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Barriers to Respectful Maternity Care from Mother's, Provider's and Administrator's Perspective: An Exploratory Qualitative Study

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Introduction

Respectful maternity care (RMC) is an approach to care based on personal choice and preferences, which supports and promotes, and doesn't undermine a person's self-respect [1]. During the past three decades, maternal mortality has decreased nearly by half but is still alarmingly high, particularly in sub-Saharan African countries. More than half of maternal mortality is associated with poor quality of care, and most maternal mortality is preventable if timely quality maternity care is delivered and evidence-based action is taken [2-4]. Responding to this, the 2030 Sustainable Development Goals include reducing the maternal mortality rate below 77 per 100,000 live births and eliminating all forms of violence against women, particularly during labor and delivery [5]. The mistreatment of women during institutional delivery could be an obstacle to these ambitious goals, especially in a low-income country like Ethiopia[6].

According to Bowser and Hill'slandscape analysis report and the Universal Declaration of Human Rights, RMC has seven components. These are freedom from harm and mistreatment, confidential care, discrimination-free care, dignified care, informed care, void of abandonment and detention [7,8]. Despite this proclamation, many women in the world experienced disrespect and abuse during institutional delivery by skilled birth attendants ranging from non-consensual care to outright traumatizing physical abuse. This is a major focus of global effort and an important obstacle to achieving the global targets [9-12]. Quality of care should be at the heart of any health care system, and every woman deserves high-quality patient-centered care [2].

The problem of disrespectful and abusive care is worsening in Africa, particularly in Sub-Saharan Africa countries where globally two-thirds of maternal mortality occurred[4]. Studies have documented RMCranging from 1.1% in Ethiopia to 89% in Nigeria [13,14]. The provision of RMC is affected by poor infrastructure of health facilities, cultural-related barriers, prolonged understaffing of health facilities, lack of skills, poor provider attitudes, weak health care systems, and poor administration and leadership[15-19].

Even though many interventions have been introduced to improve maternal health, Ethiopia has the fourth highest maternal mortality rate globally [4]. The country hadtargets to reach 90% institutional delivery and to reduce maternal mortality to 199 per 100,000 livebirths in 2019/20[6]. But,only 48% of mothers delivered in health facilities, and maternal mortality remained constant[20]. As a result of poor quality care, only 15% of mothers plan to deliver in the health facilities, and only 25% of the communities have believed that the health system serving the publicproperly[2, 21]. Providers also develop professional stress, burnout, substance abuse, and even suicide, and health facilities have lost the trust of their communities [1,16,24]. These might indicate that disrespect of women in the health facility is more than an issue of infrastructure, financial, and cultural barriers affecting the decision to deliver in health facilities[1,24].

Though RMC can be more important to women than other maternal health care interventions, RMC was not considered as a strategy until 2015. RMC can also reduce maternal mortality and stillbirth more than ANC and PNC [6,9,23].Poor quality care is a major obstacle to achieving health outcomes, along with insufficient access to health care[2]. Studies indicate that mistreatment

is often accepted as normal because women may not know their basic rights during institutional delivery [15,16,19,24]. Unless the root cause of mistreatment is identified, the problem may not be genuinely understood, and evidence-based interventions may not be employed.Although the problem of RMC is multidimensional and complex and has a major influence on institutional delivery, little is known about the barriers to RMC in the proposed study area. Previously conducted studies in Ethiopia have articulated the magnitude of RMC and reported that most women are mistreated during institutional delivery, but the reason for this mistreatment is unrevealed as yet. Therefore, this study explores the perceived barriers to RMC from the perspective of women, providers, and administrators.

Methods

Study Setting and Design

An exploratory qualitative study was conducted and focuses group discussions and key informant interviews were used for data generation. The study was conducted in Debre Berhan city health facilities, Ethiopia, from February 1-30, 2020. The city is the capital of the administrative zone of North Shoa of Amhara regional state located in central Ethiopia 130 km away from Addis Ababa. The city has one government referral hospital, three public health centers, one private hospital, and sixteen private clinics. Out of these institutions, all public health facilities and one private clinicprovide delivery services for the community.The percentage of pregnant women who had received at least one ANC visit was 71% and received at least four ANC visits was 41.6% [25]. In the city, only 57% of mothers delivered in the health facility, which is lower than the national urban level average, which is reached 70% in 2019/20[20,25].

Study Population

Postnatal mothers who delivered in Debre Berhan city administration health facilities were invited to participate in this study. Delivery care providers in the city administration health facilities who have been working for more than six months and health care managers and administrators in the health institutions and officesparticipated in this study.

Sample Size Determination and Sampling Techniques

A total of ten focus group discussions (five FGDs with women (n-35)and fiveFGDSs withproviders (n-40) and ten key informant interviews (KII) with MCH coordinators and administrators were conducted. The sample size for a qualitative study depends on the purpose of the study, the complexity of the issue, the availability of time and resources. Saturation of ideas and themes was reached after about eight focus FGDs and KIIs, but two additional FGD and KII were conducted too.

