The right to respectful maternity care: women's experiences during childbirth in East New Britain Province – Papua New Guinea

Eva Piniau Tenanga, Elisabeth Schuele

Abstract

Many women experience maltreatment during childbirth in health facilities across the world. Disrespectful and abusive treatment by healthcare professionals violates the rights of women to respectful care and their rights to life, health, freedom from discrimination. In this article, we explore women's and health care workers' perspectives and experiences during childbirth at Nonga Base Hospital (NBH) and St Mary's Hospital (SMH), Vunapope, East New Britain Province (ENBP) Papua New Guinea. The qualitative study comprised semi-structured in-depth interviews conducted with six women 72 hours after childbirth and six health care workers from the labor unit in the two hospitals. They included two midwives, two community health workers and two medical doctors. Qualitative analysis identified major themes of human rights violations. Women's experiences included witnessing being slapped, scolded, ignored, and verbally abused during childbirth by healthcare workers. The emotional effect contributed to delay in the progress of labor and maternal and newborn complications at birth. Both women and healthcare providers blamed women for being 'uncooperative and disobedient' justifying disrespectful and abusive treatment. While healthcare workers externalized the situation as beyond their control, women internalized the situation by blaming themselves. Healthcare workers considered disrespectful treatment of women during childbirth as a 'norm' and contributed human rights violations to high workload and limited resources. These findings call for immediate measures by hospital managers, policy makers and healthcare professionals to change issues of power, disrespectful and abusive treatment and resources as the key to women-centered maternal health care.

Key words: Healthcare professional, childbirth, disrespectful maternal care, maternal rights, health facility, LMIC, PNG.

Introduction

All women are encouraged to seek professional assistance during delivery. Globally, supervised births account for 62% of births, but in low-and middle income countries (LMIC) for only 39% (Valley et al., 2013). In Papua New Guinea (PNG) 37.9% of women, a professional supervises giving births (Mola & Kirby, 2013). This low supervised birth rate may contribute to maternal and newborn mortality and morbidity rate (Valley et al., 2013).

An important strategy to prevent any pregnancy related deaths is to have a professional supervised birth that allows access to emergency obstetric care and the provision of care by a skilled birth attendance (Mola & Kirby, 2013). Emergency obstetric care contains of comprehensive maternal and newborn care that has the capability to perform caesarean sections, safe blood transfusions and the provision of care to the sick and low birth weight and premature newborns including resuscitation (UNDP, 2014; Homer et al., 2014). Supervised births have the potential to improve birth outcomes by preventing and managing maternal and neonatal complications in the health facilities (UNDP, 2014).

However, there is evidence that women worldwide continue to experience some form of maltreatment, violation of their rights during childbirth by healthcare professionals (Beck, 2018). This includes physical and verbal abuse, discrimination, non-consent of procedures and lack of support during childbirth (Bohren et al., 2019; Beck, 2018). Disrespectful and abusive treatment by healthcare professional violates the rights of women to respectful care and their rights to life, health, and freedom from discrimination (Beck, 2018).

Studies conducted in low-and middle-income countries (LMIC) illustrate that not all women receive fair professional support and respectful care (Hameed & Avan, 2018; Ith et al., 2012). This includes

disrespectful care encountered by women from public health facilities compared to the private health facilities (Ith et al., 2012). Women with low social status who delivered at public health facilities experienced more negative and impolite behavior compared to women with high social status who can afford a private delivery services (Ith et al., 2012). As a result, vulnerable women continue to face abuse and violence during childbirth (Orpin et.al, 2018).

In Papua New Guinea (PNG), women continue to encounter maltreatment, disrespectful care, and negligence by the healthcare providers in the labor unit during childbirth (Fiti-Sinclair, 2002). As a result, women are reluctant to seek maternal care offered by healthcare providers. This has contributed to lower supervised birth rates and complications such as stillbirth, neonatal death, postpartum hemorrhage, and maternal death (Fiti-Sinclair, 2002; Valley et.al, 2013).

