counselling sessions (within 48 hours of birth, 1-2 weeks and 6 weeks after) were implemented to improve the dissemination of critical information, showed that counselling of maternal and newborn health problems by MHCPs improved greatly.\textsuperscript{190} As well as being able to note improvements to women and newborn health, the study found that more women than in the baseline accepted some sort of family planning method at 6 weeks after the birth (35%-63%).

\textbf{4.6 Supportive supervision}

Many authors of studies in this review emphasise the importance of supportive supervision in improving the attitudes and behaviours of MHCPs and overall quality of care. A Cochrane review concluded that it is uncertain whether supervision has a substantive, positive effect on


the quality of primary health care in low- and middle-income countries and that the long term
effectiveness of supervision is unknown.\textsuperscript{191} In the majority of the trials in this review, the
outcomes were measured within nine months of the intervention. In some of the studies the
impact of supervision was measured after only one intervention. The benefits of supervision are
likely to depend on longer term relationships and on the personal characteristics of the
supervisor. Rather than showing that supervision is not an effective intervention, this conclusion
indicates that it is not appropriate to undertake a systematic review of strategies that are not
standardised and are context specific.

Supportive supervision is not amenable to investigation using randomised controlled trials but
can be informed through qualitative studies. Supportive supervision should be thought of as part
of continuous training of MHCPs and based on mutual trust and respect so that MHCPs feel
they can discuss their problems and find solutions. Supervision should aim to improve the
confidence and morale of health workers through giving praise and understanding of work
challenges, rather than criticising and finding faults. Task-specific guidelines and protocols
provide a basis for discussions about the skills and activities of the supervisees.\textsuperscript{192} Supervisors
can be significant and inspiring role models for MHCPs.

\textbf{4.7 Community communication and participation}

There are several reasons why it is important to communicate with the community about the
subject of quality of care at maternal health facilities. Women’s impressions of how they are
likely to be treated by MHCPs are influenced by the experiences of others. Decisions about
whether to deliver with a skilled birth attendant, and whether and when to go to a referral
hospital, are often taken by men or other family members rather than by the woman herself.
The attitudes and behaviours of MHCPs are often influenced by wider cultural norms, and also
by the expectations of their patients, and the lack of knowledge of their patients. Ravindran has
argued that: “If quality of care means to meet women’s needs, then community awareness on
one side and accountability to the community on the other are required from the time that
facilities are set up”.\textsuperscript{193} A committee with community representatives can play a useful role at

\textsuperscript{191} Bosch-Capblanch X, Liaqat S, Garner P. Managerial supervision to improve primary health care in
low- and middle-income countries. Cochrane Database Syst Rev. 2011 Sep 7;(9):CD006413. DOI:
10.1002/14651858.CD006413.pub2.

\textsuperscript{192} Criel B and De Brouwere V. Managerial supervision to improve primary health care in low-
and middle-income countries : RHL commentary (last revised: 1 March 2012). The WHO Reproductive

\textsuperscript{193} Sundari Ravindran TK, Berer M. Preventing maternal mortality: evidence, resources, leadership,
action’ in Berer M and Sundari Ravindran T K,(eds), Safe Motherhood Initiatives: Critical Issues,
the operational level in monitoring and managing quality.\textsuperscript{194} Factors such as unofficial user fees, negative and disrespectful attitudes of health workers and lack of information for users increase the distance between communities and the health system and create barriers to participation.\textsuperscript{195} Supratikto et al point out that the inclusion of village leaders, religious officials and other policy-makers in audit discussions promotes an intersectoral problem-solving approach to safe motherhood.\textsuperscript{134} However, they did caution that participation of individuals or groups without clinical expertise was potentially threatening to health providers, particularly when deficiencies in clinical management were discussed.\textsuperscript{134}

Trials of community women’s groups have had positive effects on maternal and perinatal health and survival.\textsuperscript{196} They may have the capacity to increase women’s confidence and knowledge helping to overcome their fears and shyness in relation to interacting with MHCPs. They may also empower communities to seek accountability from their health services.\textsuperscript{196}

4.8 Accountability

As the UN special rapporteur 2005 report makes clear: “Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window dressing. Accordingly, a human rights - or right to health - approach emphasizes obligations and requires that all duty holders be held to account for their conduct.”\textsuperscript{175} Human Rights Watch South Africa also identify lack of oversight and accountability for recurrent problems in the health system and abuses committed by health personnel as contributors to the lack of progress in reducing the high rate of maternal deaths.\textsuperscript{12}

D’Oliveira et al urge that international organisations such as WHO, the International Council of Nursing, and the World Medical Association should recognize and lead investigation and eradication of violence in health-care settings, and that action is also needed at national and local levels.\textsuperscript{22} They also suggest that an ombudswoman could be appointed to actively encourage women to complain if they experience abuse.

