International Journal of Advance and Applied Research
www.ijaar.co.in
ISSN – 2347-7075 Impact Factor – 7.328
Peer Reviewed Bi-Monthly
Vol.10 No.1 September – October 2022

ATTITUDES AND BEHAVIORS OF PROVIDERS OF MATERNAL HEALTH CARE IN THEIR INTERACTIONS WITH CLIENTS IN THE STUDY

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DOI - 10.5281/zenodo.7444888

Abstract:

There is still a high rate of maternal death and morbidity, which is mostly attributable to insufficient access to timely and high-quality medical treatment. Both the act of seeking health care and the quality of treatment received are affected by the attitudes and actions of maternal health care professionals (MHCPs). Studies published between January 1990 and December 2014 were looked for in five different electronic databases. Studies that are included reflect on different kinds of MHCP attitudes and behaviours towards their clients, the implications of these attitudes and behaviours, or the variables that influence these attitudes and behaviours. Studies of health practitioners who work outside of the official health system, such as traditional birth attendants, were not included in this research. Neither were attitudes and behaviours that were highlighted in connection to HIV transmission. Following the screening of 967 titles and 412 abstracts, 125 full-text articles were read, and 81 were selected for inclusion. Approximately two-thirds of them made use of qualitative research methodologies, and more than half of them looked at public-sector institutions. Africa was the location of the greatest number of studies (n = 55), followed by Asia and the Pacific (n = 17). Just negative attitudes or behaviours were discussed in any of the fifty-eight research, whereas only a few of the studies described good provider behaviours, such as being compassionate, courteous, empathetic, and helpful. The most prevalent types of negative attitudes and behaviours were verbal abuse (n = 45), rudeness (n = 35), and neglect (n = 32). Verbal abuse was the most common kind of negative attitude and behaviour. In addition, studies found that women were subjected to physical abuse, that providers were either absent or unavailable, that there was corruption, that there was a disregard for women's right to privacy, that there was poor communication, that there was a refusal to accommodate traditional practises, and that there was an authoritarian or frightening attitude. These behaviours were affected by a number of factors, including the workload of providers, the attitudes and actions of patients, the beliefs and biases of providers, and feelings of superiority among MHCPs. Negative thoughts and actions, taken together, discouraged patients from seeking medical attention and had an impact on their overall health. The study found a wide variety of unfavourable attitudes and behaviours shown by MHCPs that have an impact on patient well-being, as well as patient satisfaction with treatment and care seeking. The number of reported unpleasant patient contacts far outweighs the number of reported good ones. Given the nature of the elements that impact the attitudes and behaviours of health workers, it is clear that improving health systems and

developing the workforce, particularly in areas such as communication and counselling skills, are very crucial. Within the context of initiatives to promote maternal health, more attention has to be paid to the attitudes and behaviours of MHCPs, and this is for the benefit of women as well as those who offer health care.

Keywords: Maternal health, Low- and middle-income countries, Health workforce, Abuse and disrespect, Systematic review

Introduction:

The rate of improvement is not fast enough to meet the maternal health objective of Millennium Development Goal (MDG) 5, notwithstanding the significant success that has been made in lowering maternal death rates throughout the globe [1–3]. It is estimated that 273,500 women die away either during or after giving birth each year [1], while another 10 million women suffer from pregnancy-related illness, disability, or depression each year [4]. The majority of maternal deaths and morbidities occur in countries with low and moderate incomes (LMICs), despite the fact that they are entirely avoidable [5]. Access to the necessary medical treatments that are required to reduce morbidity and mortality rates among mothers and newborns is hampered by a number of reasons. Inadequate knowledge of the signs and symptoms of illness and the services that are available, the cost of services, a lack of transport options, and poor quality of care are some of the factors that contribute to this problem. Other factors include cultural norms, gender discrimination, and the absence of a rights-based approach that emphasises human dignity and attention to the needs of women in planning and delivering health services. The second factor, the quality of treatment, has lately garnered more attention as a fundamental cause for the high rates of maternal death and morbidity that persist in a number of countries despite large increases in the percentage of pregnant women who have access to maternal health services [6].