The aim of this paper is to report on a study that compared women's accounts and healthcare professional's perspectives and experience during childbirth in two hospitals in East New Britain Province (ENBP). The research questions answered in this paper are: how do women express their experience during childbirth; how do health workers explain their work in the labor ward?

Study context

East New Britain Province has a growth rate of 4.2% and fertility rate of 3.6% (Hanson, Allen, Bourke & McCarthy, 2001). 74.9% of women giving birth are supervised by a health professional (Mola & Kirby, 2013). There are two main hospitals in the province: Nonga Base Hospital (NBH), a government facility and St Mary's Hospital (SMH), Vunapope, which is a church run facility. The SMH has a catchment population of 15,419 people out of which 7,589 are females in the age of 15-44 years (SMH records, 2016).

The St Mary's School of Nursing (SMSON) and midwifery institution is attached to SMH. In 2015, the Bachelor in Midwifery program commenced and a total number of 71 midwives graduated until 2020.

At the SMH, an average of 1,200 women deliver at the facility per year. Health workers working in the delivery unit include seven midwives, eight community health workers (CHW) and one consultant doctor (SMH records, 2016). In comparison, 1,600 women per year deliver at the NBH with a staff capacity of eight midwives, six CHWs', two registered and one senior specialist medical officer (SSMO) (NBH records, 2019).

Methods

This exploratory study applied the epistemological perspective of constructivism. According to constructivists', knowledge of the world is socially constructed by humans (Crotty, 1998). The focus of the study was to understand women's and health workers' lived experiences in the labor unit. The richness of their stories provided accounts from their own perspective.

From the theoretical perspective, maternal healthcare has a body of theories that emerge from the healthcare professional and women's perceptions during childbirth. Expert theory is based on biomedical knowledge of labour and management of the labour stages (Davis-Floyd et al., 2018). It is built on health professionals' qualifications and experiences. This differs from non-experts (Arnold et al., 2018). Lay theories are constructed on what ordinary people know, how they know and how they view the world around them, for example, how women interpret childbirth, based on their experience, culture and norms (Mukhopadhyay & Yeung, 2010).

Data were collected through six individual in-depth, semi-structured interviews with women and six in-depth interviews with health workers. This design allowed the collection of the richness of the participant's stories, experiences and feelings of the phenomena and gained insights into the phenomenon under study (Hennink, Hutter & Bailey, 2020; Mays & Pope, 1995).

The sampling strategy involved purposive recruitment of the participants. Six women who had given birth, three women from each hospital agreed to participate in the study. Women who participated delivered through a spontaneous birth or caesarean section had given birth to either a living or dead infant 72 hours after intrapartum within the 42 days of the puerperium period.
Six healthcare professionals participated in the study, including one midwife, one community health worker (CHW) and one doctor for each of the two hospitals.

The sample is presented in table 1:

Table 1 Participant details

Pseudonyms	Sex / Age	Marital status	Number of children	Type of delivery	Hospital
Antivan	F / 30	Married	2	Normal vaginal birth	St Mary's Hospital
Ray	F /30	Married	5	Normal vaginal birth	St Mary's Hospital
Catvan	F / 26	Married	1	Vacuum extraction	St Mary's Hospital
Nuty	F / 23	Married	1	Vacuum extraction	Nonga Base Hospital
Jay	F / 31	Married	4	Lower uterine caesarean section	Nonga Base Hospital
Matoks	F / 25	Married	4	Lower uterine caesarean section	Nonga Base Hospital
GeeKay	F / 41	Married	4	Midwife	St Mary's Hospital
Teemes	M / 49	Married	9	Midwife	Nonga Base Hospital
Dr Jaytee	M / 35	Married	3	Doctor	Nonga Base Hospital
Mikewes	F / 30	Married	5	Community health worker	Nonga Base Hospital
Auntrip	F / 26	Single	1/2	Community health worker	St Mary's Hospital
Dr Lexapa	M / 30	Married	5 months	Doctor	St Mary's Hospital