A convenience sampling technique was used to identify postnatal women participants in the community by health extension workers. Women who were delivered for the last six weeks in the city were identified by health extension workers and they were informed about the research aims and then recruited voluntarily. The women who have accepted the attendances were decided the place, time, and date of discussion. A convenience sampling technique was used to select health care workers who were working in all city administration health facilities during the data collection period from available providers. Health care workers who were voluntarily participated in the study were decided the place, time, and date of discussion. A purposive sampling technique was used to select health care administrators from city administration health institutions and health offices.All health facility directors, maternal and child health coordinators, the city and zonal health office heads participated in key informant interviews.

Data Collection Methods and Procedures

Pretested semi-structured FGD and interview guides were used for data collection. Data collectors were public health experts with a midwifery background currently working as a researcher and lecturer in an academic institution. The interview and FGDs were conducted in Amharic (local dialect).The voices of participants wererecorded using a digital voice recorderand written notes were also captured. The main topics of the FGD and interview were the perception and perceived barriers to RMC provision and utilization. Probing questions were used for a better understanding where necessary.

FGDs with postnatal women participants were conducted in a quiet, private space in the women's home nearby schools.The FGDs of health care workers were conducted outside of health facilities in a private place. Each FGD contained an average of eight participants and lastedone and a half hours. During the FGD, mothers were stratified based on gravidity as primigravida and multigravida. Health care workers were stratified based on their years of experience (>5 or ≤5 years in the current area). The KII were conducted in the study participant's office in the health institutions lasted an average of 40 minutes per interview.

Data Analysis and Interpretation

The FGDs and KIIs recordings were immediately listened to repeatedlyand then transcribed verbatimtranslated line by line into English by two researchers independently after each FGD and KII. Notation of nonverbal expressions of the informants and notes were captured on the paper during and immediately after the interviews. The translatednotes were captured into MS Word andthen exported and coded using MAXQDA 2020 softwareby two researchers separately.During coding, in cases where disagreements arose between researchers, a further discussion took place until consensus was achieved. The data were thematically analyzed as outlined by Braun and Clark, with a code-book developed and data inductively coded [27].

The exported data were repeatedly read by coders until data immersion. The patterns of data were identified during data collection, processing, and analysis. The analysis was conducted by constant cross-checking between the data set and the codes and

the themes developed. All data extracts were coded initially and equal attention was given for all data sets and an initial thematic map was developed. The identified codes and then grouped into representative subthemes. Finally, some of the subthemes were collected together form main themes if they are coherently patterned without losing the content or context of the text and other subthemes grow directly as themes if they are distinctive. The internal homogeneity and external heterogeneity of the themes were used to check this process and a developed thematic map was established. The developed themes were also cross-checked whether the identified themes able to capture the data sets,initial codes, and subthemes. The main themes were reviewed, defined, and refined by stating the scopes and content and examining the relationship between themes, and then a final thematic map was developed with three overarching themes.Thoseare health system barriers, provider-related barriers, and client-related barriers to RMC. Due to the broadness of overarching themes, subthemes were selected from each thematicarea for demonstration, and an illustrative quote was used to clarify the subthemes.

The data validity was maintained through theprolonged engagement of interviewers and note-takers, triangulation, incorporation of different perspectives about the problem, and thick description of the finding. The audio recordings and transcripts were cross-checked, and themes developed by interviewers were examined by another qualitative research expert for the consistency of transcripts, and the result developed.

Result

Sociodemographic Characteristics of FGDs and KIIs Participants

The age of women ranged from 19 to 42 years, and almost all of them were married. The majorities of women were a secondary school or higher educated, and most werehousewives by occupation. The median age of the health care workers was 29 years, and the majority of them were female. The majority of health care workers were first-degree holders and their experience ranged from six months to 18 years at the current working area (Table 1).

Table 1: Sociodemographic characteristics of women's and provider's in the study of barriers to respectful maternity care in Debre Berhan city administration health facilities.

Mother's FGD (5 FGDs= 35 mothers)				Provider's FGDs (5 FGDs= 40 providers)			
Variable		Freq.	Per.	Variable		Freq.	Per.
Age (yrs.)	>30	23	65.7	Age (yrs.)	>30	16	40
	≤ 30	12	34.3		≤ 30	24	60
Marital status	Married	32	91.4	Sex	Male	17	42,5
	Others	3	8.6		Female	23	57.5
Gravidity	Primigravida	16	45.7	Educational status	1st Degree	32	80
	Multigravida	19	54.3		Others	8	20
Educational status	≤ primary	12	34.3	Experiences	< 5 yrs.	18	45
	≥ Secondary	23	65.7		≥ 5 yrs.	22	55
Occupation	Housewife	21	60	Place of work	Hospital	16	40
	Others	14	40		Health center	24	60

The age ranges of the administrator's/program managers were between 27 to 48 years, and the majority of them were male. About half of administers and program managers were first-degree holders, and most of them have had less than five years of experience in their current position. Most of the key informants were health institution administrators, and a few of them were program managers at the woreda and zonal health department level (Table 2).