Definition that is generally recognised [7]. Graham and his colleagues contend that "clinical efficacy, safety, and a satisfying experience for the patient" [8, 9] are the components of excellent medical care. Bruce identifies the following components as constituting quality care in the context of family planning and reproductive health services: choice of methods, information given to clients, technical competence, follow-up and continuity mechanisms, interpersonal relations, and an appropriate constellation of services [10]. According to Hulton et al., in the context of facility-based maternal health services, quality of treatment is suggested to be characterised by efficacy, timeliness, and the preservation of fundamental reproductive rights [7, 11]. In addition, quality is described as consisting of two components: the quality of the care that is provided in relation to the service and the system, as well as the quality of care as it is experienced by users [11]. The user's perception of the quality of care has a strong correlation with the likelihood of the user requesting more services [12, 13]. The attitudes and behaviours of maternal

health care providers (MHCPs) are an essential component of the quality of maternal health care because they impact, either favourably or adversely, how women, as well as their partners and families, perceive and experience maternal health care. It is possible that a lack of respectful treatment from providers, such as physicians and midwives, might lead to dissatisfaction with the health system, which in turn would decrease the chance of obtaining antenatal (ANC), delivery, and postnatal services [14]. In addition, the attitudes and behaviours of MHCPs have the potential to have a direct impact on the health and happiness of patients and customers, as well as the quality of the connection that exists between patients and providers [14]. Furthermore, negative attitudes and behaviours have the potential to undermine the quality of care as well as the effectiveness of efforts to promote maternal and infant health [15, 16]. This puts at risk the fundamental right of women to receive dignified and respectful care during pregnancy and childbirth. When considered as a whole, the attitudes and behaviours of MHCPs are an important factor in determining the outcomes regarding maternal and infant health [17, 18], as well as whether or not women are able to enjoy their fundamental rights to be free from violence and discrimination and to achieve the highest attainable standard of both physical and mental health [19, 20]. In a statement that was released not too long ago, the World Health Organization (WHO) and the Human Reproduction Programme called for more attention, study, and advocacy in the area of the mistreatment of women when they were giving birth in medical institutions [15].

Methods:

Search Strategy:

We conducted our research using the Cochrane Library, CINAHL Complete, Medline (PubMed), Popline, and PsychInfo, which are all online resources. The population that was being studied (MHCPs in LMICs), the "intervention" that was being studied (attitudes and behaviours), and the prospective results were taken into consideration while developing search strings (satisfaction, acceptability, access, utilization, and health-seeking behaviours). The comprehensive search technique is given in additional file 1, which you may get here. In order to discover new material, we looked through the reference lists of the included research and reviews that were found on the subject. The retrieved records were then imported into the reference management programme EndNote X4, where they were evaluated in three steps in relation to inclusion and exclusion criteria: screening of titles, screening of abstracts, and lastly screening of complete texts.

Inclusion and Exclusion Criteria:

This analysis was restricted to articles that were written in English and published between January 1990 and December 1, 2014. All possible forms of research designs were considered for this investigation since the objective was to investigate the scope of the research that has been done on MHCP attitudes and behaviours in LMICs. MHCPs were

classified as trained providers (such as medical physicians, nurses, midwives, and paramedics) who delivered prenatal, abortion, delivery, or postnatal services (including family planning) up to one year after childbirth. This definition included those who worked in the medical field. Because HIV itself is associated with significant stigma and discrimination, with concomitant consequences for service usage and health outcomes [27], studies addressing the experiences of HIV-positive women while using maternal health care were not included in this review. This was deemed to be a distinct review since the attitudes and behaviours of providers on HIV are expected to vary significantly from those regarding other illnesses. As a result, this topic was excluded from the scope of this research. The LMICs that were included were selected based on the categorization of nations' income status published by the World Bank in July of 2012.