All participants were interviewed in a private room in the postnatal unit. The interviews lasted 45 to 60 minutes and the language used was mainly English with the healthcare professionals and Tok Pidgin with the women except one participant who spoke in Kuanua (ENBP language). At the end of the interviews, all participants had the opportunity to add points, which were not discussed during the interview. A reflective journal was used to document the interaction and the nonverbal communications expressed by the participants immediately after each interviews. The data from the reflective journal was included in the analysis to triangulate data (Mays & Pope, 1995). The interviews were conducted between 15 June and 3 July 2020.

All interviews were transcribed verbatim and translated into English by the principal investigator. Data were analyzed manually using content analysis (Creswell, & Creswell, 2018). The process started after the first interviews were transcribed with coding and the development of categories, which were compared, refined and themes identified. This process resulted in a coding framework with themes and categories used for interpretation of the findings (Creswell, & Creswell, 2018).

The study was approved by the Faculty of Medicine and Health Science (FMHS) research committee (FRC/MHS/06-20). Participation in the research was voluntary and participants had the right to withdraw from the study at any time during the interview without any negative consequences. That included permission to record the interview. Confidentiality was maintained throughout the research process.

Results and Discussion

Positive experiences of women's experience in the trajectory of childbirth

One of the definitions of quality maternal care is the enhancement of woman's experience of care that should achieve the highest standard of health, she experiences respect, dignity during delivery and has the availability of social, emotional as well as practical support (WHO, 2018; Hinton & Earnest, 2010). Women have the right to reproduction and the right to childbirth. Simply put, "healthy and happy mothers make healthy, happy and sustainable communities" (Childbirth in Human Right, 2019, p.4).

Three women experienced a positive experience by the healthcare workers during childbirth. They described that nurses have been helpful and responded promptly when the participants called for help. Antivan, is 30-year-old who had her second baby and mentioned that the nurses and doctor spoke kindly and assuredly as well as treated her well when the she arrived at the labor unit to give birth. That made her happy and gave her a good feeling.

> I feel alright because the nurses treated me well, they checked me and told me to go rest and sleep well then I can come again. I felt happy about the nurses here and the doctor, they talk well to me; I am not worried, I am happy. When I went in to deliver and when I called out, they helped me, I was happy until I delivered, and I came out and they looked after me.

Ray, who is 30 years old, had her fifth baby. The previous deliveries were without any complication but now during delivery the nurse advised her to pray. After praying, the doctor informed her that she should give birth at 11am. She was surprised that she delivered at that time and concluded, since she followed the nurses' advice that all went well with the delivery.

Catvan is 26 years old also described the work of the nurse during her first delivery as being helpful and good.

The positive experience of the three participants support the importance of providing quality maternal care. They testified that they have received a high standard of care and were treated with respect, dignity, and with emotional and practical support (WHO, 2018; Hinton & Earnest, 2010).

Healthcare workers' power and knowledge

Women tend to internalize unequal power relations and situations on the social, cultural, and economic level. It can invade multiple rights and women endure unequal power relations (Hinton & Earnest, 2010). The role as healthcare workers gives them power over women. Participants expressed their feelings of discontent in the way procedures were performed without information. Nuty, described how a doctor, reinforced power and control when he without informing her, put her on an intravenous drip

> He just came in, pulled my hands and inserted the needle and put drip on for pain. He should have asked me if I felt big pain, but he did not, I would say yes.

The after pain of childbirth can be very uncomfortable for the women. It can affect the women's movement and emotions. Although Catvan had a positive experience during delivery, she felt powerless when the nurse discharged her home. She was in pain, any movement was very uncomfortable, but the nurses rushed her to leave the hospital.

> Sometime after delivery and in pain they will not ask if we are ok and give us some medicine, they hurry us and don't know how we feel; we are in pain.

