Implementation of respectful maternal care in health facilities in Conakry, Guinea

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Research Article

Keywords: care, maternal, respectful, city of Conakry

Posted Date: February 10th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-153372/v1

Abstract

Objective: Describe the implementation of Respectful Maternal Care in health facilities in the capital and discuss lessons learned.

Methods: This was a cross-sectional descriptive study by direct observation of providers from November 29 to December 01, 2020. It consisted of a baseline assessment of pilot sites prior to training in respectful maternal care, followed by the traditional five-day training and an extension to urban health centers, due to their on-site training in SONUB (obstetric and neo-natal care) Basic emergency natals) including the Respectful Maternal Care Training Module (PMF). Random random sampling by random draw, three guards per site, a midwife with a parturiente and their families, providers of health centers in post-training follow-up, were observed through the seven (7) performance standards (Table2) on the skills received. The investigators were clinical synthesis students who were trained in the use of the tool.

Results: 199 providers (138 midwives, 49 nurses and 12 doctors) were trained in PMSC in the 24 health facilities in the capital. Post-training follow-up through providers made the following findings in the different areas of PMSCs: The seven (7) standards were observed prior to training in the 6 pilot sites (Center Médical Communal (CMC) of Matam, Minière, Ratoma, Coléah, Bernard Kouchner and the maternity hospital of the National Ignace Deen Hospital) (Fig.1), two were achieved or 0.3 the practice improved compared to the situation of the basic evaluation: in the seven areas of respectful maternal care evaluated and monitored, performance varied by area from 26% to 100% (Fig.2). In health centers, good practice was observed with the observation of skills during post-training follow-up: In the seven areas monitored, performance varied from 50% to 100% (Fig.3)

Conclusion: SMR. integration was effective in 25 health facilities in the city of Conakry; training, internal and external regular supervision and provider awareness are essential to sustain PMSCs in daily practice.

Introduction

Respectful Maternal Care is a key component for safer motherhood, but is often ignored by health providers. Lack of respect and abuse of women in health facilities continues to be a dominant public health issue in many countries, violating the human rights of women to be treated with respect and not to suffer harm [1]. One of the main aspects of reducing maternal mortality is, in particular, the increase in skilled assistance for deliveries and deliveries to health facilities with qualified personnel, material resources, medical supplies and the capacity to provide emergency obstetric and neonatal care [2,3]. Improving the quality of care during childbirth is therefore an important step in increasing the supply of maternal health services. However, major problems remain in Guinea, where material resources are limited in health facilities, drug supply chains are unreliable, shortages of health workers exist and the cost of care can be prohibitive [4,5].

In light of global efforts to improve maternal health and the quality of care, the issue of mistreatment of women during childbirth has received increasing attention in recent years. Likewise, the World Health

Organization has identified improving women's care experiences as an essential component of strategies to improve the quality of care [6] This includes respectful maternal care for the woman, effective communication between the provider and the woman, and emotional support for the woman during labor and delivery [6] A recent systematic review synthesized the global evidence on maltreatment during childbirth and presented a new typology to describe the phenomenon [7].. This review builds on other field work, including a landscape analysis [8] and primary studies conducted in Kenya, Tanzania and Nigeria [9-11]. In Guinea, anecdotal evidence suggests that women across the country experience abuse during childbirth. However, research in this area was carried out in Guinea by the team of Mamadou Diouldé Baldé et al [12] which enabled us to understand different forms of abuse against women.

Maltreatment research is clearly a necessary step in exploring and understanding what happens to women, working with providers to change their behavior and prevent abuse. This is the most effective way to encourage women to use health services when the climate of trust is established between women and their communities with health care providers.

Such abuse and abuse create a psychological distance between women and health-care providers, and then remove them from health-care systems, for fear of being subjected to such violence, and sometimes constitute a greater barrier than geographical or financial barriers to maternal health services in terms of use [13,14].

This important negative aspect of maternity care can influence the decision of women not to use health services during their current or future childbirth, [7] thus contributing to a decrease in the number of births attended by unqualified personnel. It is therefore crucial to know the forms of disrespect and abuse that exist, to prevent them and to better respond to the emotional, physical, sociocultural and psychological needs of women in the context of efforts broader to provide better quality care.

Disrespectful and abusive care was classified into seven areas: physical abuse, discrimination, non-consensual care, care without dignity, neglect or neglect, non-confidential care and detention in health facilities [15].

