

“There is no time for knowing each other”: Quality of care during childbirth in a low resource setting



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ABSTRACT

Objective: To explore women's and healthcare provider's perspectives of what quality of care during childbirth means to them and how this can be improved.

Design: 14 Focus Group Discussions (FGD) with women and 27 Key Informant Interviews (KII) with healthcare providers. Thematic framework analysis was used.

Setting: 14 public healthcare facilities across two districts in Malawi. Mothers who had given birth at a healthcare facility within the last 7–42 days and healthcare providers who were directly involved in maternity care.

Findings: Perceptions of what constitutes good quality of care differed substantially. For healthcare providers, the most important characteristics of good quality care included structural aspects of care such as availability of materials, and sufficient human resources. For women, patient-centred care including a positive relationship and experience was prioritised. However, both groups had similar views on what constitutes poor quality of care; unwelcoming reception on admission, non-consented care, physical and verbal abuse were described as examples of poor care. Shortage of staff, poor labour room design and a non-functional referral system were key barriers identified.

Key conclusions: Women as well as healthcare providers want good quality, professional care at birth and are disappointed if this is not in place.

Implication for practice: There is a need to incorporate women as well as healthcare provider's views when designing, implementing, monitoring and evaluating maternal health programmes. For a positive birth experience, a healthcare facility needs to have an enabling environment and good communication between healthcare providers and women should be actively promoted.

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Background

Over the past decades, efforts to reduce adverse outcomes for pregnant women have been directed at increasing the availability and uptake of skilled birth attendance (Campbell and Graham, 2006). This has resulted in higher rates of births in healthcare facilities (Global Health Group, 2014). In developing countries, the proportion of deliveries attended by SBA rose from 61% in 2000 to 78% in 2016 (Global Health Observatory, 2016). With increasing numbers of births now happening in healthcare facilities, ensuring care is of good quality is seen as a critical aspect of the global strategy to end preventable maternal and newborn deaths and

stillbirths (World Health Organization, 2015). The United Nations set ambitious Sustainable Development Goals (SDG) with health-related targets for mothers, newborns and children under the umbrella of Universal Health Coverage by 2030 (United Nations, 2015). Ensuring that healthcare services provide good quality care will be fundamental to achieving the health-related SDG targets.

In Malawi, as in other low- and middle-income countries, there has been a significant increase in the proportion of women who give birth at a healthcare facility with an increase from 55% to 91.4% between 2000 and 2015 (Malawi National Statistical Office and ICF, 2017). Despite this progress, the maternal mortality ratio (MMR) remains high at 634 deaths per 100,000 live births (Malawi National Statistical Office, 2014; World Health Organization et al., 2015). It is imperative to now ensure that increased coverage is matched with improved quality of maternity care in

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order to improve health outcomes for mothers and babies and reduce preventable deaths.

Quality of care is a key component of the right to health (Hulton et al., 2000). There is growing consensus that the perceived quality of childbirth care may also be a key determinant regarding uptake of care (Duong et al., 2004; Emelumadu et al., 2014; Worku et al., 2013). On the other hand, perceptions and experiences of poor quality care has been reported to be a major determinant of, and reason for, non-utilisation of healthcare services (Kahabuka et al., 2011; Kruk et al., 2009). Relatively little information is available particularly from low- and middle-income countries, about how women and healthcare providers themselves describe and understand what good quality of care during childbirth should consist of and how this could be improved (Bhattacharyya et al., 2015; Bowser and Hill, 2010; Proctor, 1998). To improve the quality of care for women at the time of childbirth, it is important to understand the concept of quality from the women's point-of-view as well as from the healthcare providers' point-of-view and this is essential if meaningful recommendations for the improving quality of care are to be developed and successfully implemented.

We conducted a qualitative study across two districts in Malawi to explore the perceptions and experiences of women as well as healthcare providers with regard to what they considered to be good or poor quality of care. We examined whether opinions were divergent or similar and identified enablers and barriers to providing good quality care at time of birth.