\textsuperscript{194} Ramachandran V. Incorporating women’s health concerns in health sector reforms: Key areas for strategic advocacy and citizen participation. In: Ford Foundation Globalisation, Health Sector Reform, Gender and Reproductive Health. 2003.

\textsuperscript{195} Mahmud S. Citizen Participation in the Health Sector in Rural Bangladesh: Perceptions and Reality. IDS Bulletin, 2004;35(2).

Jewkes et al, reflecting on the reasons why nurses abuse patients, consider the failure of nursing leaders to impose a system of professional ethics which would preclude abuse of patients. They also note that Gilson et al, writing about Tanzania, emphasised the lack of local accountability of staff and services and suggested that this might be related to the treatment of patients in important ways.\textsuperscript{41} But Hawkins et al in their review of a human rights based approach to maternal mortality for DFID caution that it is not sufficient to develop accountability mechanisms such as a Patients’ Charter or Code of Ethics for health workers if these are not backed by investment and institutional processes to apply and enforce them.\textsuperscript{197} This was based on experience in Ghana, where the resource deficient health system was unable to fulfill the rights of patients.

In a thoughtful paper Asha George, using case studies of participatory processes for improving sexual and reproductive health service delivery, discusses how accountability mediates relationship between service providers and communities and between different kinds of health personnel.\textsuperscript{198} She makes the important point that introducing accountability requires time, training, supervision and reorganisation of management and so requires sustained investment. She also emphasizes that to ensure that accountability mechanisms contribute to equity attention must be paid to who is represented and who has been left out; even with community participation the poorest and marginalized may remain excluded.\textsuperscript{198}

Systems for receiving and addressing complaints are important but are not helpful if patients do not know how to make a complaint, are too scared to do so, or feel it would be futile. Human Rights Watch note that in South Africa few health facilities have quality assurance officers to handle complaints and that some health workers resent the complaints system.\textsuperscript{12} They point out that the national government and its provinces have a legal obligation to uphold these rights under international and regional human rights treaties. Their report has a well thought out and detailed list of recommendations for different levels of the system to achieve improvements in patient’s rights and complaint procedures. These highlight the importance of raising awareness of patient’s rights in the community, especially among the poor and marginalised; and the need to examine management failings when investigating complaints.\textsuperscript{12}


Sanctions

Several of the studies reviewed call for punishments for staff who show poor attitudes or behaviour: “Where a hospital staff is found to be unruly, he/she should be severely punished, to serve as deterrent to other health staff.”

“The findings of the study indicate that problems in nurse-patient relationships in South Africa are also related to the absence of sanctions against staff who abuse patients. Although processes for these existed, senior managers said that they could only act if specific complaints were made by patients. This study has shown that patient resistance takes different forms, but formal or informal complaints are rarely one of them as patients fear victimisation.”

In many settings low paid MHCPs, predominantly women, work under conditions that could be viewed as exploitative. If we recognise that poor behaviour from staff often stems from work-related stress and poor conditions it makes more sense to work on improving these before introducing penalties for MHCPs. The issue of introducing effective complaint mechanisms should be discussed with MHCPs, but is an important initiative as part of improving accountability. Lynn Freedman has noted that “All too often, accountability is used to mean simply blame and punishment.” She uses the phrase ‘constructive accountability’ to make clear that a rights-based approach is not primarily about enacting a system to find fault and pronounce punishment, but to develop “a dynamic of entitlement and obligation between people and their government and within the complex system of relationships that form the wider health system, public and private.”

Maternal and perinatal death audits

In recent years there have been efforts in several developing countries to introduce maternal and perinatal death audits in order to identify and address the factors that lead to maternal mortality.