In our context there are few studies on respectful maternal care, this study aims to implement this new concept in maternity hospitals in the city of Conakry and to draw lessons learned.

Overview of Maternal Health in the City of Conakry

Comparison of the results of EDS V 2018 with those of EDS-MICS 2012 and EDS III 2005, shows that the proportion of births that occurred in a health facility has increased significantly, é 31% in 2005 à 40% in 2012 and 53 per cent in 2018 and home births are still very frequent, but falling (69 per cent in 2005 compared to 59 per cent in 2012 and 47 per cent à 2018)

In the capital, Conakry, almost all é births took place in a health é (90%). However, in the Labé (30%) and Faranah (34%) regions, these percentages are significantly lower.

The proportion of births attended by trained personnel is 96% in Conakry, the percentages of women who receive é assistance à childbirth by a é provider are relatively lower in the Labé (34%) and Mamou (42%) regions. In family planning efforts are being made, the highest contraceptive prevalence has been recorded in Conakry at 16%, the needs met in PF for spacing is 55.2% and 6% for limiting [16].

One of the barriers to improving the quality of respectful maternal care during childbirth is a lack of equipment, insufficient providers and a small working environment in Conakry health facilities. In Guinea, there are approximately 108 obstetrician-gynecologists, 409 midwives and 1189 nurses to serve a population of nearly twelve million [17]

Methodology

All methods were performed in accordance with the guidelines (Declaration of Helsinki) and regulations relevant in this study

STUDY SITES

The framework of our study was: The eighteen urban health centers of the city of Conakry, which constitute the first level of the health pyramid and offer the seven functions of SONUB, The five Communal Medical Centers of Conakry (CMC): Matam, Minière, Ratoma, Coleah, Bernard couchner, constituting level II of the country's health pyramid and offering the nine full emergency obstetric and neonatal care (SONUC) functions and the maternity hospital of the National Ignace Deen Hospital (level III of the health pyramid) which in addition to care, teaching and research activities also offer the nine SONUC functions.

1.2 TYPE OF STUDY

We had conducted a descriptive cross-sectional prospective study by direct observation of the providers that took place from November 29 to December 1, 2020. The first step was the evaluation before the formation of the six pilot sites that are the CMC (Matam, Minière, Ratoma, Coléah, Bernard Kouchner) and the maternity of the National hospital Ignace Deen, the restitution of the results of the Basic assessment followed by the five-day classical training, Four weeks after we proceeded to post-training follow-up. We have expanded the SONUB on-site training module of the eighteen urban health centers, followed by a post-training evaluation after four weeks. The standard (Table 2) is said to be reached when all the verification criteria (Table 1) are met, it is noted by yes (O)

The standard is said not to be met when at least one of the verification criteria is not met it is noted by no (N)

It is said to be not applicable when the standard is not applied and it is noted by (NA)

The performance is calculated by the ratio of the standards achieved over the observed standards multiplied by 100. (Table2)

1.3 INCLUSION CRITERIA

Included in the study were all providers (doctor, midwife, nurses) who have their names on the on-call board and who perform the service, as well as all providers who were trained and received post-training follow-up in the CSU on respectful maternal care.

1.4. NON-INCLUSION CRITERION

Non-custodial providers, trainees and non-trainees were not included. The observation begins at the taking of the guard until the end of the guard

1.5 SAMPLING

Random sampling was used with the drawing of lots from three providers, based on the midwifery watch list for sites with more than three full midwives and a thorough recruitment of all providers who had completed the respectful maternal care training in the Conakry UHC.

1.6 DATA COLLECTION

The data presented here were collected using SMR. performance standards:

 Prior to formal training, by direct observation of the providers of pilot sites on the labor process and delivery.

 Post-training follow-up for all PMQ trained providers in four weeks after training.

The three teams of guards were observed by structure, a midwife for a parturist with their companions and the seven SMR. performance standards were the main collection tool. The investigators were clinical synthesis students who were trained in the use of the collection tool.

1.7 STUDY VARIABLES

During the direct observations, the investigators reported clinical and interpersonal aspects of care, including the greetings of providers to the parturiens and their companions, infection prevention protocols, specific procedures conducted, the nature of interactions between providers and parturientes through the performance standards in respectful maternal care.