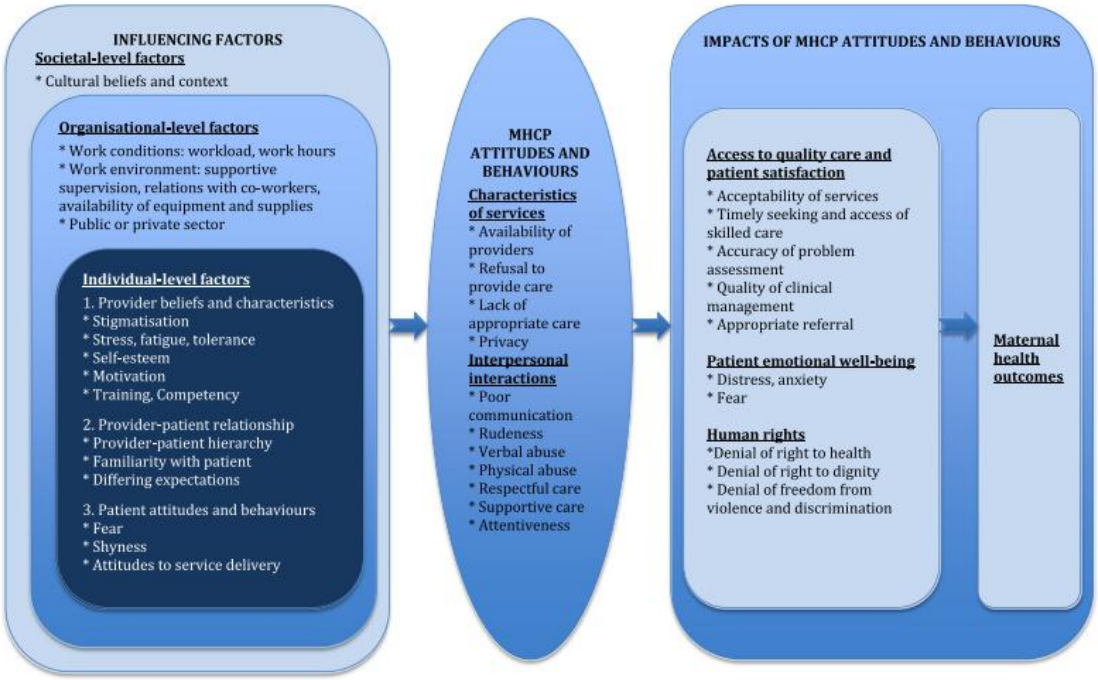

Fig. 1 Conceptual framework: Influences on and impacts of MHCP attitudes and behaviours

Analysis:

In order to compile all of the data that could be found, a method known as theme analysis was used. Text from full-text sources that was pertinent to attitudes and behaviours, as well as their effects and impacts, was retrieved, and the extracted passages that were analogous or thematically connected to one another were grouped together. Thus, for instance, speech that is demeaning and degrading, screaming and scolding were defined as examples of'verbal abuse,' while neglecting patients or being careless, dismissive, or antagonistic were examples of 'rudeness.' For the purpose of further illuminating prevalent themes and highlighting major deviations from these, selected quotes from participants that were recorded in the research were transcribed verbatim. The following categories of information were collected from each of the papers that were considered for inclusion in the review: (1) study

characteristics (first author and year of publication, study design and setting); (2) study population; (3) type of facility (public or private) and health worker cadre; (4) type of attitude or behaviour, grouped as positive and negative; (5) factors influencing attitudes and behaviours; and (6) impact of attitudes and behaviours. The information was then entered into a standardised data tool.

Results:

Following the screening of the 967 titles and 412 abstracts, 125 full-text publications were retrieved and evaluated, and 81 research were included into the review. Two of the 44 papers that were excluded on full text described experiences with only one MHCP, and the remaining paper reported on the attitudes of providers who were not skilled. The majority of the 44 papers that were excluded on full text did not provide any information on the attitudes and behaviours of MHCPs (n = 41).

The majority of the studies included, 58, were conducted using qualitative research methodologies (Additional file 2: Table S1). The other 15 studies utilised a combination of qualitative and quantitative research methodologies, while the remaining 7 were surveys of a quantitative kind, and the last 1 was a narrative review. None of the studies that were considered examined any therapies that were intended to change the behaviours or attitudes of MHCPs. Nearly two-thirds of the publications, totaling 48, were solely focused on investigating attitudes and behaviours from the point of view of patients or communities. The remaining groups either reported only the perspectives of health care providers (n = 4), these perspectives in addition to those of individual patients or community members (n = 23), a mixture of health care provider, patient/community, and researcher observations (n = 4), or only the latter two (n = 2). Africa was the most prevalent regional location, with 55 instances, followed by Asia and the Pacific with 17 instances, Latin America with 10 instances, and the Middle East with only two instances. The locations of the four periodicals span more than one nation. Nine of the single-country studies were conducted in Tanzania, seven in South Africa, six in Nigeria, five in Uganda, and four in Kenya. Kenya had the most, with four.

According to the findings of a study conducted in Tanzania, the interpersonal components of care provided by public and private institutions are distinct. Women who went to public facilities (n = 166) reported that providers showed interest in them 93 percent of the time, 70 percent of the time providers did not interrupt conversations with patients, 98 percent of patients felt providers were polite, and 71 percent of patients were asked about their concerns. When it came to women who went to private facilities (n = 188), similar proportions noted that providers showed interest and were polite (95 percent and 98 percent respectively). On the other hand, a greater number of women reported that they had not been interrupted during conversations (87

percent), and fewer women reported that they were asked about their concerns (81 percent). These changes were statistically significant (P 0.001 for the non-interruption of talks, and P = 0.02 for inquiring about concerns, respectively). Women who received services in two urban sub-district public obstetric facilities reported more respectful behaviour from health workers than women who received care in rural facilities, according to the findings of a study in South Africa that used a combination of research methods. The difference between the percentages of women who reported respectful behaviour in rural and urban facilities was statistically significant (63 and 66 percent for rural versus 75 and 72 percent for urban, P 0.01).

