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Maternal and Child Survival Program

Mistreatment of Women in Public Health Facilities of Ethiopia

Background

The Ministry of Health (MOH) in Ethiopia set a transformational agenda to improve the lives of women and children. To achieve this transformation Ethiopia has prioritized developing compassionate, respectful and caring health care providers. There are limited information on the status of mistreatment of women in Ethiopian health facilities. In 2016, the MCSP Strengthening BEmONC Project conducted a study on mistreatment of women in public health facilities of Tigray, Amhara, Oromia and Southern Nations Nationalities and Peoples (SNNPR) regions of Ethiopia with the following objectives:

1. To assess facility level norms and policies related to respectful maternity care (RMC)
2. To assess levels of components of RMC reported by women who used labor and delivery services in selected public health facilities
3. To generate an evidence base on the forms and prevalence of mistreatment of women in health facilities.

Key Study Findings

- While Respectful Maternity Care (RMC) policies exist to address the most harmful labor and delivery practices, higher RMC standards are not being met at the facility level.
- Knowledge, awareness, and the expectation of RMC and standards of care remain low for pregnant women.
- Facility managers reported higher levels of RMC practices as institutional policy, while interviews with women revealed that the policies were not universally practiced.
- Across the four elements of mistreatment (physical abuse, verbal abuse, failure to meet professional standard of care and poor rapport between women and providers), 27% of women reported experiencing at least one of the elements of mistreatment. The most cited elements of mistreatment of women during childbirth were: delivery position of women's choice not respected (56%), no explanation of next step during labor (48%), and poor explanation during admission/ examination (39%).
- Health Centers showed better performance on almost all measures compared to Hospitals.

Methods

The study used a cross–sectional, design with quantitative data collection methods. The two data sources included in this report are structured survey interviews with women who delivered in health facilities in the three months prior to the survey and structured survey interviews with facility managers who were on duty during data collection period.

Sampling: The sampling strategy was two-stage (health facility and client). The sample size calculation for the client interview used assumptions of 95% level of confidence, variability of attributes related to D&A with a proportion of 0.14 (using the MCHIP study estimate of self-reported D&A prevalence in the same regions in 2014), a total of 8,630 expected deliveries in health facilities that have at least 60 deliveries per month and an anticipated non-response rate of 10%, plus or minus 4 percentage points of relative error (which is equivalent to 0.56% absolute margin of error), design effect (Deff) of 1.2 and anticipated non response rate of 10% were used. Using these statistical parameters, 382 sample size were required. To allocate the sample to health facilities, the study grouped facilities (85 hospitals and 751 health centers) into high and low delivery case load using probability proportional to size. Using power allocation, 38 health facilities (26 health center (HC), 12 Hospitals) randomly selected for interview. 10 women were allocated to each facility for interview.

Variables and instruments: The elements of mistreatment were measured using the WHO Systematic Review on the Mistreatment of Women During Childbirth[1].

Key variables (topic areas) were physical abuse measured by single item, verbal abuse measured by single item, failure to meet professional standard of care measured by 4 items (neglect, ignore clients in request for pain relief, non-consented care and non-confidential care) and poor rapport between providers measured by 7 items from the woman's survey including not responding to women's questions, not allowing free movement of women, not respecting women's delivery position of choice and food or hot drink not being offered. Key variables (topic areas) on the provider's survey were existence of RMC policies, RMC norms and infrastructure.

Data collection was conducted inside health facilities by 12 hired and trained interviewers. Four supervisors from MCSP and the Ministry of Health (MoH) supervised the data collection.

Analysis: Data were entered using EPI data software and exported to IBM SPSS statistics version 24 for performing statistical analysis. Socio-demographic variables age, residence (urban vs. rural), level of education, marital status and occupation were included for analysis. Bivariate analysis were performed to detect a statistical association of the outcome variables and socio-demographic variables in the study group

