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Improving readiness for change to respectful maternity care practice in public health facilities, Ibadan, Nigeria

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PhD Thesis Title: Improving readiness for change to a respectful maternity care practice in public health facilities, Ibadan, Nigeria

ABSTRACT

Background: Women's mistreatment during childbirth which may result from the negative attitudes of health providers, has contributed to the low utilisation of health facilities for delivery. The global community endorsed respectful maternity care (RMC) as a way to improve women's childbirth experiences. However, transiting from mistreatment to RMC requires a change effort. Organisational and individual readiness for change are known precursors of successful change implementation, such as to RMC practice. However, most RMC interventions in the literature did not assess providers' readiness for a change to RMC practice before implementation. There are also no theory-informed strategies in the literature to address the barriers of readiness for change to RMC practice. My study aims to bridge these gaps.

Objectives: To explore women's perceptions of RMC and how it aligns with the global standards; determine the proportion of women experiencing RMC during childbirth using two methodologies; evaluate health providers' perceived organisational and individual readiness for change to RMC practice and associated factors; and identify the barriers and potential strategies that would improve readiness for change to RMC practice in Ibadan Metropolis, Nigeria.

Methods: This was an analytical cross-sectional study using a mixed-method sequential exploratory design. It was conducted in 5 selected primary and 4 secondary health facilities across the 5 local government areas in Ibadan Metropolis in three phases. A two-stage probabilistic cluster sampling technique was used to select the health facilities, the women and health care providers studied. The first qualitative phase was 8 focus group discussions (FGD) conducted with pregnant women in their 1st and 2nd trimester about their perceptions of RMC. In the second quantitative phase, 269 women were observed during childbirth using an RMC observational checklist and then interviewed using the 15-item RMC scale more than 12hrs postpartum, to determine the proportion who received RMC during childbirth. A quantitative survey of 212 health providers was also done to determine their perceived organisational and individual readiness for change to RMC practice and the associated factors. The third qualitative phase included 4 FGDs with homologous groups of 35 health providers selected from the 9 study health facilities. This phase concluded with 17 in-depth interviews with facility heads, reproductive health program managers at the Primary Health Care Board and non-governmental organisations in the state, to identify strategies that may improve readiness for change to RMC, guided by the Theoretical Domains Framework and the Behavioural Change Wheel. Quantitative data were analysed using Stata 15. The main outcome variables were observed and reported RMC and both organisational and individual readiness for change to RMC. Descriptive and inferential statistical analysis was

done. Simple and multiple linear regression were used to identify significant predictors of the study outcomes. The audiotaped qualitative data were transcribed verbatim. Deductive and inductive coding was done using a thematic or framework analysis with NVIVO 11. Triangulation of the quantitative and qualitative findings was done in the concluding chapter of the thesis. Ethical approvals were obtained from the Health Research and Ethical Committees of the University of the Witwatersrand, and the Oyo State Ministry of Health. The respondents also gave written informed consent for participation.

Results: Women's definitions of RMC may vary based on their cultural and social differences. In the FGDs, the women's definitions of RMC aligned well with seven of the defined 12 RMC domains, even though they had mixed perceptions for two of these. Their perceptions however deviated for four of the domains, and they never mentioned one (enhanced physical environment). No woman received 100% of observed RMC items assessed. There were wide disparities in the observed versus reported evaluations of RMC. The least observed RMC sub-category was informed consent (loss of autonomy), then privacy. Women's employment status and birthing facility influenced the RMC scores received. The pregnant women's perceptions about RMC were also related to the categories of observed RMC they received during childbirth. Healthcare providers' perceptions of women's rights were related to the mistreatment women received, and to observed RMC. The health providers had high mean scores for organisational and individual readiness for change to RMC practice, and the measures were positively correlated. They did value a change to RMC highly but had low perceptions of resource adequacy for RMC implementation. Both of these significantly influenced organisational and individual readiness for change to RMC practice. Key barriers of readiness for change to RMC practice were identified as being provider, leadership, health systems, and patient-related. Training and environmental restructuring were preferred of nine strategies for addressing the barriers. The nine strategies can be achieved using fifty-five identified techniques. Five of the techniques were applicable to >1 strategy. It was advised that the strategy implementation be led by committed leaders to it and using a combination of strategies.

Conclusion: Women's expectations of RMC and providers' perception of women's rights influenced what women received during childbirth. The normalisation of mistreatment and abuse may explain the disparities between the observed and reported RMC received. Socio-cultural factors, and the delivery site and workplace contexts significantly influenced women's perceptions of RMC, the extent of RMC received, and providers' perceived organisational readiness for change to RMC practice. Training and environmental restructuring in combination with other strategies could address the identified barriers of readiness for change to RMC, and improve health providers' readiness for change to RMC practice.