

Exploring the Feasibility of using a four-day Training Program to Change the Culture of Disrespect and Abuse in Maternity Care in Ghana

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Research note

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Abstract

Objectives To improve childbirth experiences for childbearing women in healthcare facilities in low-and-middle-income countries, it is important to implement a cost-effective intervention to change the culture of disrespect and abuse in maternity care. Thus, we explored the feasibility of using four Respectful Maternity Care Modules in a training program to change the culture of disrespect and abuse in maternity care in a teaching hospital in Kumasi, Ghana.

Results Midwives were trained on respect and dignity in childbirth, effective communication, focused antenatal care, and the use of alternative birthing positions for delivery. The statistical test revealed a statistically significant increase in knowledge of RMC following participation in the RMC-M training, $z = -3.43$, $p = 0.001$, with a large effect size ($r = 0.63$). The median score on the self-developed Respectful Maternity Care Questionnaire increased from pre-program (Md = 10) to post-program (Md = 15). The experts remarked that the content of the training was adequate to enhance midwives' knowledge, skills, and attitude to provide respectful maternal care. They recommended the inclusion of teaching methods that engages the adult learner in an interactive mode.

Introduction

Over the last two decades, many childbearing women in low-and-middle-income-countries (LMICs) have had skilled-birth-provider-assisted deliveries in health facilities, resulting in the reduction of maternal and neonatal morbidities and mortalities (1–3). Nevertheless, the current maternal mortality estimate is undesirable and deserves prompt policy action: about 830 women die daily from preventable causes related to pregnancy and childbirth complications globally, with 99% of these deaths happening in LMICs (4).

In LMICs, the lifetime hazard of a woman dying from risks associated with pregnancy and childbirth is greater than for a woman living in a developed country (4). As in many other LMICs, pregnancy and childbearing related disabilities, morbidities, and deaths negatively affect the quality of life and wellbeing of Ghanaian childbearing women and their families (5–7). Ghana, having failed to meet the millennium development goal of reducing maternal mortality ratio from 650 to 319 per 100,000 live births by the end of 2015(8), is expected to further reduce maternal mortality to less than 70 per 100,000 by 2030 in line with the third sustainable development goal (SDG 3.1) (9).

Financial barriers that had prevented childbearing women in the past from accessing maternity care services significantly reduced through the government of Ghana's introduction of the national health insurance scheme and the free maternal care policy. The policy has contributed to the increased utilization of facility-based deliveries with a corresponding reduction in maternal and neonatal morbidities and deaths (10–14). However, the enduring positive influence of the utilization of facility-based deliveries with skilled birth attendants on maternal and neonatal health outcomes is currently

under threat due to frequently reported cases of disrespect and abuse in routine maternity care in healthcare settings in Ghana (15, 16).

The recent demographic health survey report indicated that facility-based deliveries decrease with each childbirth, with more childbearing women choosing to have their subsequent deliveries at home (17). Childbearing women in Ghana are citing these reasons for not desiring to utilize facility-based deliveries for future childbirths: midwives' lack of sympathy and empathy, neglect, rudeness, verbally and physically abusive behaviour, lack of temperamental control, inadequate attention, and lack of privacy (15, 16, 18).

To significantly improve upon the success of childbearing women's utilization of facility-based deliveries in Ghana, it is crucial to eliminate disrespect and abusive care practices by creating an atmosphere of respectful maternity care in healthcare facilities across the country (19, 20). Cost-effective interventions that addressed the menace of disrespect and abusive maternity care in Ghana are rare (21). The available evidence of such an intervention is a pilot project implemented in the East Mamprusi District in the northern region of Ghana (21). The project revealed that training that equips skilled birth attendants to provide quality and respectful maternity care had the potential to improve women's childbirth experiences (21).

The present paper is an evaluation report of a pilot project that explored the feasibility of using a four-day training program to change the culture of disrespect and abuse in maternity care by equipping midwives with knowledge, attitudes, and skills on respectful maternity care in a tertiary health facility in Kumasi, Ghana. This pilot study provides the basis for a large-scale study to be undertaken in June 2020.

Methods

Midwives were assessed on respectful maternity care knowledge before and after undertaking the four-day RMC training in March 2019. The assessment tool used was a self-developed Respectful Maternity Care Questionnaire (SDRMC-Q), which has four domains with each containing five questions. The four-day training was facilitated by two midwifery tutors who had undergone a Trainer-of-Trainers workshop. During the workshop, two independent experts/observers from the College of Health Sciences at the Kwame Nkrumah University of Science and technology were invited as independent observers of the training; their roles were to provide critical remarks and suggestions on the content of the modules, teaching methods, materials and adequacy of time spent on training activities.