It is suggested that because a range of key people are actively involved there will be ownership of the problems and more likelihood of action to address the problems identified. In practice there are often problems, and the process takes time, but does promote accountability by health providers and policy makers. The process of analyzing the causes of deaths can bring together community level and health facility level MHCPs and community members.

In their evaluation of the maternal audit program in South Kalimantan, Indonesia, Supratikto et al noted that, while the findings provided valuable understanding of the factors contributing to maternal deaths, “Although the audit does not intend to apportion blame, there are a number of inherent features in the current system which tend to put most of the responsibility and potential blame on the actions of village midwives, largely ignoring the role of underlying systems.” They also note the importance of clear rules to ensure accountability without blame, and confidentiality. Filippi et al have proposed that auditing cases of severe obstetric morbidity might be a useful alternative or complement to the auditing of maternal deaths.

Sorensen et al, evaluated two years of experience with maternal death audits in Tanzania and concluded that they had not been able to reduce the maternal mortality ratio. One staff member said: ‘After some time you lose motivation when things do not change. You despair when you fill MDA (maternal death audit) forms and nothing happens. As it is now, MDAs are about filling the papers for the ministry of health and not to discuss improvements in care’. Sorensen et al suggested that internal audits are local and not anonymous, but ‘confidential enquiries’ conducted by experts at regional or national level can maintain anonymity of staff. A combination of local enquiries with community members, and occasional external reviews could help to strengthen quality of care. Human Rights Watch South Africa recommend that a full-time special officer be appointed to oversee the implementation of the recommendations of the Confidential Enquiries into Maternal Deaths reports.

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4.9 Continuity of midwifery care

In Britain there have been efforts to move away from distant, task-oriented and fragmented nursing care towards an emphasis on closeness and continuity of care. There has been much work in developed countries to try to ensure continuity of care by the same midwife or team of midwives throughout pregnancy, delivery and post-natal care. Midwives may be ‘on call’ to attend their patients when they go into labour. Evaluations and randomized controlled trials have found increases in patient satisfaction and reduced caesareans and other interventions in labour with no statistically significant differences in perinatal morbidity or mortality among women managed in this way. However this is an expensive strategy and requires large numbers of midwives to avoid increased workloads and decreased midwife satisfaction.

Support during labour

Supportive care during labour may include emotional support, comfort measures, information and advocacy. It may be provided by the woman’s husband, mother or other female relative, or friend, by hospital staff (such as nurses or midwives), or by women who are not hospital employees and have no personal relationship to the labouring woman (often called doulas). As well as proving reassurance and assisting women to feel in control during labour there is evidence of reduced need for obstetric intervention when women have support during labour. A Cochrane review included 21 trials, from 15 countries, involving more than 15,000 women in a wide range of settings and circumstances. Women who received continuous labour support were more likely to give birth ‘spontaneously’, (without caesarean, vacuum or forceps), less likely to use pain medications, more likely to be satisfied, and had slightly shorter labours. Their babies were less likely to have low 5-minute Apgar Scores. No adverse effects were identified. In December 2011, WHO published a global review of the key interventions related to reproductive, maternal, newborn and child health.
has been included for all levels of the health care system – community, primary health care and referral levels. All women should have social support during labour. The presence of doulas or birth support companions may also influence the norms of behaviour in the labour ward.

Interestingly, in a quality improvement study from Iran it was reported that women said that they would prefer support during labour and birth from their professional caregivers rather than from their partner or a family member, but would want their partner or family member to be present immediately after the birth. Ideally, pregnant women and expectant fathers will be asked during ANC about their preferences for support during the labour.

El-Nemer et al, after hearing the views of women who were expecting normal births in an Egyptian hospital, propose an approach to the provision of childbirth care in Egypt and beyond which combines the clinical safety of evidence based technical skills with the emotional safety of trusting, respectful, loving relationships; they call this 'skilled help from the heart'.