Materials and methods

Study design and settings

A qualitative descriptive study was conducted in two districts (Kasungu and Thyolo) including 14 healthcare facilities. All were public, high volume healthcare facilities (defined as more than 30 deliveries per month) and were purposively selected to ensure a representative number of settings and study participants. Two healthcare facilities were functioning as secondary level health institutions and were designated to provide Comprehensive Emergency Obstetric Care healthcare (CEmOC) and 12 were primary level designated to provide Basic Emergency Obstetric Care healthcare (BEmOC).

Study population

The study population comprised of postnatal mothers who had given birth at a healthcare facility within the 7–42 days prior to the interview. Both women with normal and complicated deliveries were included. We excluded mothers with poor birth outcomes such as stillbirths or neonatal deaths as we considered it unethical and insensitive to group them with mothers who had healthy babies. Healthcare providers comprised of medical officers, midwives, clinical officers and medical assistants who were directly involved in providing maternity care. They were purposively selected as information-rich participants with a variety of roles, knowledge and experience in providing care at the time of birth.

Data collection

We conducted 14 focus group discussion (FGDs) with women (7 in each district) and 27 KIs with healthcare providers (Table 1). Data were collected by two national research assistants who understood the local language using predefined semi-structured topic guides. The topic guides were developed based on a list of factors identified from a review of the literature regarding women's experiences with maternity care provision in low- and middle-income countries (Duong et al., 2004; Proctor, 1998). Topic areas included:

Table 1
Socio-demographic characteristics of women interviewed in the FGDs (n = 48).

Characteristic	Number	% (n = 134)
Age		
15–19	14	10.4
20–24	43	32.1
25–29	46	34.3
30–35	24	17.9
36 and above	7	5.2
Total	134	100
Educational Attainment		
No education	3	2.2
Primary education	120	89.6
Secondary	11	8.2
Tertiarily	0	0
Total	134	100
Marital status		
Never married	4	3
Married	125	93.2
Separated	4	3
Widowed	1	0.7
Total	134	100
Occupation		
Housewife	128	95.5
Employed	4	3
Student	2	1.5
Total	134	100
Parity		
1–0.2	59	44
3–4	70	52.2
5 and above	9	6.7
Total	134	100

definition of quality of care, perception of quality care and experiences of childbirth care as well as exploration of enablers and barriers to providing good care.

Trained research assistants visited each healthcare facility to facilitate KIs and FGDs. Women were recruited from the postnatal ward soon after delivery and before discharge from the health facility and when they came for a six weeks routine, postnatal check-up. Interviews took place at the healthcare facility but away from the main clinical area in order to preserve privacy and allow for free discussion. Healthcare providers were informed of the planned visits and interviews were held at convenient times at each healthcare facility. The interviews were audio taped and handwritten notes were made. Data were collected until saturation was reached. Participants were offered refreshments only.

Data analysis

All respondents allowed audio recording of their interviews. These records were transcribed in Chichewa and translated into English then checked for accuracy. Transcriptions were independently reviewed by two researchers and consensus reached over codes for analysis. The interviews were uploaded and coded using MAXQDA (Verbi Software, 2007). Data were analysed using a six-phase inductive thematic approach (Braun and Clarke, 2006; Ritchie et al., 2003). Firstly, two researchers familiarised themselves with the data by reading and re-reading the transcribed data, noting down initial ideas to search for meanings and patterns. The second phase involved generating an initial set of codes. Two researchers independently identified preliminary codes and the coded data extracts. As a third step, the different codes identified were subsequently sorted into potential themes and the relevant coded data extracts were selected within the identified themes. These themes were further refined and reclassified into broad categories through discussion in the fourth phase. Some themes were combined whilst others were separated or discarded. In phase five, the two lead researchers defined and further refined