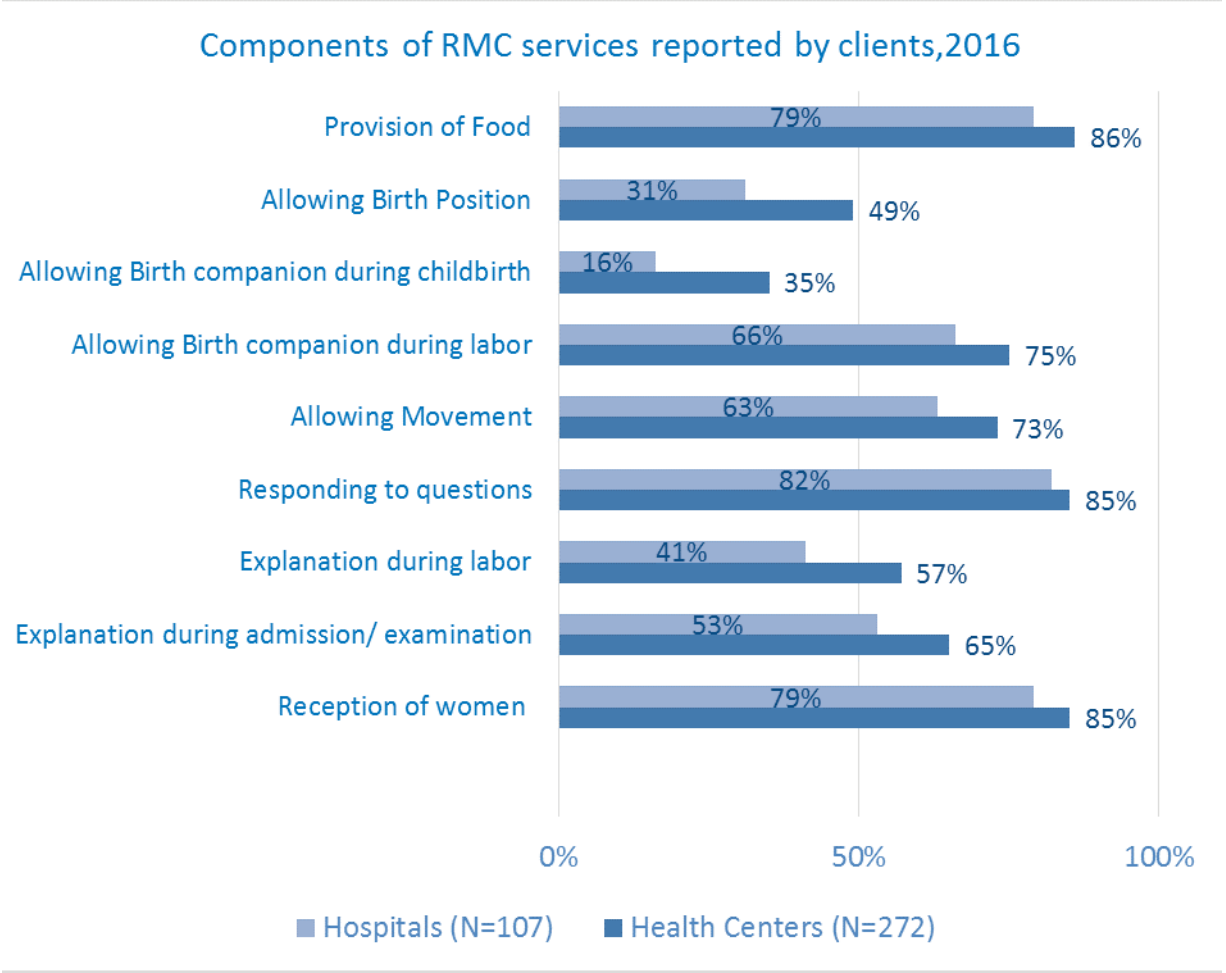
Study results

Of the 379 clients interviewed, 272 (72%) received labor and delivery services from health centers and 107 (28%) from hospitals. Half of the respondents (191, 51%) lived in urban areas.

RMC policies that included freedom of movement during labor and the prevention of institutional violence against women and newborns prevailed universally in hospitals and health centers. However, some policies were lacking, especially in hospitals. These were allowing non-harmful traditional practices, reported in 71% of facilities (85% of health centers and 36% of hospitals), and respecting women's choice of birth positions in 68% of facilities (74% of health centers and 55% of hospitals).

