Safety before comfort: a focused enquiry of Nepal skilled birth attendants’ concepts of respectful maternity care

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Abstract

Background. Respectful maternity care is the universal right of childbearing women, but in Nepal there are no midwives to deliver this care and it is provided by skilled birth attendants (SBAs), who may be physicians, certified nurses, auxiliary nurse-midwives or degree-trained nurses.

Aim. To explore how this concept of respectful maternity care was perceived by SBAs in practice.

Design. Focus group discussions were used and the setting was two tertiary level maternity hospitals in Nepal. Ethical approval for the study was obtained from the Nepal Health Research Council. A total of 24 SBAs were recruited voluntarily from the maternity units. Data were analysed using a phenomenographic approach and interpretation was verified by the focus group facilitator and note-taker.

Findings. Five categories, divided into 16 sub-categories, present the SBAs’ collective description of respectful care.

Conclusions. SBAs understood that respectful care at birth was important, but argued that ‘safety comes before comfort’. To achieve safe maternity care, the contribution of relatives is essential, in addition to the provision of medical care.

Implications. Family members need to accompany the woman and her newborn from admission to discharge to provide basic care and this needs to be reviewed. Professional midwives need to be trained, recruited, and deployed in areas where they are most needed and the government needs to regulate the profession and make it legal.

Key words: Maternity care, midwifery, phenomenographic analysis, focus group discussions, evidence-based midwifery

Introduction

The WHO’s definition of a skilled birth attendant (SBA) is someone ‘trained to proficiency in the skills needed to manage normal ( uncomplicated) pregnancies, birth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns’ (WHO, 2004: 1).

In Nepal, there are no midwives to deliver this care and it is provided by SBAs, who may be physicians, certified nurses, auxiliary nurse-midwives, or degree-trained nurses (National Health Sector Support Program, 2012). In addition to basic education, the above professionals can undergo two-month country-specific SBA training, which covers respectful care (Utz et al, 2012; White Ribbon Alliance, 2011). Nepal does not yet have midwives, according to global standards for the role of a midwife (Bogren et al, 2013; van Teijlingen, 2012; International Confederation of Midwives, 2010; Family Health Division, 2006).

Women need access to SBAs to be safe during birth, but the quality of that care is crucial (Harvey et al, 2007). Quality of maternity care and its improvement is one of the priorities in the long-term Nepal National Safe Motherhood and Newborn Health Plan, 2006-2017 (Family Health Division, 2012). The goal of the plan is to ensure delivery of healthcare services with full community participation and gender considerations. This is reported to be undertaken throughout the country by competent and responsible SBAs (Ranaa et al, 2007; Family Health Division, 2006).

In order to increase the number of births attended by the SBAs, the maternity incentive scheme was introduced in 2005 (Ensor et al, 2009). This has provided expectant women with the opportunity to give birth inside healthcare facilities free of charge. This has contributed to more women accessing such facilities for birth (from 19% to 36%) (Ministry of Health and Population, 2012). However, this increase has not reached the MDG5 target of 60% by 2015 (Family Health Division, 2012). One reason for this could be the lack of access to the healthcare system, resulting in many women choosing to give birth at home (72%) with no skilled assistance (Ministry of Health and Population, 2012). Other women choose to approach tertiary level hospitals, bypassing nearby birthing centres (Department for International Development in Nepal, 2010).

Women in Nepal give birth at an early age. It is estimated that 17% of married women aged 17 to 19 are either pregnant with their first child or are already mothers. On average, a woman in Nepal has three live born children (WHO, 2013a). The birth of a child is often a welcomed event with high involvement of family members (Bajaracharya, 2012; Filippi et al, 2006). However, a lack of professionals to assist women during pregnancy and birth and high patient flow at tertiary hospitals (Family Health Division, 2006) increases the likelihood that these women will experience disrespectful maternity care (Swahnberg et al, 2007). Disrespectful care has been identified by Bowser and Hill (2010) as physical and verbal abuse, abandonment, non-consented, non-confidential, and non-dignified care. Respectful maternity care, as set out in Table 1, is the universal
right of childbearing women (White Ribbon Alliance, 2011). However, there are limited descriptions of the SBAs’ own views of respectful care in overloaded tertiary hospitals in Nepal. Furthermore, recent publications can be critical of SBAs and their disrespect to women (Bowser and Hill, 2010; Swahnberg et al, 2007). This study aims to explore how this concept of respectful maternity care was perceived by SBAs in practice, based on their professional working life experiences at two tertiary maternity hospitals in Nepal. The SBAs in the study are nurses and not all of them have undergone additional Nepalese country-specific two-month SBAs training. The terms ‘at birth’ or ‘in maternity care’ are used in this study to define the care a woman receives from admission to discharge. The term ‘comfort care’ refers to non-medical tasks regarding basic care.