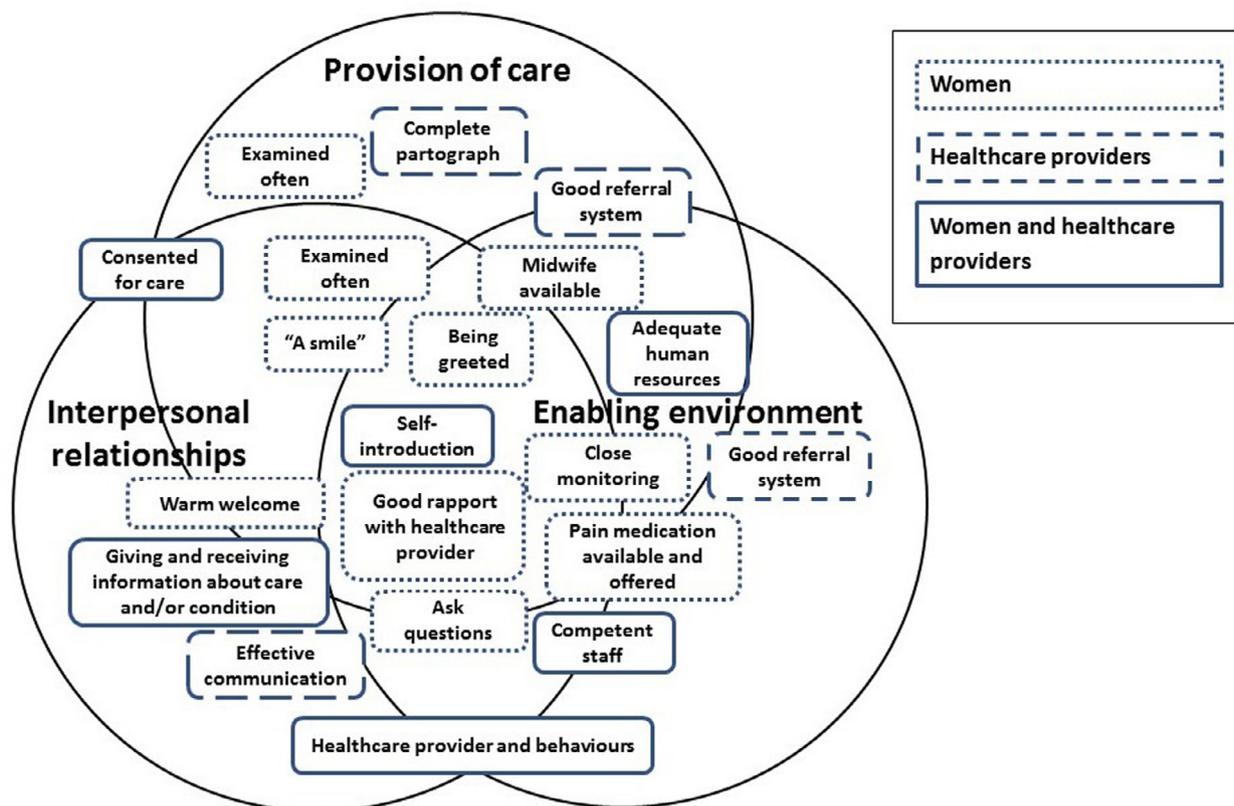


Fig. 1. Aspects of good care as perceived by women, healthcare providers and by both women and healthcare providers.

the themes and agreed on the final major- and sub-themes reported in this paper. The final phase involved the write-up of this manuscript using extract examples that relate to the themes, research question, and literature.

Results

The two main themes that emerged were; (1) the understanding of what quality of care is, and, (2) examples and thinking regarding the perceived and experienced aspects of good and poor quality of care. Three main sub-themes were identified; (1) the importance of interpersonal relationships, (2) the provision of maternity care, and, (3) the availability or not of an enabling environment. The findings are presented as a comparison between women's and healthcare providers perspectives on quality of childbirth care and their reflections on their actual experiences of childbirth.

Aspects of good and poor care

The understanding and description of quality care differed substantially between women and healthcare providers. Women described quality of care in terms of good interpersonal relationships such as; "being greeted", having a "feeling of belonging", and, also having a live baby and mother at the end of childbirth. In contrast, healthcare providers defined quality in terms of availability or not of structural components of care such as having adequate equipment, consumables and/or numbers of staff.