**Partnerships between traditional midwives and skilled birth attendants**

Davis-Floyd has called for skilled birth attendants to work in tandem and cooperation with traditional midwives. TBAs often have good inter-personal skills and show mothers empathy: "The issue is that TBAs treat women well. They relate with them. This is very important because it makes them come and even refer others to us. .... If your service is bad, then expect everyone to know about it. We also show them love, sometimes the hospitals don’t have time for them. We respect them and they respect us . . .". [TBA in Kenya] But there are sometimes conflicts between TBAs and trained midwives. For example Osabor et al report that in Nigeria there was little willingness from government health workers to work in partnership with TBAs.

Since 1998 the Indonesian government has had a policy of promoting partnerships (pendampingan) between the TBAs (dukun bayi) and the village trained midwives (bidan desa). The AusAID Healthy Mothers Healthy Babies project in South East Sulawesi, Indonesia (1998-2003) encouraged the dukun bayi and bidan to work as partners throughout pregnancy,

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delivery and post-partum. The situation analysis study in Buton district found a willingness to work together: “‘I go to meet the dukun bayi at the delivery. We are both friends. I tell her, if you lose income (because the family pay me also) I will give you some of mine. We will share any money we get.”[village midwife, Buton] “If I work with her (the village midwife) she does most of the work, I massage, clean the dirty sarong and also deal with the placenta. I keep it in the coconut shell and mix it with rice, salt and betel leaf. I wrap it and throw it in the sea. The reason is the placenta should also eat. It means the baby won’t get illnesses and won’t cry.”[TBA, Buton].

Participatory workshops using drawings and mapping enabled discussions to clarify roles. For the mothers it was important both to have the fully trained village midwives at the delivery and the TBAs to provide traditional, cultural, spiritual and psychological support. Local teams also undertook community education and midwives received competency based training. Attendance by trained midwives at births increased from 36% to 56%.

In a similar program in West Java Province, Titaley et al found that the partnership program was beneficial and that community participation was the key to success. “We prefer having both of them. Before calling the midwife, we called the traditional birth attendant. The traditional birth attendant will gently touch the mother, and have some special prayers for that. For us village people, that is helpful. The midwife can take care of the child; the traditional birth attendant can look after the mother. If only a midwife is available, she might not be able to handle everything. There should be both of them.” [Father, Benteng, Ciamis].

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212 AusAID In Indonesia Healthy Mothers Healthy Babies (HMHB) http://www.kangguru.org/ausaidprojects/2003healthymothershealthybabies.htm
4.10 Accreditation

Accreditation of health facilities has long been a strategy to improve quality of care in developed countries. It has been defined as a formal process by which an authorized body assesses and determines whether a health care facility meets applicable, predetermined, and published standards.\(^{214}\)

Evaluation has proved difficult with challenges in linking the structure and process of health care to health care outcomes, and results have been inconclusive. Interest in accreditation has been growing in developing country settings but there are few evaluation reports in the literature. A randomised controlled trial was conducted in Kwazulu, South Africa in 1998, with 10 hospitals in the control group and 10 that undertook an accreditation program with the introduction of a large number of standards of care, including some explicitly calling for greater recognition of patients’ rights and greater patient participation in the care received.\(^{214}\) After about two years, the intervention hospitals’ performance to standards according to the accreditation measurements increased from 38\% to 76\% while no appreciable increase occurred in the control hospitals (37\% to 38\%). However, the study did not find an improvement in independently developed quality indicators, and the researchers present their analysis of why this was, including the likelihood of insufficient time for the program. Patient satisfaction, measured with an 18-item questionnaire with a 4-part Likert scale, was unexpectedly high (about 90\%) both before and after the study, in both intervention and control facilities. An analysis of the methodology concluded that the indicator was likely to be flawed. The authors also point out that the broader environment of increasing HIV epidemic, poor hospital salaries, and emigration of nurses may have prevented full benefits from the program being realised.\(^{214}\)

Rooney’s commentary on this study summarises the lessons learned for such research in resource-poor settings and concludes that “the changes in standards compliance as seen in the intervention hospitals were dramatic and widespread across many areas of hospital operations, leading one to conclude that accreditation does serve a unique role in stimulating a hospital’s quality initiatives.”\(^{214}\)

This analysis highlights the general methodological challenges in undertaking research on quality of care and patient satisfaction. Sitzia, for example, has reviewed patient satisfaction

questionnaires used in 195 studies, predominantly in developed countries, and found that almost all lacked reliability or validity.\textsuperscript{215}

