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Original Research Article

Live experience of community health workers on respectful maternity care in rural Odisha, India: a phenomenological study

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ABSTRACT

Background: Every woman deserves respectful maternity care, throughout her journey to motherhood. However, disrespectful maternity care is prevalent in various settings. It has an effect on the utilization of services. It can be more explored from the witness of maternity. The aim of this study was to explore the experience of accredited social health activists on respectful maternity care in Odisha, India.
Methods: A qualitative exploratory study was conducted among 24 ASHAs with more than two years of experience to gain a deeper understanding of the phenomenon. This study was conducted in three distinct Odisha districts, India.
Results: Two main themes emerged: Community health workers' experiences and perception towards disrespectful care, and Factors contributing to irrational care. Participants explained that verbal abuse was the most common use of health care providers. The consequences of such abusive behavior hinder the effective and efficient performance of their role, especially when it comes to their role in the facility. The study highlighted major gaps in the behavior and attitudes of healthcare providers at the facility level.
Conclusions: Despite the lack of knowledge and training related to RMC, ASHAs acknowledged the abusive and disrespectful behavior of health care providers not only towards the child-bearing women but also towards the accompanying person, i.e., ASHA or a member of the family. Such mistreatment often acts as a barrier to the use of public health services, such as the institutional delivery of child-bearing mothers. A need for orientation and training on RCM among healthcare professionals, along with appropriate monitoring of implementation.

Keywords: Respectful maternity care, Healthcare providers, Perceptions, Disrespect and abuse, Mistreatment, Birth companion, ASHA

INTRODUCTION

Maternal and child health (MCH) is considered to be one of the key development indicators of any country.[1] Over several decades, improvements in maternal deaths around childbirth have been quite moderate in low-and middle-income countries (LMICs) leading to the MCH strategy as a global campaign to improve maternal health.[2] The reduction of maternal and child mortality as well as morbidity remained at the center of successive family welfare programs implemented in India through the Government of India, various state governments, and partners including international organizations and civil society platforms; however, India still bears an

unacceptable burden of maternal and infant mortality.[3,4] Evidence shows that institutional delivery reduces the risk of neonatal mortality by 29 percent in LMICs; it also reduces stillbirth and perinatal mortality as well as maternal mortality.[5-9] Therefore, including the international organization; the national and state government of India promoting various scheme and programs to encourage women for institutional delivery to ensure safe birth.[10] Similarly, efforts have been made in India to encourage families to change their health-seeking behaviors so that the majority of underprivileged families can be mobilized for institutional delivery in public health institutions. The demand side financing scheme, Janani Suraksha Yojana (JSY), was launched in 2005 by the National Rural Health Mission of India, which also included cash incentives for community health workers (CHWs) accredited social health activist (ASHA). In addition, in order to strengthen the supply side, Janani Sishu Suraksha Karyakram (JSSK) was designed as an entitlement scheme for pregnant women and newborns in 2011.[11] The World Health Organization (WHO) initiative to improve the standard of care given to pregnant women during childbirth is as critical as providing clinical care to achieve the desired human-centred outcomes.[12] Access to health care facilities may not, however, guarantee good quality of care.[13] Across the world, disrespectful and unworthy care is prevalent in many facility settings, especially for underprivileged populations which violates their rights to create a significant obstacle to seeking healthcare and discourage them to favor institutional delivery.[13]

However, the literature revealed that there is little evidence in India regarding respectful maternity care (RMC). Therefore, the purpose of this study was to explore the experiences of ASHAs on RMC in Odisha, India.

Rationale

Disrespect and abuse (D&A) is a concept closely related to obstetric violence. Also, respectful maternity care (RMC) is not only a crucial component of quality of care; it is a human right. There have been many anecdotal reports which depicts pregnant women seeking maternal health services receive discrimination, abandonment, disrespect and abuse in a health care facility. In the Indian context, there is an urgent need to execute specific research which will explore and highlight the community peoples' knowledge and perception regrading disrespect and abuse not only at the facility level, but also at the community level. ASHA is the grassroot level worker which connects community as well as the health system. ASHA could be a helping-hand in spreading awareness among the community related to disrespect and abuse, which enrich the concept of respectful maternity care among the child-bearing mothers in a community. Hence, it is important to know the perception of ASHA towards respectful care in the facilities and her role in providing knowledge about respectful maternity care in the lens of human rights.