Method

The settings

This study was conducted in two tertiary level hospitals in Nepal. Both are recognised as teaching-learning facilities and training and research sites in reproductive health. One was a specialised maternity hospital with more than 25,000 births annually and the other was a multidisciplinary hospital with more than 4000 births each year.

Focus groups and participants

A focus group interview was conducted with the optimal size of four to eight participants. They aim to capture perceptions, opinions, beliefs and attitudes towards a concept or service. The interaction between the focus group members can be considered as a dialogue rather than a discussion, although in less depth. The moderator is leading the session, focusing the topic and notes are taken by an assistant to get the best outcome and understanding of the tape-recorded focus group interview when transcribed (Morgan, 1998; 1996; Kitzinger, 1995). In this study, the four focus group discussions (FGDs) took place in meeting rooms at two maternity hospitals in Kathmandu. The interviews were conducted by two nurse-research members of the research team, one acting as moderator, the other as note-taker (Morgan, 1998; 1996). The group was mixed regarding work experience and age. Inclusion criteria was: a minimum of three months in a maternity unit; and at least five deliveries attended during their professional career. They were informed and assured that they were free to withdraw from the discussion at any time. Participating SBAs gave written informed consent and all the data remained confidential within the group of researchers. The SBAs were female nurses, aged 21 to 56, with the average age of 32. Details of participants are in Table 2. Ethical approval for the study was obtained from the Nepal Health Research Council (reference no 1434).

Procedure

The focus groups were conducted between July and November 2013, with between five to eight participants in each group. Information (including

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<th>Variables</th>
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<th>FDG 3</th>
<th>FDG 4</th>
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<tbody>
<tr>
<td>No of participants</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Education in nursing/midwifery</td>
<td>Masters</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bachelor</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Proficiency certificate</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Average working experience:</td>
<td>9 years</td>
<td>5 years</td>
<td>3 years</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Received additional SBA training</td>
<td>5</td>
<td>3</td>
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The outcome of the analytical process is presented as a collective phenomenographic description of the perceptions (presented in the finding section) which constitutes the ‘outcome space’ with sub-categories and categories (Wenestam, 2000).

The first step in the analysis was familiarisation. In the first reading of the transcribed interviews, the perceptions of the SBAs were assessed with a view to capturing their understanding of respectful care at birth. Step two identified 150 different conceptions. In step three, each statement was carefully examined for meaning and refined, while preserving the original context and meaning, and described. In the fourth step, similar statements were grouped together. The groupings were: caring on demand; one-to-one care by relatives; communication; information; emergency; environment; professionalism; education; definition of respectful care; public versus personal; perception of respectful care; relatives’ support maintained the basic care in the ward; knowledge gaps; respecting visitors; respectful care; woman’s right; time is changing. In step five, the text in the different groupings were read and re-read, separated, and similar topics were grouped together, condensed, described and labelled into a structure of five categories and 16 sub-categories.

The SBAs’ collective perceptions were described in five categories and within the 16 sub-categories in a varied way. The final step, the comprehensive description was confirmed as an accurate reflection of the original data. The analysis was a dialectic process between the authors. The focus group facilitator and the note-taker verified the description to be presented in the ‘outcome space’ with sub-categories and categories and the SBAs’ perceptions were in that way confirmed.

Findings

The five themes from the SBAs’ collective perceptions of respectful care are broken up into 16 sub-categories.

Relatives’ involvement in mother and baby’s care facilitated respectful care at birth

This category was represented by four sub-categories:

It was easier for SBAs to ensure respectful care when relatives were there with the woman

The SBAs’ perception was that the relatives’ support maintained respectful care of the woman as they could stay close to the mother and baby during antenatal visits. The SBAs arranged counselling sessions with the husband or mother-in-law to bridge gaps in understanding and convince them about what needed to be done to ensure good health of the woman and baby. Relatives then counselled the woman to ensure that she was agreeable to the work being undertaken by the SBAs. When there was shared decision-making with the woman and her relatives, this enhanced respectful care. The woman felt secure with relatives accompanying her:

“Here one visitor is allowed (husband/mother-in-law/ anyone),... and she feels comfortable and her spirit rises up giving her a feeling that she can give birth” (Shanti, FDG3).