Factors Influencing Positive Attitudes and Behaviours:

There were five research that looked at the causes for the positive attitudes and behaviours of mental health care professionals. According to the researchers who conducted the study, the understanding and caring character of physicians in private hospitals in Bangladesh may be linked to the clinicians' acquaintance with the cultural customs and communities of their patients. In a similar vein, mental health care practitioners (MHCPs) working in public and private facilities in a few countries in Africa, as well as in the Dominican Republic, were more likely to show positive attitudes and behaviours when the patient was from the same catchment area as the health facility or when the patient was known to them. This was the case regardless of whether or not the patient had mental illness. One of the people who took part in the research remarked that "Doctors and nurses only pay attention to their friends and family." [Female Parents in Nigeria] however the authors of a different research that was carried out in Ghana, Kenya, and Malawi noted that "in health facilities, communication tended to be more two-way if a woman...had a family bond or friendship with the health professional."

Discussion:

Surprisingly few studies have attempted to gain a comprehensive understanding of these topics in LMICs, despite the fact that the attitudes and behaviours of MHCPs have a significant impact on women's and their families' perceptions of the quality of care, and consequently, their decisions to seek care, as well as their ability to access appropriate and adequate maternal health care. It is particularly surprising that there has not been more interventional research conducted on this subject. No studies that were expressly designed to change the attitudes or behaviours of MHCPs were found.

This review came to the conclusion, similar to what was discovered in the case of health worker performance and motivation [25, 26], that MHCP attitudes and behaviours are complex phenomena, shaped by a number of macro- and micro-level interrelated factors. These factors include the larger cultural context, working conditions and the environment of the workplace, provider beliefs and

characteristics, clients' attitudes and behaviours, and the overall provider-client relationship (Fig. 1). When providers had a pre-existing connection with the patient, or when they were acquainted with the patient's culture or community, they were more likely to be compassionate and understanding of the patient's situation. Negative attitudes and behaviours are typically tied to bad working circumstances, which include severe workloads, long working hours, and shortages of equipment and medications. These factors may all contribute to a toxic work environment (Fig. 1). The traits, beliefs, and biases of the providers, as well as their judgments of unfavourable patient attitudes and behaviours, such as delayed treatment seeking or seeming lack of compliance with medical recommendations, were also critical contributors in the formation of negative attitudes. In their study of the USAID programme, Bowser and Hill came to similar results. They reported that variables such as provider bias, demoralisation due to poor working conditions, and provider position led to the disrespect and maltreatment of women in institutions [21]. The effect of MHCP attitudes and behaviours on care seeking was the one that was mentioned most often in the research. When MHCPs exhibited positive attitudes and behaviours, there was an increase in the likelihood that women would attend ANC and give birth at a medical institution. On the other hand, when physicians were known to mistreat patients and were nasty to patients themselves, women experienced anxiety and discomfort, were less happy with the care they received, and were more likely to choose home delivery with a conventional birth attendant. These individuals are typically characterised as being helpful, compassionate, and empathetic. The findings of the few research that included quantitative data on the attitudes and behaviours of MHCPs give support for the qualitative evidence. The risk of adverse mother and newborn health outcomes is increased when there is reluctance to attend antenatal care visits, deliveries, and postnatal checkups. Additionally, difficult communication and connections between patients and clinicians are likely to stifle the passage of vitally essential health promotion messages pertaining to mothers and newborns.

Conclusion:

There are certain holes in the evidence that may be pointed out. More research is required to better understand the attitudes and behaviours of mental health care professionals in a variety of contexts, the variables that promote positive attitudes and behaviours, and the efficacy of treatments to alleviate poor patient experiences. In a broader sense, maternal health system interventional research has to include investigation into possible consequences on the attitudes and behaviours of MHCP. Notable as well is the fact that the majority of studies have been conducted in sub-Saharan Africa (roughly two thirds of all studies), which highlights the need for research to be conducted in other regions, particularly given the fact that strategies to improve

attitudes and behaviours will need to take into account factors that are contextual. The findings of this study have considerable ramifications for the accomplishment of both MDG 4 and MDG 5, as well as other goals, and they imply that much more attention needs to be paid to this problem. Negative attitudes and behaviours are crucial deterrents, on par with the expense of services or geographical restrictions, in terms of their importance. The disrespectful and violent treatment of women is another factor that inhibits current attempts to improve the number of births that are attended by a trained medical professional [17]. The abuses of human rights that emerge from such behaviour, namely the right to care and to health information, as well as the freedom from physical abuse and neglect, call for a reaction from the government on an equivalent level. Not only will positive attitudes and behaviours among MHCPs contribute to improved maternal health outcomes, but they may also help to reduce neonatal mortality and morbidity as a result of increased seeking of skilled care by pregnant women and mothers. This is because positive attitudes and behaviours among MHCPs will contribute to improved maternal health outcomes. It is thus essential to address the attitudes and behaviours of providers in order to ensure continuous progress towards the MDGs and to save the lives of women and children living in low- and middle-income countries.

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