\section*{Discussion}

This review draws on a wide range of studies from several disciplines: human rights, epidemiology, anthropology and the social sciences, policy analysis, human resources and health systems research. Although there are few studies that have the attitudes and behaviours of MHCPs as their primary focus, we found relevant information in studies that aim to document the influences on attending ANC; to identify the determinants of access to and use of delivery care services and to emergency obstetric care; to analyse factors affecting home delivery; to evaluate quality of care; to explore the experiences and perceptions of women giving birth; to assess determinants of uptake of family planning; to document traditional beliefs and practices in relation to childbirth; and to understand factors affecting the motivation and retention of health care staff. This complexity makes it impossible to undertake a formal meta-analysis, as Gabrysch et al also found in relation to reviewing the determinants of seeking delivery care.\textsuperscript{20}

Most of the studies that provide insights into the attitudes and behaviours of MHCPs and their influences and impacts have used qualitative methods to explore the perspectives of women, men, TBAs and health care providers. These are appropriate methods for studying a topic which is complex, sensitive, context-specific and has inter-related influences and impacts. With these methods it is possible to learn things that the researchers might not have known to ask about, and to understand the range of different attitudes and behaviours. Questionnaire surveys of the influences on use of maternal health care may fail to identify provider attitudes and behaviours as a factor because they were not asked about.\textsuperscript{216}

It can be difficult to interpret the findings of quantitative structured questionnaire surveys about, for example, level of satisfaction with care, because it is not known how respondents have


\textsuperscript{216} Ram Jat T, Ng N, San Sebastian MS. Factors affecting the use of maternal health services in Madhya Pradesh state of India: a multilevel analysis. Int J Equity Health 2011;10:59
understood the questions. Partly for these reasons quality of care studies have tended to focus on criteria that are thought of as more objective and evidence-based.\textsuperscript{8}

Efforts to improve attitudes and behaviours of MHCPs necessarily depend on the context and are influenced by other variables related to quality of care, including staffing levels, workloads, financing mechanisms, working conditions, availability of equipment and supplies, strength of referral systems, and the expectations and behaviours of patients and clients. The attitudes and behaviours of MHCPs also influence these variables. Quantitative evaluation of the efficacy of interventions to improve attitudes and behaviours of MHCPs is difficult for these reasons. It is easier to measure clinical aspects of quality so communications and interpersonal skills tend to be relatively neglected.\textsuperscript{217} However, there is a need to be able to quantify the frequency of good and bad attitudes and behaviours, and to evaluate interventions.\textsuperscript{218}

Qualitative findings can be used to develop better quantitative research tools. For example, explicit observation checklists have been developed and used to review both technical and interpersonal skills in the process of providing antenatal, curative and nursing care in primary health units, and tools developed to measure health worker motivation.\textsuperscript{18,219}

Despite methodological challenges there is clear evidence that poor provider attitudes are often a barrier to decisions to seek care and to being referred when complications occur; affect quality of care and patient satisfaction; cause distress and psychological problems for many women; add to stressful working environments for MHCPs; and prevent MHCPs from receiving the respect and gratitude from their patients that they deserve and that provide job satisfaction. The potential for positive attitudes and behaviours to improve outcomes requires more attention.

Efforts to improve MHCP interpersonal skills need to address broader health service issues including workload, remuneration, conditions of facilities, availability of equipment and supplies, staff training, supportive supervision, management, and accountability. Appropriate responses depend on local assessment of attitudes and behaviours and the reasons for them, and will be context specific. Such responses cannot generally be standardised and subjected to

randomised controlled trials.

Antenatal, delivery, postnatal, newborn and child health care should form a continuum, and be integrated with sexual and reproductive health care. All are influenced by the attitudes and behaviours of MHCPs, but the different stages are influenced in different ways. Labour and delivery are short but especially vulnerable times with potential to be stressful for both the woman and the MHCP. Dangerous complications can occur suddenly and unexpectedly. They are culturally significant times with associated traditional rituals but also a time of clinical interventions. Even during a normal labour a woman needs someone to be with her; while the busy midwife is under pressure to look after many women and manage complications and referrals. The antenatal and post-partum periods are significant because they are times of opportunity to give important preventive care services and messages, and encouragement to attend for delivery care with a skilled birth attendant, promoting better outcomes for the mother and her child. Communication skills, showing empathy and respect, providing privacy and confidentiality, are essential in all reproductive and maternal health care provider-patient interactions. But the period of labour and delivery requires additional responses in relation to the patient-provider relationship, including policies and processes to ensure that women have support and are not left alone during labour, that privacy and confidentiality are assured, and that husbands, partners and family members are included.