Birth preparedness of the woman-relative dyad

The SBAs wanted to be transparent and felt that they guided the dyad in steps throughout the birth process. They ensured that the woman and her relatives continuously provided information and told them about what would happen next. The information provided would vary depending on the woman, her relatives and their education:

“Family support, providing proper information and records to the patient party and hospital orientation is what I think is respectful care” (Madhu, FDG4).

Knowledge is beneficial to respectful care

The SBAs found it beneficial to the woman when she had comprehensive knowledge about birth. A lack of knowledge meant that sometimes the SBAs had to be more assertive with the woman-relative dyad to ensure the best outcome. The SBAs recalled that during a natural labour process, some women would complain about the SBAs being uncaring because the woman did not understand the normal birth process and why the SBAs preferred normal birth instead of interventions. There is a need for the woman-relative dyad to have more perinatal knowledge. In order to raise the quality of care, it is vital that the woman and her relatives are provided with adequate information during antenatal visits. This lack of knowledge did, however, ensure the mother’s compliance:

“In other countries the patient, husband and family are given information which we do not have here. They don’t know in which position to deliver the baby... therefore they don’t make us do that” (Anu, FDG3).

Respecting the woman-relative dyad

The SBAs had a wider patient focus that included respecting the family. The SBAs felt that, in order to maintain respectful care for the women during birth, they should respect and inform the woman’s relatives about her progress. The relatives were expected to monitor the labour and report to the SBAs:

“If one person is allowed to stay with the mother then they will be able to see if the labour is progressing and whether or not the mother is getting proper care” (Deepa, FDG1).

A respectful environment enhances respectful care

This category was represented by three sub-categories:

Communicate and seek advice and support from colleagues

It was said that if an SBA was not able to manage a situation, they should seek advice and support from their colleagues instead. The SBAs felt that during antenatal visits the SBAs should not take place in front of the woman or other colleagues:

“An environment of respectful care should be created from the time of antenatal care through to delivery and postnatal care” (Shwari, FDG1).

Importance of professional behaviour

The SBAs felt that it was important to show their identity with a name badge, post and field of work. In that way the woman and her relatives would feel they were being treated by fully trained and skilled service providers. This increased the woman’s and relatives’ trust of the SBAs. The SBAs wanted

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Table 1. Seven articles of women’s right to respectful care (White Ribbon Alliance, 2011)

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<th>Every woman has the right to:</th>
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<tr>
<td>1. Be free from harm and ill treatment</td>
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<tr>
<td>2. Information, informed consent and refusal, respected for her choices and preferences, including the right to choose her birth companion</td>
</tr>
<tr>
<td>3. Privacy and confidentiality</td>
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<tr>
<td>4. Be treated with dignity and respect</td>
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<tr>
<td>5. Equality, freedom from discrimination and equitable care</td>
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<tr>
<td>6. Health care and to the highest attainable level of health liberty, autonomy, self-determination</td>
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<td>7. Freedom from coercion</td>
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The study aim and data collection methods and request for voluntary participation in the FGDs was communicated to all SBAs (also physicians) through the nursing directors. Potential participants were able to contact the research team directly. When at least five SBAs had expressed their interest, a time and place for a focus group was agreed. The opening question was: ‘Most of you have heard about the term “respectful care at birth”. What does that mean to you in your working life?’ The participants shared their conceptions, stories and experiences. The interview continued with questions designed to capture their professional experience with the focus on the SBAs’ conception of respectful care at birth. Participants were encouraged to talk freely and, when necessary, the moderator asked follow-up questions. Each focus group interview lasted 90 to 120 minutes, was tape-recorded and transcribed verbatim. A total of 110 pages were produced and translated into English. A WHO guideline for translation and back translation was used (WHO, 2013b).