METHODS

Design and settings

A qualitative exploratory study was conducted in Odisha, India. Three districts were chosen from the 30 districts of the State, with one district from each of the three revenue zones of the State. Total of 24 In-depth interviews (IDIs) were conducted among ASHAs eight from each district. All of these participants were actively involved in the provision of MCH services, motivating and accompanying women for institutional delivery.

Inclusion and exclusion criteria

Participants were recruited by authors who belonged to the study settings (SS, KP, and SJ). Providers were, on average, 30 years old ranging from 23-38 years, and everyone had working experience for more than three years. All participants belonged to rural areas. Those who are not willing to participate were excluded from the study.

Ethical consideration

The names of the districts were not maintained in order to protect confidentiality. A brief overview of the study, the intent, and their position over the research study was provided to the participants prior to participation and their written consent was obtained. The interview was conducted at the home of the participants according to their convenience.

Data collection and analysis

The data were collected using semi-structured face-to-face interviews between March to May 2019. The interview guide was developed in the local language in this case 'Odia'. The interview guide contained questions about the participants' understanding of RMC and their perspectives as well. Participants were asked about their involvement as a birth companion, the facility's situation, and the health care provider's behavior. In addition, they were questioned about their opinion on addressing disrespect and violence at the facility level. All the IDIs were recorded digitally. The interview lasted between 30 and 65 minutes, with an average length of 45 minutes. The interviews recorded were transcribed and translated into English. The data were analyzed using content analysis methods.[14]

Interview guide

The interview guide was developed in English and later translated into Odiya by the researcher. The interview guide was at first piloted and pre-tested for comprehensibility with a sample of five ASHAs at Khurdha. The interview guide contained questions on participants' perceptions and current opportunities and practices on respectful maternity care. To address our first research aim, participants were asked about their perception towards respectful maternity care, how they

assess child-bearing mothers' needs and expectations prior to the delivery in a hospital, and their job responsibilities towards a delivery mother. They were also asked directly about their health promotion activities in terms of respectful maternity care at the village level. In addition, our second research aim was to explore ASHA's respectful maternity care practice opportunities, specifically in the view of promoting institutional delivery and their role in delivering respectful care. The researcher also asked for their suggestions or recommendations regarding disrespect and abuse or practicing respectful care at the individual level.

RESULTS

Two main themes emerged: Community health workers' experiences and perception towards disrespectful care, and Factors contributing to irrational care. The findings are presented under each major theme/category with quotes from the participants.

Theme 1: Community health workers' experiences and perception towards disrespectful care

Category 1: Disrespect towards the childbearing women: A number of experiences have been perceived by ASHAs regarding the behavior of healthcare providers. Although some said about the warm and gentle actions of doctors and nurses, others shared their negative encounters. The most common expression of the study participants was in reference to medical negligence, misbehavior, and bribery. In addition, inadequate contact to support mothers who have discomfort during work has been rooted in maternity care practices. "The senior gynecologist is really nice. He is very polite, and he treats us and pregnant women as members of his family, however, the nurse expects money from the family of delivery women" (Participant 1). In addition, discrimination in maternal health services was expressed by ASHAs, which identified social determinants such as economic status, and caste as factors affecting mothers' accessibility and experience in health services. For example, a poor mother from a lower social caste was more likely to be discriminated against and exploited when receiving maternal health care in public health facilities. "There are two-three nurses who only tend to work with cases of higher castes. The staff nurse is very reluctant to deal with cases coming from the scheduled tribe (ST) community. We have no issues with mothers who have a good financial background. Mistreatment often happens with poor ladies-they have been unable to provide bribe" (Participants 16, 20 and 22). Participants also established the notion of the insensitive and coercive essence of maternal care given at health facilities. The abuses have been encountered both verbally and physically, often both. During the intrapartum period, the mothers were scolded, eve-teased, and slapped. Another dimension of disrespect witnessed by ASHAs was during the episiotomy process. In a few health facilities, episiotomy is performed by service providers without the consent of the mother or accompanying person. If questions raised by the mother or the accompanying person, the health service providers threatened to refer them to another hospital or insist on visiting private hospitals. "After delivery, Rama (name of the mother) shared her terrible experience of being scolded during delivery; you didn't have any pain during sexual intercourse, and now you're behaving like dying out of labor pain (stated with much anger)" (Participant 14).