Table 2: Sociodemographic characteristic of the administrators for the study of barriers to respectful maternity care in Debre Berhan city administration health facilities.

Key informant Interview participant (n=10)			
Variables		Frequency	Percentage
Age	< 30 yrs.	4	40
	≥ 30 yrs.	6	60
Sex	Male	7	70
	Female	3	30
Educational status	1st Degree	5	50
	Others	5	50
Experience at current position	< 5 yrs.	7	70
	≥ 5yrs.	3	30
Position	Program Manager	3	30
	Administrators	7	70

Barriers to Respectful Maternity Care

Health System Barriers

Participants stated that weak health systems and poor facility conditions were perceived to be a barrier to RMC. Women, health care providers, and administrators stated that poor infrastructure, poor leadership and administration, poor implementation of existing policies, educational institution training provision gaps, lack of resources, and system readiness were stated as the barriers to RMCprovision and utilization in the health facilities.

Poor Infrastructure

Participants reported that the poor infrastructure of the health facilitiesinfluencesthe quality of maternal health services. Almost all of the administrators, health care providers, and mothers stated that the poor infrastructure of the facility, including scarcity of water in the health facilities for equipment preparation and cleaning of the contaminated rooms, were contributed to disrespectful maternity care.

"Sometimes we fetch water by the plastic jar from another ward for material preparation and also mothers didn't take shower until discharge in the facility due to scarcity of water and bathroom in the delivery ward. Few mothers might be also uncomfortable when they see the bloody floor if the rooms were not being cleaned well due to water shortage" (FGD, HCW).

Besides, Participants also stated that frequent power supply disruption especially during the nighttime,and unavailability of backup generators, inadequate beds, and rooms which lead women to labor on the floor perceived as the barriers to RMC.

Two years experienced midwife stated this condition as *"In our institution, it is unthinkable to provide respectful maternity care to all mothers, for example, we can't maintain the privacy of mothers because we have no enough delivery room, there are many women delivered on the floor in front of other clientsbecause all four delivery coached were occupied"* (FGD, HCW).

A 33 years old multigravida mother also said that *"I went to a facility X at night, there was no electricity in the health centers and when I entered into the delivery room for examination there was one dummy bulb with little light. When I asked the providers about the presence of other light sources, he responds to me this is what we have, and said if you are comfortable stay here. So, I immediatelyleave the facility and went to other private clinics"* (FGD, Mother).

Lack of Resources

Lack of adequate resources is a bottleneck of effective service delivery for any institution. This becomes particularly challenging when we come to the health sector. Almost all administrators and delivery care providers stated that lack of adequate resources; both human and materialwere perceived as the main obstacle for the health facilities to deliver the service effectively. They also raised thatlack of adequate human personnel might create a high workload for available providersand obligate them to work for long hours andtaking excess responsibility at a time particularly during the nighttime. The participants perceived that this lack of adequate resources might influence the quality of maternal health service and might leads to huge malpractice claims and dissatisfaction in the communities.

A two-year experienced midwife states that *"Due toworkload in the nighttime it is challenging to provide respectful maternity care. We will have four or more mothers in delivery at one night; look here it is difficult to manage even one mother by one provider; the newborn may develop distress and the mother will also develop hemorrhage or other complications during such time, maintaining all components of respectful maternity care is unthinkable"* (FGD, HCW).

Participants also outlined that lack of drugs and supplies, equipment, delivery coach, and screens create a complaint in the communities about nearby health facilities.They perceived that, this lack of necessary equipment in health facilities contributes to the poor delivery outcomes; malpractice claims, poor satisfaction, and stress for the providers who try to give standardize quality care.

A primigravida woman stated this condition as *"We had a meeting with facility staffs seven months ago, and we asked them to have an ultrasoundmachine in the facility, but we are still paying for the private institution for this service"* (FGD, Mother).

A two year experienced general practitioner (GP) stated that*"We are talking a lot to create home-delivery free whilewe have conducted pregnant women conference in community. However, we haven'teven adequate medicine, equipment, and supplies needed for the mother who gave birth in a facility. Some mothers obligate to buy drugs and supplies in private clinics and others give birth on the floor in front of many peoples due to inadequate delivery coach which is distressing"* (FGD, HCW).

Poor Leadership and Administration

Strong leadership and administrationarethe backbones of health facilities to function properly and serve the community by established aims. Health care providers, administrators, and mothers stated that poor administration, including poor leadership skills and governance at all levels, has a major influence on the quality of maternal health service.

"...our management system has a problem at all levels, leaders should be pathfinder, but poor leadership and governance at health facilities, and starting from this office is a big problem. As we know, lack of competent leaders and administrators is a national problem; so poor management and leadership is the obstacle for respectful maternity care" (KII, Administrator).