Table 1: Variable of study

Category of disrespect	Audit criteria
Physical violence	Pinching, slapping, episiotomy without anaesthesia, pushing, hitting
The woman's right to information, informed consent and choice/preference is not ensured (non-consensual care)	Procedure carried out without information to there parturiente,
Confidentiality and privacy of the woman is not maintained (Non-confidential care)	Health-related information revealed to others, Discovered during treatment or examination, no barriers blocking vision during treatment or examination
The woman is not treated with dignity and respect (Undignified care)	Shouting, reprimanding, threatening to suspend services, laughing or scorning,
Women do not receive equitable care, discrimination	Social behaviour, religion, ethnicity, skin colour.
The woman is never left alone without care.	Leaving the woman alone During labour, during delivery, during a complication, after delivery,
Detained or confined against their will.	Keeping for reasons other than health

Table 2 : Performance Standards

STANDARDS NOMBER	Performance Standards	standard achieved Y N or NA	COMMENT
1	The woman is protected from physical harm or ill treatment.		
2	The woman's right to information, informed consent, and choice/preferences is protected		
3	Confidentiality and privacy is protected.		
4	The woman is treated with dignity and respect.		
5	The woman receives equitable care, free of discrimination.		
6	The woman is never left without care.		
7	The woman is never detained or confined against her will.		

Total of standards	7
Standards observed	
Standards achieved	

1.8 DATA ANALYSIS

The analysis of the data was carried out using the Excel software

Results

The baseline assessment of the pilot sites showed that two (2) out of seven (7) standards were met, or 0.3%. equitable care without discrimination and never held against her will (Fig2)

Twenty-one (21) providers in the pilot sites received the traditional training, of which twenty (20) trained providers received the post-training follow-up, or 95% (Fig2)

178 providers from the 18 urban health centers in the city of Conakry received respectful maternal care training and post-training follow-up was 100% (n=178) of the trained providers.

Discussion

The results presented here are among the first direct observations of the lack of respectful maternal care during childbirth, as well as the first known specific results in an urban hospital in Guinea. The study found that disrespect and abuse of women during childbirth were common. Of the seven standards observed in the baseline assessment prior to training, only two were met or 0.3% (Fig.2) due to the free availability of care kits. This low frequency encountered in our study would certainly be related to the lack of training or the lack of knowledge of this practice.

The lack of training of providers in respectful maternal care is a determining factor in the lack of respect and abuse of women during childbirth [18,19].

Studies have shown improvements in the administration of care and in client relations following the training of providers in PMSC [20,21,22]. This form of targeted training could improve the self-awareness of providers and raise their awareness of how to better involve women during childbirth. In addition, to advise women in advance on what to expect during childbirth, including their right to informed consent, their privacy and their confidentiality, and whether they have preferences for a person of their choice to attend their labor, which improves their experience in childbirth [21].

The absence of physical violence increased from 38% during the baseline assessment of pilot sites to 75% during post-training follow-up (Fig.2) which in turn remains low at the Conakry UHC result with a frequency of 86% (Fig.3). The finding in our study was higher than that reported by Okafor et al [11] which was 36%, and from Anteneh and Col in Ethiopia 25.9% use of physical force where abrasive behavior such as slapping or striking [22]. This high frequency in our series would be explained in part by the training and follow-up of providers after training.

Women's right to information, in turn, saw a marked improvement from 26% in the baseline assessment to 35% in post-training monitoring of pilot sites (Fig.2) and 80% in UHC (Fig.3). Our results were also

higher than those of Uzochuwu and al [23], which accounted for 54.5% of non-consensual care.

Confidentiality and intimacy, a challenge in all sites of our study that was low at baseline 41% and post-training 35% (Fig.2). This situation was little improved at the CSU, i.e. a frequency of 50% (Fig.3). The observations in our study are higher than those reported by Igboanugo et al. [24], which was 16.5%. The literature review [11] focuses in particular on the lack of privacy. This observation could be explained in our context by the fact that providers do not encourage accompanying persons to stay in the room; and this is easily understood by the small size of our procedural rooms that cannot accommodate so many people. Moreover, they do not answer questions promptly, politely and truthfully. The explanation is not given to the woman or her companions on the development, the progress, the progression of the work and on the delivery periodically, nor do they allow the woman to walk during the work.