While facility managers reported higher levels of RMC practices as institutional policy, interviews with women revealed that the policies were not universally practiced. The following graph shows RMC practices reported by clients who delivered in health facilities:

1 *M. A. Bohren, J. P. Vogel, E. C. Hunter, O. Lutsiv, S. K. Makh, J. P. Souza, et al., "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," PLoS Med, vol. 12, p. e1001847; discussion e1001847, Jun 2015.*



Using four elements of mistreatment (physical abuse, verbal abuse, failure to meet professional standard of care and poor rapport between women and providers), over a quarter (27%) of women reported experiencing at least one of the elements of mistreatment (see table). The most cited elements of mistreatment of women during childbirth were: delivery position of women's choice not respected (56%), no explanation of next step during labor (48%), and poor explanation during admission/examination (39%). Elements of mistreatment more often reported in hospitals than health centers were: no explanation of next step during labor (59% in hospitals and 43% in health facilities, p=0.006), verbal abuse (20% in hospitals and 14% in health centers), and delivery position of women's choice not respected (69% in hospitals and 51% in health centers, p=0.002).

Overall, 12% of women responded that they experienced mistreatment during labor and delivery by health workers, measured by the question – "did you feel humiliated or disrespected?" However, when asked about anyone of the three components of mistreatment (physical abuse, verbal abuse and poor rapport between women and provider, 27% reported mistreatment by health providers.

The forms of mistreatment reported in this study were as follows:

Elements of mistreatment of women during childbirth	Health center		Hospital		Total	
	%	N	%	N	%	N
Any mistreatment reported by women	24	66	32	35	27	101
Physical abuse						
Women being hit /slapped/ pinched by the provider	2	5	2	2	2	7
Verbal abuse						
Women being shouted at, scolded, threatened, insulted	14	38	20	21	16	59
Failure to meet professional standards of care						
Neglected or left unattended	10	28	10	11	10	39
Requests for pain medication ignored during complications	45	36	19	7	37	43
Consent was not requested prior to procedures	14	38	20	21	16	59
Confidentiality was not ensured	7	18	6	6	6	24
Poor rapport between women and providers						
Poor reception of women by health workers	15	40	21	23	17	63
Poor explanation during admission/ examination	35	96	47	50	39	146
No explanation of next step during labor	43	117	59	63	48	180
Not responding to women's questions	15	28	18	14	16	42
Free movement not encouraged	27	73	37	40	30	113
Delivery position of women's choice not respected	51	136	69	72	56	208
Food or hot drink not offered	14	39	21	22	16	61

Recommendations

The study team makes the following recommendations for MOH, Regional Health Bureaus and zonal and district level health management structures, health facilities, MNH implementing partners, and the donor community:

Based on the identified gaps in facility level norms and policies related to RMC, policies are needed on the promotion of RMC and the elimination of mistreatment of women in health facilities to include:

- Allowing birth companions of a woman's choice into the health facility including early labor and delivery rooms for all health centers and hospitals. Where space constraints make this challenging, facility management should be supported to make small but notable changes to furniture, equipment, screen arrangements, and where required provide financial resources to support infrastructure changes to enable birth companions into facilities whilst not compromising the privacy of other clients, and the quality of care.

- Support facilities to use their facility-generated revenue to make small infrastructure changes to enable RMC to be provided (e.g. patient screens, gowns/slippers for birth companions to wear in delivery rooms, additional mattresses to allow women to adopt alternative birthing positions).

- Measures of success in reaching these standards should be built into current quality checks (e.g. National MNH Quality Assessment Tool).

- Facilities should set-up reporting mechanisms for clients to report mistreatment confidentially and forms of redress should be tied to the regulation of health care professionals and improving accountability.

- Efforts should be directed towards educating and sensitizing the public on elements of RMC and the level of care to expect from a facility and health care providers. These could be in the form of public posters, as well as posters in facilities, and integration of messages on RMC and rights of child bearing women into e.g. Safe motherhood campaigns.

- All in-service and pre-service training related to provider/client interaction should ensure compassionate and respectful care (CRC) is included, and in-service training focused on MNH care should place an emphasis on improving RMC and reducing mistreatment.

- For health care providers, RMC within the wider CRC framework should be initiated at pre-service education to promote RMC, eliminate mistreatment, and to develop a compassionate caring and respectful health workforce as they enter the workforce.

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