The other big problem identified during a discussion with providers was that the health sectors were led by professions without a health background. Thismight lead to frequent quarrels between

providers and their supervisors. They perceived that this conflict might affectthe quality maternal health service quality and customer satisfaction.

Six years experienced program manager stated that *"In our health institution, the administrators are not health professionals, so we have frequent nagging with our bosses, and even when they come for supervision, we are always in argue"* (KII, program manager).

Besides, participants stated that delaysin resolving provider's and community's questions and concerns, and lack of support and appreciation system for ethical and professional workers, were also stated asthehindrance ofRMC provision.

A midwife during FGD stated that*"You will serve the community heartily for a few years, but as human, you need something for that, but no one remembers you even you will fight with your bosses if you asked them (administrators) to solve community complains and concerns. So, at last, we will give up and leave it"* (FGD, HCW).

Policy Gap and Implementation

The availability of RMC health policy and supportive systems at all levels is the basis of quality maternal health service delivery. Mostof the administrators, few health care providers, and mothers stated that weak and unfavorable health care structures at all levels contribute to the dissatisfaction of providers and abandonment of their profession. Lack of adequate physical infrastructure, poor administration, and lack of available policy might have a great impact on the level of service quality during facility childbirth. Moreover, participates perceived that poor implementation of existing policies (CRC), and ethical standards might contribute to providers being ignorant of ethical principles during care provision.

A four years experienced midwife stated that *"Usually, we fight with ourselves due to substandard care provided to mothers, we have a great desire to provide humanizing care for every mother, but sometimes the facility condition doesn't allow us. And also, we heard some policies particularly compassionate and respectful care initiatives at the top level since 2015, but it is floating on air and not implemented at ground level till now"* (FGD, HCW).

Besides, most providers believed that delivery care is a risky job; however, the salary and other payments didn't take into consideration its risk and workload. They also claimed that the job evaluation and grade systems victimize health care providers when compared with other sector employees.

"As humans, we have to work more than survival, as we know being midwifery is a risky job. We may acquire different communicable diseases during care provision, but the government paid us risk allowance to just close-up our mouth, and we haven't health insurance yet" (FGD, HCW).

Most of the participates raised that,the educational institutions have training provision gaps as they predominantly focus on theoretical knowledge, and medical students are enrolled based on their good grade rather than their ambition.They also believed that most private colleges and universities are also enrolling students for the sake of getting money rather than generation building and to make their students competent. Participants also claim that profession is sold for money because of poor government regulation and monitoring systemswhich might havea positive correlation with poor quality care provision.

A 35 years old multigravida mother stated that*"I think that being a health professional is not an opportunity-driven work, and it is a life duty, sometimes it should not be enrolled because of your good grade in school. And also there is a problem in training institutions itself in our country; the training is not adequate without enough practice someone might have become doctors"* (FGD, Mother).

The Ethiopian Federal minister of health has started to train the health professional for compassionate and respectful caring practice since 2015 and it's one of the Ethiopian health transformation agendas. However, almost all health care providers and administrators claim that one-time training is not enough to get the expected outcome and multisystem intervention and their creation of a supportive health system is needed.

A 32 years old BSc nurse stated that*"I don't think so before training, system readiness and creation of favorable structure should be established. So training may help us to know about the standard and to rehearse the art of respectful maternity care, but nothing is done in a weak health system. Hence, creation of favorable health system is more than of that"*(FGD, HCW).

Provider Related Barriers

Provider Dissatisfaction

Almost all health care workers and administratorsindicated that the provider dissatisfaction due to unfavorable working conditions, absences, and low-risk allowances, unbalanced payment based on working conditions, and lack of care for careers by their administrators werereported as the barriers to RMC provision.

"You will acquire some infectious disease during an emergency, but no one cares about you and understands your condition. And also, when you ask repeatedly administrators about to avail equipment, drug and supply, risk payment, and other allowed benefits, theyconsidered you as a troubling person. You never know how much the work is challenging, I never think of my future family job; if get an opportunity, I need to get out of this job" (FGD, HCW).

Few women also perceived that providers might have unresolved questions and they believed that providersmight not be satisfied in their work. They have observed that health worker's peaceful demonstration and consider that providers might have problems from government or their administrators that mightcontribute to

thereduction of provider's sympathy and changing of behavior during care provision.

"*We have seen health worker'speaceful demonstration in the city and they had many slogans; that may indicate that they may have problems from their sides. And also I am a government employee and I know their salary despite them working day and night, no educational opportunities, and due to night shift their entire life will be disrupted particularly for females'providers "*(FGD, Mother).

Most providers stated that lack of educational advancement opportunities, lack of voice in the health facilities, and unequal treatment of providers by facility directors were raised during discussions and interviews that make them unsatisfied with their jobs.They perceived that professional development opportunitygenerates motivation and psychological satisfaction for them, but rarely given.