Matoks raised her concern on the reaction of nurse when newborn babies are left crying alone, while nurses sit around and chat with colleagues. She explained:

> Some they do not attend quickly to pick the babies and they cry, cry, cry. One nurse was with me; another one was sitting talking with a workmate (Matoks).

Jay was waiting for the theatre staff to bring her to the theatre for caesarian section when she heard a woman crying due to pain. The nurse told her to shut up. Jay "felt sorry for the woman" and pointed out that the nurse did not perform her duty.

Matoks said nurses instructed the women to walk around until the time to give birth. She observed a nurse shouting at a woman to stay outside of the labor ward. This woman delivered in the toilet and the baby died. Matoks told her experience with a sad expression.

> The mothers walking outside who want to deliver and went inside labor ward, nurses screamed at them to stay outside and walk about. We all saw a woman with severe pain delivered her baby in the toilet and the baby died. I was afraid and felt so sorry for that mother because the nurse got cross to her and so she feels pain and deliver her baby in the toilet.

Mikewes, a 30-year-old community health worker, justified that the reason nurses spoke harshly with women was to save their babies. She justified using discretionary power over clients and expert knowledge because women must listen to the nurses when instructed to push and need to follow the nurses' advice so that the baby may be delivered safely.

> Sometimes like when the mothers do not listen to us like, they are uncooperative then we use to talk hard at them. We talk hard with them it is like saving the baby. So, she must listen to us about what we tell her so that she can push or follow our advice and the baby can come out good and save the baby then the mothers do not listen then the staff will be get cross to the mothers.

These findings show health workers are experts in their own profession and tend to display power over the women in decision-making (Arnold et al., 2018; Parry, 2008). Nuty experienced that her "right to bodily integrity (Cohen & Ezer, 2013, p. 1) was violated when the doctor as expert performed biomedical procedures without considering her psychological needs to be informed and treated with respect (Davis-Floyd, 2018). This finding confirms medicalization dominates the features of childbirth (Kabakian-Khasholian et.al, 2000).

In addition, participants testified that healthcare workers exercise authoritative power over the women by leaving them alone in labor, which indicated disrespectful treatment and violation of the human right principle of dignity (Miltenberg et.al, 2010). Women in this study were reluctant to complain but clearly voiced their disapproval when given the opportunity to express their thoughts. A few studies, such as Miltenburg (2016) described similar findings. Milternburg (2016) noted that women are silent about the dissatisfaction with substandard quality of care, which sadly is a reality in this study.

In our study, the manner in which nurses respond to women during labor and the newborn, their insensitivity to react towards women needs demonstrates lack of commitment by the healthcare providers (Izugbara & Wekesah, 2018; Ith et al., 2013). This finding reveals a serious neglect and lack of commitment to the women and infants but also of the impact (D'Ambruoso et al, 2005).

Blaming themselves, blaming women

Women tend to blame themselves for the action of healthcare workers. A common statement is "people get what they deserve and deserve what they get" (Culda, Opre & Debrin, 2018, p. 101).

Ray heard another woman screaming, saw her crawling on the floor and heard her shouting all kinds of words due to pain. She really wanted to tell the other woman to listen to the nurses. Ray justified that it was the other woman's fault because "she wanted to kill her unborn baby and continued to swear".

Catvan also pointed to and blamed other women for their actions in the labor room. She provided a justification when nurses became angry and mistreated a woman during labor because she broke a

louver window. While Catvan justified why the nurses became angry she concluded that if "we make little mistakes the nurses get at us".

> The nurse got on her because it was her fault, she pushed but accidently broke the louvres that's why the nurse did not treat her well.

Healthcare workers blame women for the outcome of labor when instructions are not followed (Miltenburg et al., 2016). Auntrip, a 26-year-old CHW with 6 months of working experience, stated that some women are uncooperative and do not listen to the nurses when they explain how to breathe during labor. That is the reason why nurses scold women and blame women for their behavior.