Women and healthcare providers were asked to describe their perceptions and give examples of good care. Fig. 1 outlines the emerging themes and illustrates where these converge or diverge. These themes are described further below and illustrated using quotes from healthcare providers and women.

Building rapport

Women value a "positive" or a "close" relationship with healthcare providers that involves mutual trust, being attentive and understanding what each person is trying to communicate. In most FGDs with women, a "good rapport" was considered to be one which encompassed a greeting, self-introduction by the healthcare provider, being called by name, a smile, and, being offered a place to sit when women arrived in the labour ward.

"As for me I feel relaxed when a midwife greets me upon my arrival. Just a greeting and a smile assures me of good care." (FGD, Woman, District Hospital)

While some healthcare providers recognised the need for a good interpersonal relationship during childbirth, they did not feel able to provide this due to staff shortages:

"We need to build a positive relationship with women during childbirth. However, it is quite difficult. A midwife is sometimes alone and the only thing she can do is to make sure the mother and the baby are alive. There is no time for knowing each other." (IDI, Healthcare provider, District Hospital)

Effective communication

Women were very clear about how they want to interact with healthcare providers but reported that often the communication with healthcare providers is more about receiving and following instructions than "caring". The majority view among women was that healthcare providers are more interested in women's compliance with instructions than in responding to women's needs and/or facilitating good communication.

“When I went into labour, they told me to cover my bed with a plastic and I was instructed to get on the bed and I followed. When I was about to give birth, I was told to bend my legs which I did. A midwife re-examined me and requested me to push and I pushed.” (FGD, Woman, District Hospital)

Most women had a preference for healthcare providers who are “interactive”, “approachable”, provide consented care and keep women updated on their own and baby’s wellbeing.

“One important thing is to know that your baby is doing well during labour. Last time, I gave birth to a dead baby. It was shocking because no-one told me about it throughout labour.” (FGD, Woman, Health Centre)

A minority of healthcare providers recognised the importance of the mother-healthcare provider relationship during childbirth. However, they repeated that they were not generally able to affect this as they were so busy. Communication was mainly seen as a means of ensuring care procedures were delivered rather than as important for building rapport.

Privacy

Both women and healthcare providers were very clear regarding the importance of privacy during childbirth.

Both groups were unhappy with the condition of most labour rooms which lack privacy due to poor design. With no separate rooms or partitions in place, women were often exposed to other women, their families and providers. Most delivery rooms contain several beds and if curtains are available, they are tattered, not closed properly and sometimes left open to allow the only midwife to be able to observe all women in labour. In some healthcare facilities, windows and doors were broken and lacked curtains and so passers-by could, in fact, look in.

“Even when I was giving birth maintenance people were passing by, they were looking at me and there were no curtains. I felt embarrassed.” (FGD, Woman, District Hospital)

Only a small minority of women were not concerned with the lack of privacy and accepted this as being “normal practice”.

Healthcare provider attitudes and behaviours

Women preferred healthcare providers who were respectful, welcoming, caring, friendly, helpful and sympathetic. Women also reported they had noticed or heard of an improvement in the attitudes of healthcare providers when compared to previous years and attributed this to a women’s rights campaign taking place in their respective districts. Male and student midwives were sometimes perceived to be more sympathetic than female midwives.

“I was so lucky during my last child, I found this loving, male midwife who made my birthing experience smooth.” (FGD, Woman, Health Centre)

The majority of women reported that negative attitudes and poor behaviour by healthcare providers as poor quality of care. A substantial proportion of women reported that they had experienced healthcare providers displaying negative attitudes and behaviours during childbirth, including verbal and physical abuse, rude behaviour and neglect (failure to attend to the woman). Women reported that healthcare providers are generally “unapproachable” and “always look too busy”, “too serious and scary” to approach.