A 12 years experienced midwife stated that *"I have been served the communities for the last 12 years. But, I have never got professional development opportunities, despite nearby Government University in the town. So, lack of educational opportunities makes us unambitious and unsatisfactory inour work and we don't care about quality care provision"* (FGD, HCW).

Most providers stated that all maternity and child health services were covered by few midwives, including delivery care, ANC care, postnatal care, abortion care, and a complex report system. They perceived that too many maternity assignments lead them ignorant of ethical principles and provide poor quality care.

Two years experienced male midwife stated that*"We are serving the communities by melting us like a candle, and all maternal and child health service delivery is covered by one or two midwives. So, we have exhausted and providing the service that we can, not what they want and not concerned about customer satisfaction due to multiple burdens we have"* (FGD, HCW).

Provider's Behaviors

The majority of administrators and a few mothers stated that provider behaviors include being tedious for ethical principles and undermining of mothers feeling due to longtime exposure to service areas were reported as the barriers of RMC.

A 28 years old primigravida mother reported that *"The care given to mothers is regular work for providers; so any pain and any concern of us will be nothing for them (providers) because they had many exposures on such types of condition, but we feel strange to our pain and concerns but not for them"* (FGD, Mother).

Provider's Attitude

The majority of administratorsstated that most providers believe that counseling and getting informed consent for every procedure may not be necessary during service delivery and thisargument is also supported by few providers.

"I believe that informing every procedure for mothers may not be necessary unless medically mandatory and we usually informed them and perform what we want, and also we have no time to inform for every procedure" (FGD, HCW).

Few administrators reported that the primary intention of a civil servant is being served, and the lack of serving intention in most government employees was also stated as the barriers to RMC. They perceived that this lack of serving intention might be associated with erosion of community norms and values, failure of training institutions, children's socialization, and personal nature.

"In general the majority of civil servant intention needed to be served rather than being a servant. They are not considering their payment is from the collected community tax and the community has a right to be served respectfully. They have not believed that, to respect their (civil servants) right; they should serve the communities honestly and responsibly, this is the gap of majority government employees. This may due to the erosion of community normand value, failure in the education systems, and individual nature" (KII, Administrator).

Poor Communication

Good provider-client interaction is a key to client satisfaction. The majority of health care administrators and women stated that having good communication with care providers during facility stays had a direct relation with RMC. Sometimes providers may not have enough time to talk to women, and the women felt they were being ignored and lost trust in the providers, despite they are experts in the area. Health care workers also did not allow women or their families to participate in the decision-making for maternal health services, and over-medicalization ofmaternal health services was raised during FGD with women.

A primigravida mother stated that *"When I arrived in the health facilities, the doctors don't ask me well and leaves me alone for around four hours, but I had concerns and need to know the status of my labor. They may be exhausted due to workload, but they should give us time to talk about the concerns we have because we are going to them for help"* (FGD, Mother).

Poor Provider Competency

To build trust in women and the community, providers should have expected competencies both clinical skills and theoretical knowledge. A few mothers stated that they were observed fear and hesitation, sweating and shivering while they (mothers) are bleeding and in delivery in some providers. The other reported claims of mothers were they do not confidently tell them about the condition of labor. Sometimes some laboring women were discharged from the facility and informed them they are not in labor, but then delivered soon after or on the way home. Mothers reported that such circumstances lead them to loss of trust in the providers, and avoid coming to the facility unless they have experienced a complication.

A 32 years old multigravida mother stated that*"During my deliv-*

ery experience in the health facilities, the provider was shivering and sweating while I near to delivery my child. When I see her, she is pick-up and down materials now and then I asked her about any problem, but she said no and I shouted at her and said don't touch me and call me another doctor" (FGD, Mother).

Client-related Barriers

Lack of Continuous Care

A few mothers stated that continuous care at the facility leads to good relations between providers and women during delivery care. They believed that acquaintance between them helps to develop rapport, and the providers feel more confident about their general health condition during delivery that leads to RMC. Providers also stated that due to lack of continuous care in the health facilities, women might not have reached care early enough, leading to maternal and newborn complications due to lack of birth preparedness and complication readiness plan.

A 21 years old primigravida mother stated that *"In my experience in facility X, I went to the facility for retained placenta after a home delivery, and my care provider shouted at me because of late arrival and alsoI haven't been gone to the facility for subsequent antenatal visits on my date of appointment"*(FGD, Mother).

Poor Community Perception Toward Health Facilities

Few mothers and key informants stated that self-referral requests due to lack of trust in nearby health facilities, community rumors about mistreatment in the facilities, fear of being served by students, and bad expectations about the care in the health facilities were the barriers to RMC in the health facilities.

A 34 years old multigravida mother stated that *"We have one thing in our mind (Poisonous thing in our mind!) about health facilities, we expect bad things at the beginning. So, everything in that institution (health facility X) makes us upsetting and leads patience lost early because of prior community hearsays and our expectations"* (FGD, Mother).