It was notable that there were far more relevant studies from sub-Saharan African countries than from other parts of the world. While many of the influences on MHCPs’ attitudes and behaviours are likely to be common in resource constrained settings, the cultural and societal context in which MHCPs work clearly has a significant influence and will vary greatly between countries. For example, where politeness is an important cultural value this is likely to be reflected in the behaviour of MHCPs. There is a need for more studies in low and lower middle income Asian and Pacific countries, especially where maternal mortality remains high. In their review of quantitative studies of inequalities in the use of maternal health care in developing countries Say and Raine concluded that there has been an inadequate grasp of the context-specific issues that must be addressed if inequalities are to be reduced.

In this review we have focused on the attitudes and behaviours of health care providers. The relationship between MHCPs and their patients is also influenced by the expectations and behaviours of the patients. This is influenced by several factors in addition to the attitudes and behaviours of MHCPs that they may have experienced previously or read about from other women. Such factors include ethnicity, age, level of autonomy, cultural beliefs about pregnancy and childbirth, education, parity and marital status.\textsuperscript{20}

**Conclusions**

Most MCHPs are caring, respectful and supportive to their patients and clients. But poor provider attitudes and behaviours have been frequently documented in many parts of the world and have significant impacts on health-care seeking behaviour, on the physical, psychological and emotional health of women and their babies, and on the job satisfaction, motivation and retention of MHCPs themselves. These impacts are greatest on the poorest in the population and so add to inequalities in health outcomes.

Influences on the attitudes and behaviours of MHCPs are context-specific and include differences in knowledge and understanding of childbirth, poor working conditions with heavy workloads, class prejudice and stereotyping, feelings of superiority in relation to socio-economic status and ethnicity, frustration at patients’ behaviour, gender inequality, cultural and workplace norms and the implications of the HIV epidemic.

In addition to encouraging a focus on patient-centred care we also need to pay attention to the well-being and rights of MHCPs who too often work in poor and stressful conditions, lacking the effective management, training, supervision, equipment, and supplies that they need to do their jobs. Bensing has discussed the differences between the ‘separate worlds’ of evidence-based medicine and patient-centered medicine.\textsuperscript{221} She suggests that the focus on evidence-based practice can inadvertently result in a neglect of the individual needs and preferences of patients and their emotional status in decision-making. There is a need to ensure that MHCPs develop an appreciation of both approaches and work in an environment that enables them to practice ‘what we know works’. The evidence for interventions to improve maternal and perinatal

survival and achieve the fifth Millennium Development Goal has been reviewed and essential interventions documented and promoted. But these interventions cannot be implemented effectively and at scale without greater attention to the attitudes and behaviours of MHCPs. The need to strengthen health care systems and improve quality of care in order to be able to provide effective reproductive and maternal health care has been well recognised; the attitudes and behaviours of MHCPs and the significance of the provider-patient relationship are now receiving increasing attention. There have been successful efforts and there are useful resources available. But much greater investment is needed.
Appendix 1. Useful manuals and guides
Useful manuals and guides

WHO. ‘Transforming health systems: gender and rights in reproductive health. A training manual for health managers’ 2001. This manual offers a session-based and case-based curriculum on how to promote gender equity and reproductive rights through the use of evidence, policy development and service delivery. Available online and on CD. 


WHO Department of Making Pregnancy Safer: ‘Counselling for maternal and newborn health care: a handbook for building skills.’ 2010. The Handbook has a self-directed learning approach, and can be used in groups with a facilitator or by an individual. There are practical activities to encourage reflection, provoke discussions, build skills and ensure the local relevance of information.
http://www.who.int/entity/maternal_child_adolescent/.../en/index.html


http://www.who.int/hrh/retention/guidelines/en/index.html