Study Setting

The study setting was a tertiary health facility in Kumasi, located in the Ashanti region, the central part of Ghana. The study setting was chosen because of the major role it serves in Ghana's healthcare delivery. It serves patients across the country and has a bed capacity of approximately 1,200 and a staff strength of about 3,000. It is the main referral hospital for the Ashanti, Brong Ahafo, Western, the three Northern regions (Northern, Upper East, And Upper West), and neighbouring countries. It has twelve (12) clinical directorates, one of which is the maternal and child health directorate (MCH-D). The MCH-D has two main

units—the general ward and the special ward. The general ward is an open ward the use of which is covered under national health insurance, and the special ward is a private ward which is accessed at an extra cost.

Study Participants

We recruited fifteen midwives who were working in intrapartum facility-based childbirth units in the study setting.

Brief Description of Respectful Maternity Care-Modules

A training manual, called Respectful Maternity Care Modules (RMC-M), was used to guide the four-days training intervention. The RMC-M comprises of four modules (Additional file 1). The manual contains detailed contents on each module: 1) respect and dignity in childbirth; 2) communication; 3) focused antenatal care; and 4) use of alternative birthing positions for delivery. The training employed interactive teaching and learning methods such as role-play, discussion, brainstorming, demonstration, and case study to inculcate in midwives the acceptable practices, skills, and attitudes for respectful care provision.

Data Analyses

The Statistical Package for Social Scientist (SPSS) version 21 was used to analyse the quantitative data. The full-scale and subscale scores were generated. The scores were generated by awarding the mark of “1” to any of the correctly answered questions and a mark of “0” to a wrong answer. The highest mark a midwife can obtain on any of the subscales is “5,” and the total mark for the full-scale is a “20.” The authors examined the differences in scores between the pre-intervention and post-intervention using Wilcoxon Signed Rank Test. Also, the independent observers and midwives remarks and recommendations on the training program were presented under themes. Answers to the questions on birthing positions were analysed thematically presented under a theme in the finding’s section.

Results

Demographic Features of Participants

The midwives were, on average, 33 years old, with a range of 31-48 years. They had engaged in professional practice for an average of eight years. Seven participants obtained a bachelor’s degree in midwifery and the remaining a diploma [diploma is a qualification above high school certificate but lower than a bachelor’s]. Only one of the midwives was a Muslim, and the others were Christians. Eleven were currently married. Those with children (n=10) had an average of 2.3 living children (range = 1-3).

Pre and Post Assessment Results

Generally, the midwives have had improved scores on each of twenty questions on respectful maternity care after the training (Additional file 2). To ascertain the actual impact of the training on midwives’

knowledge of RMC, a Wilcoxon Signed Rank Test was performed.

A Wilcoxon Signed Rank Test to compare midwives' scores on the SDRMC-Q before and after the four-day RMC-M training program (Table 1). The result revealed a statistically significant increase in knowledge of RMC following participation in the RMC-M training program, $z = -3.43$, $p = 0.001$, with a large effect size ($r = 0.63$). The median score on the RMC-Q increased from pre-program ($Md = 10$) to post-program ($Md = 15$).

(Please insert Table 1 here)

Midwives and Experts' Remarks and Recommendations on the RMC-M Training

The experts noted that the RMC training program is feasible to implement and has the potential to equip midwives to effectively provide respectful maternity care. They further commented and provided general recommendations on the content of the modules, teaching methods and materials, and the time spent on training activities. They indicated that the contents of the four modules were comprehensive and they specifically addressed issues related to disrespectful and abusive maternity care in childbirth. They further noted that the total time allocated for the delivery of each module was supposed to be 8 hours. However, the average time spent on each day was about 4 hours. The experts concluded that each module should be delivered within six hours with short coffee breaks, and modules three and four should be combined and administered in a day. According to them, reducing the duration of training will encourage the release of staff by employers and enhance participation in future training sessions.

Midwives expectations

The midwives were satisfied with the training program and provided recommendations to improve upon the quality of the training program. First, the organizers of the program should involve all healthcare professionals in the hospital in the training program because childbearing women were sometimes disrespected and abused by staff that are not midwives. Also, the principles of RMC, as elaborated through the training program, should be emphasised in all nursing schools across the country.