Lack of Awareness

Few providers and administrators stated that mother's lack of awareness about their rights in the health facilities could be one reason for disrespect during institutional delivery. Moreover, a lack of awareness about health facilities' service provision mechanism during pregnancy and childbirth and limited demand for quality care might be contributed to disrespectful maternity care. Lack of awareness results in any mistreatment and abuse, particularly verbal abuse considered as appropriate by mothers and even by providers too. Almost all mothers accepted providers shouting and scolding as normal practices during delivery care, and half of the mothers believe that non-informed care is normal, and providers did what the best for mothers.

Six years experienced maternal and child coordinator stated that *"Occasionally, few mothers may not be voluntary to some life-saving procedures even after deep counseling. Such unwillingness to life-saving procedures might lead to bad delivery experience; Even if it might arise due to lack of awareness about their rights and obligation in the health facilities that are tenant for respectful maternity care provisions"* (KII, Program manager).

Women's Behaviors

Half of the health care workers, few administrators, and mothers stated that unwillingness to some lifesaving procedures and disturbance of the health facility by shouting might leads to disrespectful maternity care. Providers reported that sometimes they are abused and intimidated by women and their families that might influence client-provider's interaction and service quality.

"Sometimes we experienced kicking by mothers and intimidations by her families make us viral. And also, if a mother may not cooperate with the lifesaving and mandatory procedure, so we may shout at her to make her cooperative. We know it's out of standards, butfor the sake of preserving the life of mother and fetus" (FGD, HCW).

Community Norm and Cultures

Participants stated that due to the community's existing norms and culture sometimes delivery care provision may be challenging, particularly if the providers are male and for mothers who have first-time delivery. This might create misunderstandings between service providers and mothers. Most providers mainly focus on the provision of care based on their ethical standards but this may not appropriate in the community culture.

A primigravida mother stated that *"The first thing that comes to my mind when I think about facility delivery is if my delivery care provider ismale and many. How can I open my leg for them, but I have got a female provider? Look here when they give you a service in the hospital they are many and talk to each other in other languages that make us irritated"* (FGD, Mother).

Condition of The Delivery

Most providers stated that sometimes the childbirth process becomes an urgent event if the mothers didn't arrive in the health facilities timely. During this occasion, the standards of all components of respectful maternity care practice may not be maintained properly; particularly, if the mother and her newborn came with some lifesaving conditions, the provider's primary intention is to save the life of the mother and her child rather than respecting their basic rights.

"Sometimes it's is difficult to provide respectful maternity care based on standards especially in critical condition, for example, if the mother comes with profuse bleeding or fetal distress during such occasion, the standard will be violated"(HCW, HCW).

Unwanted Pregnancy

Few providers stated that if the pregnancy is unintended, unplanned, and unwanted a mother not be comfortable with her birth attendants during delivery. They also reported that if the pregnan-

cy occurred by rape and abduction, and the mothers might not be psychologically well prepared to have a child that threatens providers and mother's relation during delivery care.

A six years experienced midwife stated this condition as *"In my experience, a mother comes to me with the second stage of labor, and during the examination, she was not voluntary for examination. I tried to counsel her, but she never accepted me. After a few minutes, she has experienced a strong contraction, and her baby head was half expelled. She can't open up her leg, and I shouted at her unless her newborn will be suffocated, but not heard me, and I slapped her leg and delivered her child with war and but I can't save her child"* (FGD, HCW).

Discussion

This study aimed to explore the barriers to RMC provision in health facilities. A weak health care system due to poor infrastructures, inefficient utilization of available resources, and financial problem were perceived to be barriers to RMC. Participants reported thatlack of infrastructures such as unavailability of water supply, lack of an adequate toilet, andbathroomsperceived to be a barrier to qualitymaternal health care provision. Besides, frequent electric power interruption particularly at night, and unavailability of back power sources in the health facilities were also identified as the perceived barriers to RMC provision. This finding agreed with other studies finding conducted in other countries;which showed that poor infrastructure of the health facilities negatively affectsRMC provision [12,15,26–30]. These might indicate that RMC requires not only ethical and compassionate providers but also need well-organized and adequate resources. Accordingly, health facility capacity building through health care financing, efficient uses of resources, and real commitment from governance might be required to improve RMC provision.

Poor leadership and governance were perceived to be a barrier to RMCin health sectors, particularly lack ofadministration by professions, delaysin resolving providers and community concern, and lack of support and appreciation systems for champions were identified as the barriers to RMC. Weak leadership and administration of the facility might compromise the whole health care system and discouraged energetic staff. This finding is supported by the studies conducted in Nigeria [15,27]. Besides, providers raised that poor and infrequent supervision, which focused on blaming and harassment rather than supporting and appreciation, contribute to their poor quality care provision. This finding was consistent with the two systemic review studies conducted in middle and low-income countries and Nigeria [15,28].