> As I said, some mothers are uncooperative, telling them to breathe in and out, but they are very naughty that's why the midwives get cross. It is a normal way nurses do to help them to listen and deliver quickly.

There are many contributing factors for women not to attend antenatal care. These may include financial or socio-cultural issues, sociodemographic and attitudes of healthcare providers towards women (Gilleatt, 2004; Valley et al., 2013; Andrew et al., 2014). Auntrip constructed two women as bad women and blamed them for not attending antenatal care. When they were admitted late to the labor ward one women had a cord prolapse and the other one had an arm prolapse after their membranes ruptured. For Auntrip it was the women's' fault that their babies died.

> This mother that came last week only, she did not attend clinics and had a cord prolapse and her baby died and the other a midwife ruptured her membrane and she had an arm prolapse and her baby died, too.

In settings were abusive and disrespectful behavior is normal and accepted, it is expected and difficult to change (Kruk et.al, 2018). This is the experience of Dr Jaytee who does not approve this type of behavior of health workers but admitted it is challenging to change the practice. He added that some midwives even blame women for having another baby after a year.

> Yes, I think almost every day especially, harshness towards our mothers that is the thing that is out of our control. Even when we raise these issues, it is not an easy thing to deal with. Like when a mother delivers last year and comes again this year with another pregnancy this makes midwives very cross and they scold the mothers.

These findings highlight that some participants perceive disrespectful treatment as a deserved punishment for breaking rules, also noted in a study in Zambia (Sochas, 2019). Healthcare workers used blame attribution to women using a language of victim blaming but exempted themselves from blame (Jason & Turgeon, 2021). These findings are of great concern that both women and healthcare workers blamed women as disobedient in a situation where the women should receive the best support possible (Bohren et al, 2016). Auntrip blamed women who seems not to follow the rules of attending antenatal care and constructed them as bad women. This reinforces "women's perceived immorality outside the health facility" (Sochas, 2019, p. 284).

Violation of women's rights

Women's perspective

Women continue to encounter verbal and physical abuse during childbirth by healthcare workers, which is a violation of woman's right (Hodges, 2009). Five women provided a narrative of violation of their rights. Ray witnessed verbal abuse when a woman in labor jumping up and down in bed, crawling on the floor due to labor pain and saw the nurse repeatedly slapping and shouting because the woman disobeyed the nurses.

Observing such traumatic experiences can cause emotional and psychological trauma. Ray explained, "I just felt that it was me they were slapping and shouting at me and I kept on thinking, that it is me they were slapping me over this baby".

Nuty and Jay witnessed that nurses scolded women during labor. They yelled and used abusive words when women cried in labor pain.

> The mothers are feeling pain, they should not shout at them because sometimes the nurses say to the mothers ("mama ino salim yu") 'your mother did not send you' when we cry and call out for our mothers they use to say that.

Several women expressed that they felt traumatized and abused during childbirth. Similar to other studies in LMIC, this study identified that women were repeatedly slapped, shouted at and verbally abused as they cried out with pain (Ith, Dawson, & Homer, 2012; Bohren et al.,2016; Hameed & Avan, 2018; Orpin et al., 2018; Aziato, Acheampong, & Umoar, 2017). Women shared that they have witnessed other women in labor who were also being scolded and yelled at by the nurses and even to the point of telling the women to shut up (Ith, Dawson, & Homer, 2013; Orpin et al., 2018). These findings confirm serious human rights violatens of women in labor (Hinton & Earnest, 2010) at the two hospitals, St Mary's Hospital and Nonga Base Hospital.

Healthcare workers' perspective

In PNG, the midwifery curriculum addresses respectful maternity care and women's rights, irrespective of race, religion, color, education, or culture with the aim to strengthen respectful maternity care (Neill et.al, 2016).

GeeKay, a midwife who has worked for four years in the labor unit, confirmed women's accounts and pointed to other nurses and midwives who disrespected mothers and use abusive words.