Category 2: Disrespect with accompanying persons: Lack of information related to dignified care; the bureaucratic nature of the health care system was the key reason why ASHAs were scolded by healthcare providers. Few ASHAs said they had to establish a good relationship with their ANMs and other health professionals to prevent mistreatment. For example, most of the time, they had to do the job of an attendant, such as buying coffee or tea. "Sometimes, after birth, the mother was left without a cloth. I wrapped her up when I was allowed to enter the room. We were asked to clean the floor and the bed; if we refused, my patients would be referred to a private nursing home, where high out-of- pocket expenses" (Participant 3). The understanding of the ASHAs was that the presence of the relatives ensured a loving care of the child-bearing mother as they could stay close to the mother and the newborn during and after birth. Although few ASHAs have been reported, most healthcare providers have not allowed anyone inside the labour room. Often, if the relatives inquired about the women, most of the time they were verbally abused. The lack of information related to women during a crucial time was also a form of disrespect usually experienced by relatives in health facilities. One ASHA reported that the husband of a child-bearing woman faced disrespect and chose not to use the services in the future. "Just close your mouth and stay out there. Don't question us again and again. If you inquire another time, just take your wife to another hospital" (Participant 8).

Category 3: Birth preparedness and complication readiness and case priority: When asked to identify the participants as to their responsibility and obligation towards a child- bearing woman, few participants reported that Birth Preparedness and Complication Readiness (BPCR) often contributes to mistreatment by health care providers. The two important components of the BPCR are the identification of the birth companion and the organization of the mode of transport. Few ASHAs reported on the various challenges they faced while taking a child-bearing woman to the facility, specifically in terms of transportation. In the event of an emergency, sometimes the ambulance could not reach a time that restricts mothers not only from providing maternal health services, but also ended up facing disrespectful behavior on the part of health providers. Although few ASHAs acknowledged their mistake in this situation, few blamed the management of the health care system. Some participants have clarified the adverse situation they had to face from both the community and the health system, which sometimes resulted in an uncomfortable state. "Listen to" was just the term, no one really tried to grasp it. As a result, they felt devoid. In resource-limited facilities, eight women had to

be taken care of simultaneously most of the time by one health care provider, and at that point, emergency and life-saving treatment had to be given priority over comfort to a woman. Few participants also made it clear that caste, socio-economic status, and multiparity could lead to discrimination and abusive behavior on the part of healthcare providers. "The staff usually focus on the only high-risk cases. If health providers treat everyone equally and provide equal services, then no one will feel superior and inferior" (Participant 11).

Theme 2: Factors contributing to irrational care

Category 1: Institutional factors: According to the participants, many of the facilities have been under-equipped, which has always compromised patient safety and quality of care. The scarcity of human resources and workloads eventually led to abusive behavior and to the mistreatment of patients. In some cases, doctors suggest referrals to other private health facilities from which commissions are received. "Most of the cases were referred to the nearest private hospital. The doctor does this, knowingly, in order to get extra income from there" (Participant 17). Lack of transparency was also a factor leading to disrespect and violence at the facility level. ASHAs clarified that no one at the facility level would like to take responsibility for offering any potential solution to the actions of the providers. They also indicated that if anyone could track and supervise them and inform them about the attitudes they exhibit to the patients. "I couldn't understand whom to approach about the problem at the hospital. Nobody is going to listen" (Participate 20, 21).

Category 2: Non-compliance with guidelines and ineffective enforcement mechanisms While numerous policies have been introduced in India, which depict health rights, the definition and theory have remained abstract and their implementation has been neglected in public health facilities. In addition, participants had no clear knowledge of health policies and regulations, suggested developing possible policies, strengthening the care delivery system or strictly monitoring existing regulations, so that mothers would be able to receive respectful care during their maternity period. Taking feedback from and accompanying pregnant women could be an effective strategy for improving the delivery of quality maternal care. The respondents suggested for few rules and regulations at the health facilities which should be legitimized and followed strictly by every single resource person. The implementation of a grievance redressal mechanism would be an appropriate solution to improve the quality of care in the form of respectful and dignified care. The respondents suggested a few rules and regulations for health facilities that should be legitimized and strictly followed by every single resource person. Implementation of the grievance redress mechanism would be an appropriate solution to improve the quality of care in the form of respectful and dignified care. "Feedback must be received from the mother or family members on their experience of service. Then only the doctors and nurses will be afraid of being abused" (Participant 8).