Poor leadership and governance paralyze the whole health system. So, the health sectors shall enable leaders in the health facilities to become visionary and pathfinders through different capacity-building mechanisms such as training, experience-sharing meetings, andproblem-solving skills. The health sector leader shall have to develop a shared vision of quality of care, capacity building of workers through continuous learning, develop a clear quality care provision strategy, develop strong monitoring and evaluation system, and adopt continuous quality care assurance mechanisms.

The health system policy and its implementation might affect the quality of service in the health facility. Participants reported that weak and unfavorable health care systems at all levels and poor implementation of existing policies were perceived as thehindrances for RMC provision. The studies conducted in Nigeria and Kenya also reported that under-resourced and strained health care systems contribute to poor quality health service delivery [16,27]. The other policy-related claims raised by the majority of the study participants were a gap in training provision, weak regulation and monitoring, and license provision and renewal of private college's license. The study participant perceived that the majority of private educational institutions, their primary consideration are how they can get money from the students rather than enable them competent graduates that have a direct negative impact on the quality of care. This might indicate that a regular and functional monitoring and regulation mechanism system is required at all levels of academic institutions.

The policies of the Ethiopian government previously focus on the prevention aspect of disease and improve access to health care services. However, unless the quality of care accompanying by sufficient access the desired health outcome may not be achieved. The community demand for quality of care and expectations increasing nowadays, so incorporating quality parameters with coverage might be necessary. Participants outlined that, recently interventions focused on provider's behaviors have been taken to improve the service quality, but this intervention may not have a sustainable effect on the quality of care. So, the policy shall focus on multi-sectorialinvolvement including educational institutions, private sectors, civil societies, and others.

The Ethiopian Federal Minster of health develops a new compassionate and respectful care approach for all clients. It has been also one of the health sector transformation agendas since 2015 and has received much media attention, but the participants believed that little is done in the service delivery level. Besides, there is no implementation guideline and strategies at a service deliveryarea and the absence of care standards are another claim raised by lower-level managers and providers. Moreover, lack of appreciation and championship for model providers is also another hidden barrier to RMC reported during discussions and interviews. This finding is consistent with the studies conducted in Tanzania and Kenya that showed, lack of accountability and standard of ethical practice was one obstacle to RMC provision [31,32].

Provider dissatisfaction with their work was perceived tobe an influential factor of poor quality service delivery. The major complaints raised during the discussion were, providers are unsatisfied in their job due to unfavorable working conditions including unfair payment based on workload, and lack or low-risk allowance. And also, lack of care for carriers by respective administrators, lack of respect by the community, and lack of training and educational op-

portunities were raised by providers as the barriers to RMC. This finding is also reported in the different studies conducted in Nigeria, Ethiopia, Namibia, and Kenya[15,26,29,33,34].This might indicate that maximizing providers' satisfaction and the creation of a favorable working environment might have a positive effect on quality care provision.

In this study, the provider's behavior was identified as the perceived barrier of RMCduring institutional delivery. The majority of mothers stated that most providers didn't understand their feelings and preferences during service provision despite they are experts and experienced in the working area. The study conducted in Kenya also reported that lack of supportive care, inattentiveness, and insensitiveness to women's feeling and need was the major complaints of mothersduring facility childbirth [31]. The participants believed that due to prolonged exposure of providers in the service area might make them being ignorant of mothers feeling and emotions. Besides, it might be due to prolonged understaffing, lack of accountability, leadership and administration challenge, and lack of required equipment and drugs for prolonged times leads to providers giving up andignorant of client needs. The other reason raised by participants wasthe adaptation of such mistreatment as normal, imitating such behaviors from seniors, being tedious for ethical principles, and lack of direct claims of customers might influence the poor quality service delivery.

The provider's attitude was identified as one perceived barrier to RMC. Most providers and mothers believe that informing every procedure has no importance for the mothers unless medically necessary. This might indicate that some form of mistreatment is also accepted as normal from both the provider's and the mother's side. Besides,administrators reported thatthe majority of provides adherent to the clinical aspect of care, but they ignore the psychological aspect of care. As a result, participants perceived that even clinically competent providers didn't satisfy their clients despite serving the communities day and night. The qualitative systematic review in low and middle-income countries and the studies conducted in Tanzania, Nigeria, and Guinea reported thatRMC is greatly affected by the provider's attitude and belief [15,27,28,30,35]. Accordingly, the traditional way of health care service provision culture shall be changed and the providers should facilitate the decision of clients through the provision of information about their health condition. This provider's attitude might be changed by modified the care provision protocols, health system culture, adherent to ethical principles, and behavioral change training.