Both women and healthcare providers provided detailed accounts of when they had witnessed healthcare providers insulting, shouting, scolding, criticizing, and speaking harshly (using abusive

words) during the time they had given birth. Sometimes, healthcare providers had made judgmental comments about a woman’s sexual history. Women felt shamed by healthcare providers who made inappropriate comments. As a result, women often felt that their healthcare provider had been disrespectful, uncaring, and rude. One woman recalled a healthcare provider saying;

“Those are the fruits you enjoyed with your husband, I was not available that time, why bother me, labour is painful, I cannot not use my hands to extract the baby from your womb, you need to push.” (FGD, Woman, District hospital)

However, views about slapping during labour and birth differed. While the majority of women in almost all FGDs, did view this as “intentional abuse” and “hurting”, some women (in three out of four FGDs) and, most healthcare providers (18 out of 27 healthcare providers), believed that slapping was accepted practice and was primarily used to help progress labour and birth. Healthcare providers reported that they could not control many women at the same time in a labour room without applying some authority. For example, if a woman was not “cooperative” during childbirth, healthcare workers would slap the woman to “encourage” her to “to push and give birth to a live baby”.

“We are exhausted, we are working 24 hours, and how can we talk affectionately to women? We too sometimes lose patience.” (IDI, Healthcare provider, Health Centre)

Some women believed that healthcare providers do work in the best interest of the woman.

“We were two in labour ward and my friend almost killed her baby; she was jumping out of the bed, shouting and closing her legs. Had it been that the midwife did not slap her, the baby would be dead.” (FGD, Woman, Health Centre)

Both women and healthcare providers mentioned either being neglected or neglecting women during childbirth. This was evident from almost all the FGDs with women and from most IDIs with healthcare providers. A common experience among women was; being left alone in the delivery room without being attended to because healthcare providers were either “chatting” or “sleeping”.

During FGDs with women, it became apparent that most women are not monitored during labour even if complications arise. The majority of healthcare providers agreed that women are sometimes unavoidably left alone due to deficiencies in working conditions such as a heavy workload which in turn, results in stress, fatigue and frustration among healthcare providers.

“You have more women giving birth at the same time and you are alone, I mean what can you do? The Ministry of Health is aware of this.” (IDI, Healthcare provider, District hospital)

Availability of a skilled birth attendant

Women and healthcare providers were in agreement that most obstetric complications could be prevented or managed if women had access to a skilled birth attendant. Women were not very conversant with most technical aspects of care but believed prompt care as soon as they arrived in the labour room, and, support throughout labour, could save the life of a mother and/or her baby. On the other hand, healthcare providers felt that a significant reduction in maternal deaths could be achieved if all components of emergency obstetric care, pain relief, and, monitoring during labour, were in place and could be provided by them as needed but noted that these were not generally in place.

Some of the women reported having given birth on their own and/or were assisted by a relative or a ward attendant/cleaner rather than by the trained healthcare provider. They perceived

this to be because; the midwife was on the phone most of the time, there was only one healthcare provider with more than one woman giving birth at the same time, the healthcare providers went home on lunch or dinner break, and/or had gone to sleep at night.

“I arrived at the healthcare facility at 6pm and found no one, a cleaner came after some time and took me to a delivery room. The cleaner went to call a midwife and she did not come. I gave birth on my own.” (FGD, Woman, Health Centre)

“Often midwives do not respond when you need them, with these “Facebook midwives” they comfortably sit, and laugh with their friends when you are in great pain.” (FGD, Woman, Health Centre)

Healthcare providers (especially those from health centres) confirmed that they asked cleaners to attend to women during their break times and felt they had no other alternative. While a few women and some healthcare providers said there was a definite need to have pain medication during childbirth, the majority of both groups felt that pain relief was not a priority and their common perception that pain medication would affect the foetus and delay labour and progress during labour.

“My grandmother told me childbirth pain does not need any medication. It is written in the bible that women will suffer during childbirth. Any pain medication will slow down labour progress.” (FGD, Woman, Health Centre)

Healthcare providers were of the opinion that women should be able to “cope” using other measures such as back massage, breathing and relaxation exercises. Some healthcare providers reported withholding pain relief medication even if this was available, to avoid delaying the labour progress. Others reported frequent stock-outs.