Hospital administrators and other managerial level staff should be invited to participate in the training because it will help them understand RMC, and they will appreciate the need to provide the midwives with the necessary equipment for respectful maternity care. The midwives further recommended that the hospital CEOs and other relevant authorities should be persuaded to equip the maternity wards with the necessary equipment and tools for the effective, alternative birthing positions.

Furthermore, an aspect of the training module should include lessons on the psychological effect of disrespect and abusive care and information on the legal implications of rendering disrespectful maternity care. They also indicated that the training should be frequently organized to achieve the training's main objective of changing the culture of disrespect and abusive maternity care.

Finally, they noted that role plays were very effective in helping participants understand the concepts of the RMC, therefore, they proposed that this teaching method should be allocated enough time. They further noted that participants that are selected for the role play should be pre-informed to rehearse a day before so that they can effectively demonstrate the lessons during the training period.

Discussion

The results suggest that using the RMC-M for training has the potential to enhance midwives' knowledge of RMC. The results obtained from this study add to the growing body of knowledge that suggests that low-cost RMC training for healthcare providers has the potential to equip midwives with the right knowledge and attitude in providing quality respectful maternity care (21, 22).

The post-test results indicated that majority of the midwives had higher scores on the effective birthing position subscale, with nine of them obtaining perfect scores. The reason for this result could be that the midwives may consider the birthing position as the most crucial aspect of helping childbearing women safely deliver their babies. Another reason for their high scores could stem from the fact that the effective and alternative birthing positions were the last module taught before the post-test assessment. There was no noticeable difference between the pre-test and post-test scores of midwives on the dignified and respectful childbearing women care. Results obtained from other studies also confirm that short-term training of this nature has little impact on midwives knowledge on dignified and respectful care (21).

Limitations

The study has several limitations that are worth mentioning. The findings of the pilot study were based on a very small sample size, making it impossible to generalize for all midwives. However, a pilot study engaging a handful of study participants is ideal because it is a cost-saving approach and now that the results are positive, a larger, actual project involving a representative population of midwives can be pursued.

Declarations

Abbreviations

MCH-D: Maternal and child health directorate; D&AC: Disrespect and Abusive Care; Low and Middle-Income Countries (LMICs); SDRMC-Q: self-developed Respectful Maternity Care Questionnaire; RMC-M: Respectful Maternity Care Modules; RMC: Respectful Maternity Care

Ethics approval and consent to participate

The Committee on Human Research, Publication, and Ethics (CHRPE) at the Kwame Nkrumah University of Science and Technology (KNUST) gave the ethical clearance for the study (CHRPE/AP/181/18), and the managerial board of the teaching hospital gave the institutional approval for the study

(RD/CR17/289). Participants were briefed on the study and their rights to voluntary participation and withdrawal from the study with no consequences. Only participants who consented were involved in the project. The participants gave their consent to both the qualitative RMC knowledge assessment and the training. Participants' confidentiality was ensured by interviewing in an enclosed office. Information that could reveal the identities of the participants were excluded from the filled assessment questionnaire to ensure participants' anonymity.

Consent for publication

Written informed consent for publication was obtained.

Availability of data and materials

The dataset supporting the conclusions of this article are included within the article and its additional files.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

DMV, DP, and LJ are the project leads, and they contributed to the conceptualization, data curation, formal analyses, writing of the original manuscript, as well as editing and review of the final manuscript. BAB, AL, and NKE contributed to the data curation, formal analyses, writing of the original manuscript, editing, and review of the final manuscript. AP contributed to formal analyses, writing of the original manuscript, editing, and review of the final manuscript.

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Table 1

Table 1: Comparison of Pre and Post Assessment

RMC Domains	Pre-test Score		Post-test Score	
	Median (Min-Max)	<i>n</i>	Median (Min-Max)	<i>n</i>
Dignified and respectful childbearing women care	3 (1-4)	8	3 (1-4)	9
Communication in childbearing women care	3 (2-4)	10	4 (3-5)	8
Focused antenatal care	1 (0-3)	9	3 (3-5)	10
Effective birthing positions	3 (2-4)	8	5 (3-5)	9
Overall Score	10 (7-12)		15 (12-17)	

Min: minimum score; Max: maximum score; n: number of midwives who obtained the median score out of the 15 recruited midwives.

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