Participants outlined that effective communication between delivery care providers and mothers can increase patient satisfaction and reduce unnecessary anxiety. Most women reported that they are ignored by providers during facility stay. This might be due to workload and facility culture providers may not give enough time to talk to mothers, and the mothers may consider that being ignored. Moreover, poor communication affects mother autonomy in decision making and the mothers might not understand the importance of procedures and interventions undertaken unless well informed about itwhich might leadto misunderstanding and claims. The study conducted in Guatemala supported this argument and stated that poor communication between mothers and providers was one barrier to RMC [36].Effective communication might be the first impression that might influence the providers and client interaction throughout care provision. This develops trust, improves confidence, helps to be transparent and comfortable, and unless it may erode mother's trust in their nearby facilities and affects future birthplace choice. Accordingly, providers shall receive capacity building for effective communication through regular refreshment training, bedsides, and seminars.

Lack of clinical skills and knowledge of providers such as lack of confidence during service provision and increase bad delivery outcomes were raised by mothers as barriers to RMC. This might worsen when the outcome of delivery is bad and creates dissatisfaction of women in the service has received. The studies conducted in Ethiopia also reported provider's incompetencycontributed to poor quality of care and client dissatisfaction [26,34].

The community perception toward health facilities might have a great psychological influence even if the actual care in the health facilities is good or bad. During the discussion, women were raised that previous health facility stories, perceptions, and bad experiences of the communities and community members distort the health facility image and communities-health facility relationship. Women stated this situation as a pre-arrival bad perception "poisonous thing" feels every activity in the health facilities makes them viral. This finding consistent with a study conducted in Namibia showed that the client's and community's attitude about health facilities, providers, and quality of care, identify as one barrier to RMC [29].Therefore, the community bad perception should be changed through awareness rising workshop, incorporate community feedbacks in planning, eliminate barriers of poor quality care obstacles, prepare meetings, and enabling members of the community as of health facility quality assessment committee.

Having continuous care in the health facility was one positive reinforcing factor for rapport building between the service provider and mothers during maternity care. Mothers stated that if they have previous acquaintance during antenatal care or other services, their relation with providers improved during delivery care. This might be due to the mother may develop trust for providers, and providers may develop a positive attitude toward mothers who have good health-seeking behaviors. The study conducted in Kenya also reported that mothers who had continuous care visits at the hospital were received better care than they haven't [31]. The continuity of care may be indicated that the customer level of satisfaction in the care they have been received.Hence, customer's satisfaction should be assessed in different mechanisms including after they served and in the communityassessment that helps for an evidence-based intervention for quality improvement. So, identifying the root causes of poor service quality through community feedback mechanisms and research might highlight the area of quality care provision gaps.

Most mothers believe that non-informed care, shouting, and scolding during delivery careto some extent is considered normal, and for the sake of their health and newborn wellbeing. Besides, the majority of mothers didn't know legal steps and mechanisms how to makethe provider accountable. This finding is supported by other studies conducted in low and middle-income countries and Ethiopia [26,28,37].The community demand for quality of care shall be required; unless further progress in health might not be step-up. So, to reduce mistreatment of women, awareness creation about their basic rights during facility childbirth, advocacy about quality of care, andstrengthen legal accountability mechanism shall be a major intervention area.
Participates stated that sometimesa woman and her family'saggressive behavior might lead to poor provider-client interaction. Providers stated that mother's unwillingness to lifesaving procedures leads to violation of their basic right during care provision; in fact, the provider's primary intention is to save the life of the mother and her child. Besides, the mother and her family might abuse and intimidate provider that leads to the violation of their rights back and increase client claims. This is consistent with the studies conducted in Ethiopia, Guinea, and Nigeria [27,30,37]. Providers should accept that, a patient came to them with complex physical, mental, and psychological problems, so the providers should understand the client's condition and treat them empathetically.

Conclusion

The barriers to RMC are originated at micro and macro levels. Some forms of the mistreatments were normal by the providers and mothers as well. Lack of resources, poor governance and policy gap and implementation at the health system level, and provider dissatisfaction, attitude and behavior, and poor competency and communication at the provider level, and lack of awareness, condition of pregnancy and delivery at client level were the perceived barriers to RMC. The intervention shall be system-wide ranges from health facility capacity building and structural reform at all level. Moreover,examining the existing health policy, community involvement, and feed-backing system about the service quality, context-specific research, developan evaluation system for the quality of care, strict monitoring, and regulation andreform the educational institution training provision mechanisms might be the intervention area.

Strength and Limitation

The strength of the study was all actors of RMC were included in this study, which helps to view the problem from multiple perspectives. The study was conducted within six weeks of delivery that minimize the recall bias and helps the mother to rehearse the care they received in detail. The limitation of the study might be, the recruitment of study participants was not random, so the finding of this study might not be transferable to the source population. Forthcoming studies should consider quantitative analysis of qualitatively explored barriers to knowing how much the identified barriers influence the level of RMC.Forthcoming studies should consider an assessment of client satisfaction in maternity health service and a quantitative analysis of qualitatively explored barriers to knowing how much the identified barriers influence the level of RMC.

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