Companionship during childbirth

There were different views regarding having a companion during labour or birth. Companionship was not considered “acceptable” to most of the women. Having a companion during labour or birth was seen as disrespecting and violating their privacy. Many women indicated that labouring women were entitled to receive care from health professionals (rather than companions). A birth companion’s presence would be difficult to accommodate as most labour wards had no curtains. Undressing or being undressed in the presence of a mother or friend was not accepted practice. Women also reported that companions would gossip within a community about “poor performance” during childbirth especially if a woman had a stillborn baby or developed complications.

Other women stated that companions would feel “sorry” for the woman, make the woman “lazy” and this would contribute to a poor outcome. There was concern that if men were allowed in as birth companions, they would lose interest in sex;

“I would not allow anyone else to present at time of birth from a midwife. We are mostly escorted by our mothers-in-law at the time of birth. I can’t imagine myself undressing in front of my mother-in-law. It is so embarrassing.” (FGD, Woman District Hospital)

“My friend was with her husband during childbirth, she tells me since that time her husband has lost interest in her, and life has completely changed.” (FGD, Woman, District Hospital)

Only a very small minority of women valued the presence of a companion and considered this part of good quality care. These women were of the opinion that companions would assist a woman in giving birth if there was no healthcare provider and

also would stop healthcare providers from verbally and physically abusing women during labour and childbirth.

The majority of healthcare providers regarded companionships beneficial for psychological and physical support and also for providing assistance to healthcare providers. However, healthcare providers reported that they faced many challenges including with regard to design of the labour ward.

“In most of our labour rooms, it is not possible to allow a companion to be with the woman. I guess we were quick to preach about companionship at the time of birth. We need to work on our infrastructure before we start advocating for companionship during birth.” (KII, Healthcare provider, District Hospital)

Essential equipment, supplies and human resources

The vast majority of healthcare providers reported deficiencies in supplies and insufficient numbers of staff which caused a lot of stress. Staff shortages were of particular concern and led to longer waiting times, neglect of patients, and, poor-quality care.

“Imagine some health centres have one healthcare provider to provide all the services. A provider may be exhausted and can transfer [her] aggression to the woman.” (KII, Healthcare provider, Health Centre)

Women and healthcare providers both reported that staffing constraints not only directly affected provision of care but also contributed to negative attitudes and poor motivation among staff. In addition, both women and healthcare providers reported that public healthcare facilities are often overcrowded with inadequate numbers of delivery beds and some women give birth on the floor. Irregular supply of both water and electricity meant that women brought their own lighting and water at the time of birth.

Referral system

A functional referral system was considered important by both women and healthcare providers especially at primary healthcare level. There was general agreement that women could easily be referred if there was a reliable referral system which included a functional ambulance and fuel available all the time. Both women and healthcare providers described the current referral system as a “nightmare”. Healthcare providers reported that most health centres did not have an ambulance to be able to refer women with complications to a higher-level facility. In most cases, women had to arrange their own transport which could be either an ox cart, bicycle, motorcycle, or, they would have to privately hire an ambulance.

“This is my sixth pregnancy, and my labour progress was slow, guess what, I was told to put fuel in the ambulance worth MK800 (£8). As a poor woman, where can I get such money?” (FGD, Woman, Health Centre)

Discussion

Main findings

This study sought to obtain information regarding what women and healthcare providers living and working in low-income settings consider to be important aspects of good quality of care during labour and childbirth and explore the “real life” barriers to providing this.

While women prioritized the importance of a “good relationship” with healthcare providers, healthcare providers prioritised the structural and “technical” components of care. Both women and healthcare providers agreed that the current care provided at

the time of childbirth does not meet their expectations. Healthcare providers mostly attributed this to system failures, insufficient human resources, lack of an enabling environment and non-functioning referral systems. Both women and healthcare providers were in complete agreement regarding the main desired outcome, namely, the safe delivery of a live, healthy baby. There were diverging views on the need for and importance of companionship (not considered acceptable) at birth and pain relief (considered as delaying progress in labour and resulting in adverse birth outcomes).

