Preventing Disrespect and Abuse of Maternity Care Clients in Sub-Saharan Africa

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Background

- Disrespect and abuse (D&A) of clients by healthcare providers during labor, delivery, and the immediate postpartum period discourages institutional delivery, contributing to avoidable maternal morbidity and mortality.
- Dimensions of D&A include: 1) physical abuse; 2) non-consented care; 3) non-confidential care; 4) non-dignified care; 5) discrimination based on patient attributes; 6) abandonment; and 7) detention in health facilities.[4]
- Meta-analysis of data from 33 studies across Africa estimated that D&A occurred in 44.09% of all births.[10] Individual studies have estimated prevalence rates as high as 78.2% in some settings.[9]
- The prevalence of D&A varies by type of healthcare facility; provider cadre and gender; and client characteristics.[3] Young women and rural women are more likely to experience D&A than those who are older, more educated, or more affluent.[6]
- D&A is influenced by policy (lack of laws); service delivery (lack of standards and supervision; understaffing; provider bias), and individual/community factors (normalization of D&A; lack of empowerment; lack of community oversight).[4]
- Most interventions addressing D&A rely primarily on in-service training of providers and employ a multi-day workshop format combining didactic content with case studies and role plays.[7]

Objectives

This review examines the effects of multi-component interventions on disrespect and abuse of maternity care clients compared to provider training alone.

Methods

Literature for this review was gathered through a search of the PubMed database using the terms “disrespect and abuse” “maternity care” and “Africa.” Parameters were (1) peer-reviewed; (2) original research papers; (3) published since 2015; (4) in English. This search yielded 91 studies; of which 85 were excluded because they were non-experimental in nature or conducted outside of sub-Saharan Africa. Reference lists of remaining studies were reviewed for additional resources, as were the websites of organizations active in maternal health globally. Six studies were considered for full-text review.

Evidence Summary

Author (Year)	Sample	Intervention	Results	Level (Melnyk, JHNEBP)
Abuya (2015)	Client survey: 1369 Observation: 1200	Policy dialogue, provider training, supportive supervision, maternity open days, community dialogue, reporting system.	Reported D&A decreased from 20% - 13%. Significant reductions in physical abuse (OR 0.5), verbal abuse (OR 0.6), and non-confidential care (OR 0.5).	VI IIB
Dhakal (2022)	9 studies	Provider training: 5 studies. Multi-component interventions including training: 4 studies.	Results were mixed and study quality variable. No definitive conclusions regarding effectiveness of provider training.	V IIIC
Kujawski (2017)	Client survey: 3068	Client service charter, private admissions, privacy curtains, client satisfaction surveys, staff tea, staff counseling.	66% reduction in odds of D&A ($p<0.0001$). Increased likelihood of rating provider and quality of care excellent or very good (RR 3.44, $p<0.0001$, RR 6.19, $p<0.0001$).	III IIA
Mengistu (2021)	23,129 births in facilities in study area, number sampled unclear	Varied by facility. Common interventions included maternity ward tours, privacy screens, and group counseling for pregnant women.	In one region, significant increase in privacy and birth companionship, which was maintained one year post-project (increment trend of 18%, $p<0.001$). Results were mixed in other two study regions.	IV IIB
Ratcliffe (2016)	Client survey: 149 Observation: 459 Provider survey: 55	Provider training and action plan development, staff recognition events, staff tea, privacy screens, client exit feedback, maternity open days.	75.8% of women were very satisfied with their delivery experience at endline, compared to 22.8% at baseline. 63.1% rated care excellent/very good at endline, compared to 2.9% at baseline.	VI IIC
Smith (2022)	Client survey: 152 Provider survey: 68	Client-provider promise, pain management toolkit, facility refresh funds, provider workshop, client feedback box.	Clients at intervention facilities were 15 percentage points less likely to report any form of D&A than at comparison facilities ($p=0.01$).	III IIB

Implications for Research and Programming

- Despite more than a decade of global discourse, there are few interventions deliberately addressing D&A.
- The most common elements of multi-component interventions are provider training; client feedback mechanisms; and maternity ward tours.
- The quality of provider training addressing D&A varies widely. Interventions may be strengthened through greater focus on communication skills; exploration of provider values and attitudes; and use of QI and human-centered design processes. Low-dose, high-frequency approaches should be prioritized.[8]
- D&A is a multi-factorial phenomenon, and it is unlikely that a single intervention package will be effective in all contexts; research should focus on identifying “best-odds” interventions and documenting how to adapt them to new contexts.
- Future studies should allow for attribution of effects to specific intervention components and employ validated instruments (such as those developed by Afulani et al.). Enhanced HMIS data may be used to support research findings.
- Collection of detailed cost data will inform advocacy and allocation of scarce health sector resources.
- CNLs are uniquely qualified to contribute given training in promotion of evidenced-based practice; quality improvement processes; interprofessional communication; and change management.

Conclusions

Multi-component interventions designed in consultation with clients and providers have the potential to reduce D&A and improve client satisfaction. This may contribute to increased rates of institutional delivery – a key priority in countries where institutional delivery is low and maternal mortality is high, including much of the Horn of Africa and selected regions of Tanzania, Ghana, and Nigeria. Improved client-provider interaction may also yield broader benefits, including renewing trust in health systems that faltered during the COVID-19 pandemic and reinforcing equity in health service delivery.[16]

References

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