According to dignified care, provider performance improved from 46% at baseline to 85% at pilot sites (Fig.2) and 100% at UHC (Fig.3). Our results were higher than those reported by Idris S and col. in Niger ranging from 11.3% to 70.8% of unworthy care [25]. In the David sando et col study in Tanzania, 84% of women did not consent to the examinations they received [26]. We noted in our study that the behavior of the providers did not allow the woman and her companion to observe their cultural practices as much as possible (Ms. remove your black dress before entering our room about a midwife). Care was provided in an equitable manner without discrimination; this was one of the strengths of our study from baseline to post-training follow-up in both pilot sites and CSU with performance ranging from 90% (Fig.2) to 100% (Fig.3). This could be explained by the free care and availability of consumables in the procedure room. This was contrary to the Okafor et al. in the state of Enugou in Nigeria, which reported 20% of care with discrimination based on ethnicity, low social group, young age and HIV status [11]. According to the fact that the women were left alone without care, the performance improved from 48% to 70% of the baseline assessment to follow-up-post training in the pilot sites of the study and 67% in the CSUs. This decrease in performance is due in part to the mobility of providers often found in front of the television or in telephone communication. “Midwives also threatened to leave women alone during childbirth if they didn't comply with their demands, for example to lie on the delivery table and remain silent.” Our results are higher than those reported by Okafor in Nigeria which was 29.16%. [11]

In our series no woman is detained against her will in our study sites, a performance of 100% (Fig.2 ,Fig.3) . This could be explained by the free care offered to pregnant women, deliveries and the care for newborns that the Guinean government has granted to the population.

In our study, the finding is contrary to that reported by Okafor in Nigeria where 22% of women were incarcerated for non-payment of their bills and those of their baby [11].

Conclusion

The integration of PMSCs is effective in 24 health facilities in the city of Conakry, training, regular internal and external supervision and the awareness of providers are essential for its sustainability in everyday

practice Highlights RMS can be done with 57% and 70% of the skills that have been achieved in the CMC, National Ignace Deen Hospital and Urban Health Centers respectively.

 No woman is detained against her will in all structures

 Better performance in urban health centers compared to CMC and National Hospital.

 Follow-up-post training of all providers

Study limits

 This study was conducted on direct observation of providers

Declarations

Acknowledgements

We would like to thank the HSD project carried out by JHPIEGO for the training and follow-up of SMR. providers in the city of Conakry. Competing interests Authors state that they have no competing interests

Abbreviations:

CMC: communal medical center

CSU: Urban health center

EDS: Demographic and health survey

SMR: Respectful maternal care

SONUB: Basic emergency obstetric and neonatal care

SONUC: Comprehensive obstetric and neonatal emergency care

HSD: High quality health service for development

Contributions by authors

Soumah Aboubacar Fode Momo was the principal investigator who contributed to the study design, collected, entered, analyzed and interpreted the data, Soumah Aboubacar Fode Momo, Diallo Mamadou Cellou, Conte Ibrahima, Sylla Ibrahima, Bah Oumou Hawa, took charge of the design and analysis. Soumah Aboubacar Fode Momo, Diallo Abdourahamane Kadiatou, Bah Ibrahima Koussy, have prepared the first version of the manuscript, which will then be read and modified by Abdourahamane Diallo, Sy Telly, Keita Namory. All authors have read and approved the final manuscript.

Funding : not applicable

Availability of data and equipment

The datasets used and /or analyzed during this study are available from the corresponding Author

Ethical approval and consent to participate in the study

Ethical approval and consent to participate. The Human Research Ethics and Publications Committee of Gamal Abdel Nasser University in Conakry Guinea, approved the research protocol for this study. Prior informed consent was requested and obtained from all participants (investigators, patients, their families) recruited for the study, anonymity was used throughout the process. Administrative authorization was requested and obtained from the managers of the study sites.

Consent to publication

Not applicable

Competing interests

The authors declare that they have no competing interests.