Strengths and limitations of the study

Our sample included women who had accessed care at a healthcare facility during labour and childbirth and the study did not include women who did not access care or women who gave birth at a private hospital. However, we note that the vast majority (>90%) of women in Malawi give birth in public healthcare facilities. Women who had a stillbirth or other adverse outcome requiring special debriefing and counselling and were not contact as part of this study. It is likely that these women might have different views or had more negative perception and experience of the quality of care they received. A limitation of the study was the inability to assess the quality of care provided in these settings via direct observations. However, the findings reflect broad concerns that would likely be recognisable in other low- and middle-income settings where the proportion of women who access a healthcare facility for birth has significantly risen during the last few years, but, where concomitant infrastructural and human resource challenges have not been addressed. Data were collected across different types of healthcare facilities and at different levels of the healthcare system allowing for a comprehensive understanding of context aspects of care and valuable insights into how the quality of care could be improved.

Comparison of findings with other studies

The observation that perceptions of what constitutes good care differ between women and healthcare providers and has been reported in previous research from Malawi and from other countries (Bohren et al., 2015; Cham et al., 2009; Jolly et al., 2019; O'Donnell et al., 2014; Pettersson et al., 2006). The attitude of healthcare providers and the way they talk is very important to women and is often perceived and reported as being of a greater significance than the “technical” content of care even though women want to be attended to and helped by a trained and professional healthcare provider. In this study, women and healthcare providers reported instances of verbal and physical abuse, non-consented and non-confidential care, non-dignified care and abandonment of care. A comprehensive, USAID-supported review of the occurrence of disrespect and abuse during childbirth in healthcare facilities identified similar findings (Bowser and Hill, 2010). Women want to have support and help from healthcare providers and what women expect from healthcare providers e.g. a smiling and being called by their names does not require extra time per se. Women perceived healthcare providers to be “sleeping” or “chatting” whereas healthcare providers describe a heavy workload, stress, fatigue and frustration as factors contributing to inability. These findings call for healthcare providers to move beyond just provision of services and to more explicitly consider the preferences, needs, and values of the persons receiving these services (Batt-Rawden et al., 2013; Kungwimba et al., 2013; Lambert et al., 2018; O'Donnell et al., 2014). Healthcare professionals have an ethical, legal and professional obligation to provide safe and respectful care (ICM, 2014). Studies have shown that a rights-based approach that involves clients in the decision-making process creates trust between the provider and the recipient of care and that this is

linked to improved outcomes and satisfaction with care (Adhikari and Sawangdee, 2011; Das et al., 2010; Mateji et al., 2014). Quality of care is a key component of the “right to health” (Hulton et al., 2000; Jolly et al., 2019).

This study also shows that healthcare providers face real barriers and are often not able to provide the care in the way that they would like. Healthcare providers in this and other studies know, in principle, what good quality of care is and how this can be provided. However, many spoke of their frustration because of lack of resources, poor and late salaries, organisational and structural challenges, all of which negatively impacted their work (O'Donnell et al., 2014). Staff motivation and a strong healthcare system with adequate human and material resources are linked to the ability to provide a better quality of health care (Das et al., 2010; Gerein et al., 2006; Wong et al., 2013). This finding is not unique, similar problems with regard to infrastructure and problems in the supply of medicines as well as staff shortages have been reported previously (Cham et al., 2009; Pettersson et al., 2006). Demoralization among staff, related to poor working conditions, contributes to disrespect and abuse of women in healthcare facilities (Bowser and Hill, 2010). This includes physical and verbal abuse such as slapping and use of abusive language reported in this and in other studies (Attree, 2008; Bohren et al., 2015, 2017; Das et al., 2010; Freedman et al., 2014; World Health Organization, 2009).