Category 3: The hierarchical structure of the health system: It has been understood that breaches of the concept of respectful and dignified care have always been the product of professional hierarchical systems, power relationships, education and cultural attitudes. Responses of the participants showed that the overpowering perception of health care providers often transforms to shame and contempt because of the hierarchical nature of health care providers. "Education and status play an important role. They are the doctors and the nurses. How much we are going to try and convince and make patients and families understand, they are going to say we are just a nurse. When the patients arrive, they must listen to the doctor" (Participant 9).

DISCUSSION

Community health workers explained that the type of abusive behavior of the child-bearing women was significantly different. Verbal abuse was one of the most common and often used by healthcare providers toward community health workers. The consequences of such abusive behavior hinder the effective performance of their role in the facility. Although many community health workers did not have sound knowledge of RMC, the study highlighted major gaps in the behavior and attitude of health care providers at the facility level. The use of institutional health services for delivery reduced the risk of complications between the mother and the newborn baby. Various studies have shown that institutional delivery reduces the risk of maternal and newborn mortality and reduces stillbirth.[7] A comparative analysis performed by Chinkhumbaet.al revealed that perinatal mortality was 21 percent higher for home delivery compared to facility delivery.[15] A substantial decrease in maternal, fetal and neonatal mortality was associated not only with institutional delivery but also with the involvement of professional workers.[16] Similarly, the study found that, compared to women with intrapartum complications at home, the incidence of perinatal mortality among women with intrapartum complications was 43 per cent higher for women who performed at a public health facility.[17] Another study also explained that women living in areas near facilities offering comprehensive emergency obstetric care (CEmOC), emergency neonatal care, or high-quality routine care, or facilities with satisfactory skills found a lower risk of intrapartum mortality.[18] The Government has implemented a variety of schemes to promote institutional delivery in public health facilities. The drivers of this shift from home to institutional delivery include the social pressure of the Accredited Social Health Activist (ASHA) to deliver in a health facility and individual perception of the importance of safe and easy delivery, most likely an expression of the new social norm. In addition, the incentive was a significant factor in many women's decisions to be taken at a health facility.[19] Usually, women are likely to go to health facilities due to knowledge of: increased provision and

birth-preparedness education; prior delivery of health facilities; and improved quality and usability of facilities in recent years.[20] Women preferred delivery to healthcare facilities to better manage complications.[21] Furthermore, the various maternal schemes implemented to increase institutional delivery have the potential to reduce maternal and neonatal morbidity and mortality, along with ensuring maternal health equity in India.[22] Various factors are associated in the search for maternal health services from a healthcare facility. The JSY cash incentive scheme played a smaller role as an enabling factor due to higher opportunity costs in the use of healthcare facilities compared to home delivery.[23] Other emerging factors that deter the process of seeking maternity services are the mistreatment and abusive behavior of healthcare providers, which has been identified not only in Indian public health facilities but also worldwide.[24-28] Especially, when planning and implementing maternal healthcare, a right-based approach must be developed and implemented. WHO describes such an approach as one in which human rights norms and values are integrated into policy planning, execution, supervision and assessment. Such values and ideals include equality, respecting vulnerable population needs, fairness to health services and protection from discrimination. This study will contribute to the existing knowledge regarding the quality-of-service delivery along with the abusive treatment among childbearing women. Policymakers should consider these findings while planning maternal health-related policies.

Limitations

A major limitation of this study is its reliance on Health workers' self-reports. Another limitation of the study relates to the generalizability of findings, as these may be limited to the experience of health workers in Odisha for the women who deliver at public health facilities.

CONCLUSION

Despite the lack of knowledge and training related to RMC, participants claimed the disrespectful behavior of healthcare providers towards the child-bearing women and the accompanying person. The findings of this research study have important implications for the promotion of maternal health and well-being, indicating the need for significantly increased exposure to this issue. Mistreatment and abusive behaviour, as important as the quality of health services or geographical constraints, are essential dissuasive for obtaining care. The violation of women's health again threatens current attempts to improve the quality of birth attendance. Respectful and dignified care, along with positive attitudes among healthcare providers, will contribute to improved maternal and neonatal health outcomes.

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