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Figures

Figure 1

Health map of the city of Conakry

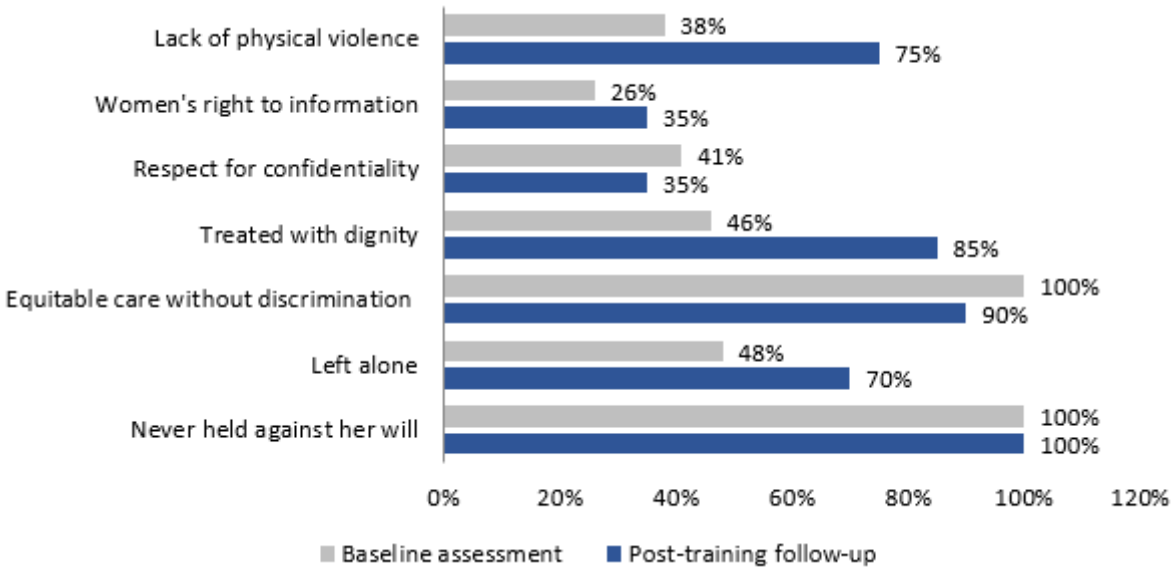

Figure 2

Providers' performance in practicing RMS in health pilot sites the baseline assessment and during post-training follow-up (n=6)

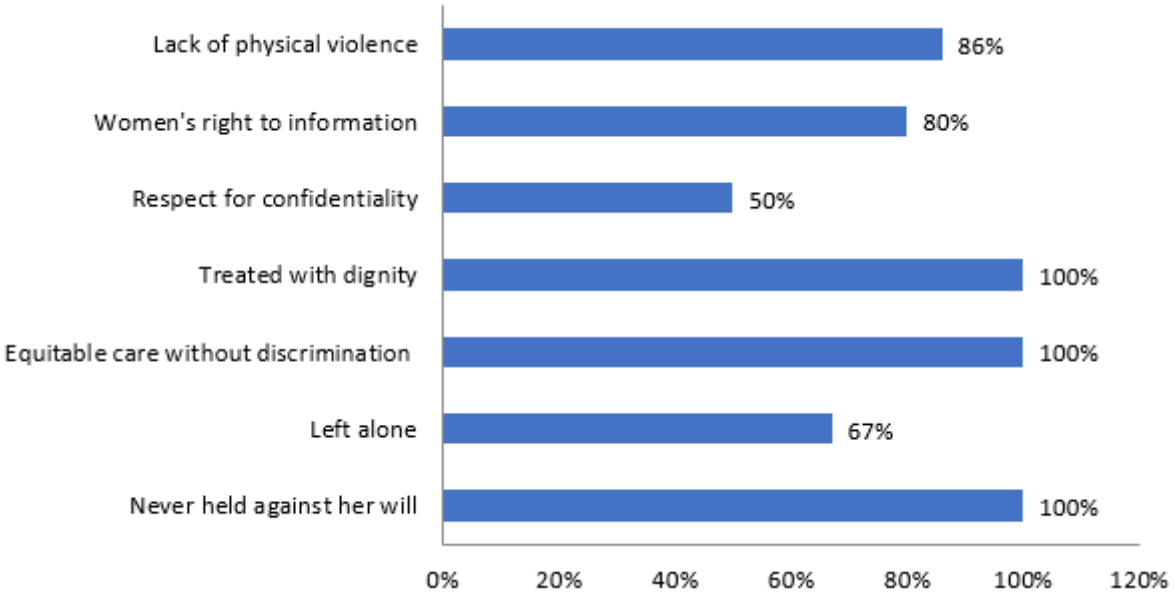

Figure 3

Providers' performance in practicing RMS in Urban health center during post-training follow-up urban health center (n=18)