Analysis

The analytical approach of Marton (1986; 1981) inspired the design of the present study with the aim of exploring how the construct respectful maternity care was perceived by SBAs in practice by capturing their conceptions. The phenomenographic method was originally developed by Marton (1986; 1981) in the field of learning to identify different aspects of reality as conceived by different people.
to be recognised and encouraged by senior staff members for their professional behaviour. They felt that if a professional attitude was lacking among themselves, it would influence their ability to provide respectful care to the woman.

Respectful care at normal birth empowered SBAs. The SBAs defined respectful care as caring without discrimination of, for instance, caste and religion. They told how they felt empowered when they were held responsible for a normal birth and fulfilled the woman’s psychological and physiological needs during birth. Lack of privacy for the women during labour were identified as barriers to providing respectful care. Dignity and security were the priorities for the SBAs to prevent unnecessary interventions.

Preservation of hierarchical roles and structures was not beneficial to respectful care at birth

This category was represented by three sub-categories:

A blame culture

The SBAs described how, when complications arose, a culture of blame threatened respectful care. When complications or problems occurred, the doctors sometimes blamed the nurses: “On one occasion I told the doctor that when I informed you about the complication in time, you did not take heed and when the problem became serious you blamed me” (Meeta, FG3).

Hierarchical structure – an obstacle to respectful care

The SBAs reported that respectful care was not always possible due to a hierarchical structure and cultural attitudes, gender roles and social status. Nurses were considered by doctors, families and patients as helpers or assistants due to their gender and lower social status. The SBAs felt that tension was created by the overpowering view of the medical professional overshadowing the rights and desires of the woman for a normal birth. Barriers to provision of respectful care identified included: power dynamics, high patient needs, lack of privacy and a low salary: “Social status also plays a role. How much we ever try to inform and make the patients and families understand, they will say that we are just a nurse. Then when the doctors come, they will listen to the doctor” (Pramila, FG3).

Teamwork – essential for respectful care

The SBAs said they wished teamwork was a priority above all else. The SBAs felt it was critical of SBAs and their disrespect to women (Bowser and Legare, 2012). Would education programmes for women and girls regarding their own sexual and reproductive health and rights empower them to make decisions? (United Nations Population Fund, 2013)? An education programme that specifically addresses female reproductive health would be in line with the expressed intentions of the Government of Nepal to consider education to gender issues and improve the quality of care (Family Health Division, 2012).

Strength and limitations

Regarding trustworthiness of the literature review, no review analysis or analysis of the quality of the referred article has been performed. The search strategy was to find and present Nepal-specific articles related to SBAs and respectful care. Moreover, the broad overview of the field documents and reports from the Nepal government and international organisations were prioritised and might be a threat to the depth of the literature review. As the participants were self-recruited, it’s likely that they were already interested in the subject, threatening the trustworthiness of the findings. Although the translation from Nepali to English and back translation in the first phase by a Nepali person with appropriate knowledge of Nepali and English, as well as the topic, there is no guarantee that in the translation process some of the findings were not unintentionally distorted or misrepresented (WHO, 2013b). To achieve trustworthiness (Polit and Beck, 2012), data gathering and analysis was carefully conducted and data collected in a systematic and reliable way. The translation process, analysis or analysis of the quality of the referred article was conducted. The analysis process, members of the research team discussed the analysis and findings, and the focus group facilitator and note-taker verified the conceptions, thus ensuring credibility. Quotations presented along with the findings support our interpretation. However, these findings should not be transferred to other contexts and settings without careful consideration (Polit and Beck, 2012).

Conclusion and implications

The SBAs understood that respectful care at birth was important, but argued that ‘safety comes before comfort’. The SBAs identified that women can only have respectful care if facilitated by relatives. Hence, the contribution of relatives, in addition to the provision of medical care, is essential. For practice, family members need to accompany the woman and her newborn in maternity care from admission to discharge to provide basic care and this needs to be reviewed. SBAs need to support and educate relatives to enable them to provide comfort care to the mother and her...
newborn baby. Multidisciplinary staff meetings could also be recommended to build trusted relationships and a mutually respectful environment. For policy, the development of a midwifery workforce planning tool to determine the required number of midwives for safe and respectful maternity care would add weight to the recommendation to employ sufficient midwives in Nepal. Professional midwives need to be trained, recruited, and deployed in areas where they are most needed and the government needs to regulate the profession and make it legal. Further studies could be undertaken into all levels of healthcare facilities to develop country contextual respectful care interventions.

References