Findings also reveal potential and continuing misunderstandings regarding the need for and perceived risks of, providing pain relief to women in labour and at the time of birth. Many women and healthcare providers are still of the opinion that medical pain relief has adverse effects for the baby, mother and progress of labour. Although there is a range of safe medication to help relieve pain including Fentox® (nitrous oxide with oxygen) and Pethidine, these are often not available in low- and middle-income settings. Instead, women are only offered options such as help with focused breathing, back massage and walking around when in early labour. There was a general belief among women in this study that labour pains “must be endured”. Previous studies have reported similar concerns among women and healthcare providers in other low- and middle-income country settings (Callister, 2003; McCauley et al., 2017). Lack of awareness, misunderstanding regarding acceptability, safety as well as lack of availability of the correct medication or other pain relief methods, are considered to be the main reasons healthcare providers do not offer, and, women in many low resource settings do not receive adequate pain relief during labour and birth. It is important that more attention is paid to this. Education is needed to allay undue fear among healthcare providers as well as women and to understand that pain relief during labour and birth is safe and does not cause adverse events ().

Similarly, this study illustrates that companionship in labour is still controversial in some settings. Evidence suggest companionship brings about positive childbirth outcomes (Ivers et al., 2012). Health policies in Malawi “allow” companionship during labour although in practice the existing infrastructure in healthcare facilities does not permit this. Childbirth companions were viewed as “violating a woman's privacy” and cultural values mean men are not expected to be present during labour and birth. This finding was somewhat surprising and is different from the observations by other researchers in Malawi and other countries (Banda et al., 2010; Kungwimba et al., 2013). The group of women interviewed in our study were mainly from the rural areas and may have had different cultural and societal beliefs and norms. More education about the relevance and benefits of companionship during childbirth is required. Also, it should be made clearer that companionship is not a substitute for skilled birth attendance. Further research is needed to explore in more depth the specific cultural and

societal norms which prevent women from having a suitable companion during labour and birth and how these can be addressed.

Implications for clinical practice and research

Findings of this study have important implications for the achievement of sustainable development goal number three and beyond. This study highlights the need to incorporate both women and healthcare provider views when designing, implementing, monitoring and evaluating maternal health programmes low resource settings. The quality of the relationship between the nurse-midwife and the woman she cares for is highlighted as of particular importance. While working on efforts to improve health system factors that are needed to be able to provide good quality care, there is a need for policies that emphasize a rights-based approach and promotes respectful care in both pre- and post-service training while at the same time ensuring the enabling environment in place (Freedman et al., 2014; Jolly et al., 2019; Raven et al., 2012).

Although the health system related factors may provide contextual explanations for poor quality of care, this cannot be considered as justification of the continued mistreatment of women. A lack of identified routes to do so, as well as fear of, reporting dangerous or unethical practice underlies the importance of introducing strong clinical audit methods as an effective intervention to improve the quality of care (Kongyuy and van den Broek, 2008). Consistent and targeted audit and feedback, including feedback from women themselves on their care experiences, can have a significant effect on improving healthcare providers' compliance with good clinical practice (Bohren et al., 2016). The key aspects identified in this study could be included in a monitoring tool that would allow women to provide feedback on their experiences of care.

Conclusion

The quality of care at time of childbirth can only be improved if healthcare providers and women have a shared understanding of, and jointly make decisions on, what actions should be taken to improve the availability and quality of care. This study provides further insights into some of the poor quality, harmful care experienced by women during labour and birth at healthcare facility level in low- and middle-income settings. Ensuring healthcare providers have a "caring" attitude and addressing the health system barriers to providing good quality of care are recommended first steps. Importantly, a rights-based approach must be consistently adopted when designing and delivering healthcare programmes for mother and babies.

Ethical approval

This study was approved by the Liverpool School of Tropical Medicine Research Ethics Committee (ref:17-053) and the National Health Sciences Research Committee in Malawi (ref: 17/11/1932). In addition, district authorities gave permission to conduct the study at all healthcare facilities.

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Competing interest

The authors have no conflicts of interest to declare.

Authors' contributions

FM, JL& NvdB - Conceived and designed the study. FM - Collected the data. FM, JL & NvdB - Analysed the data. FM, HS, AA & NvdB - Helped to draft the manuscript. FM & NvdB - Edited and revised the manuscript.

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