> We have staff who do abuse mothers. One of the typical examples is that sometimes they get angry at the mothers and they used to slap mothers, saying put your legs up (sanapim leg), put your leg properly (putim leg gut), put your ass down (putim ass go daon) and all these typical examples of disrespect and abuse.

There is a limited choice for women to select the health facility for childbirth. Women's preference to giving birth in one of the two hospitals was not supported by nurses. GeeKay explained that some women coming from far places are being send back and told to deliver at a health facility close to their home. She highlighted that this practice is abusive to women and against human rights.

> When they come to give birth, the nurses used to send them back. Like there are seven universal rights so they use to tell them to go to the nearest health facility and don't come here. That's one thing that is abusive to the mothers again.

Dr Lexapa, a young clinician observed disrespectful approaches of nurses towards women during childbirth. Midwives do not talk to women in a respectful manner and tend to shout at the women to wait and shut up if they call for help from the labor room. He was wondering if this is due to the workload or just laziness.

> Most of the time it is disrespectful and the sister will just tell the patient to shut up. But it is an ongoing behavior, so this is disrespectful and neglectful. So sometimes, when the patient is in the labor bed and is calling out saying she wants to give birth now, the midwives would shout back at her and say you wait. It is either she is busy with some work over there or here or with a patient or she is just lazy and is sitting down for a little while. So, it is like disrespectful at times and neglectful at times.

Dr Lexapa highlighted the difference in the way educated and uneducated women are treated by healthcare workers pointing to unequal power relations. He stated that women from villages do not have the power to stand up for their rights.

> I think it's related to power because you can see the difference if an educated woman comes, you can tell by the positive approach of the staff. You can see when a mother comes from the village she is treated differently. It's something to do with power, so the mothers have no way to fight back.

In comparison, staff members are treated well, nurses "take observations on time and this type of attitude should be happening to everybody, so this type of attitude is unfair treatment He also pointed out the huge difference in treatment of a staff member" (Dr. Lexapa).

These issues identified show unequal treatment by healthcare workers, which can be recognized as a violation of human rights (Finlayson & Downe, 2013). Limited autonomy for women to decide about the health facility use is considered as underlying factors of the "three delays" related to the limited access to emergency care in labor (p.8). Consistent with other studies women in our study with low educational levels and different social status are treated unequally by healthcare workers, which violates their rights (Kabakian-Khasholian et.al, 2000). This practice by health workers with their own privileged social status uncovers unequal power relations (Yakong et al., 2010).

Health system factors

Multiple factors related to the health system influence maternal health services delivery including human resources, finances and availability of medical supply and technologies (de Savigny & Adam, 2009).

Human resource issues

In the labor unit, doctors and midwives have clear roles and responsibilities in the way they work together to manage the women in various stages of labor. Doctors give orders to nurses and midwives to assist the women to progress in labor and for the wellbeing of both the mother and the unborn child. Nurse and midwives monitor the progress and inform the doctor of any changes. Dr Jaytee commented nurses do not carry out the orders. He attributed the poor attitude of nurses in the labor unit to frustration and the workload:

> The challenges I am facing in the labor ward is especially regarding giving orders. When you give orders and the nurses are not following your orders this is a big challenge. The nurses have different multiple reasons why they don't follow your orders that make everything more difficult. The attitudes in the labor unit towards our laboring mothers is frustrating.

Healthcare workers know the performance of colleagues very well. Senior staff may leave the workplace without informing colleagues. Mikewes experienced this behavior by a senior midwife who left her as a CHW alone in the labor unit. This can lead to negligence of duty.

> Sometimes when I am at work, I work with hard feelings towards my colleagues because they do not cooperate with me. When I am working with him, he will disappear and leaves me alone to attend to his client after he has examined the mothers and it's very frustrating for me. If I want to complain, he is gone and so I want to also leave the client because she is his client (Mikewes).

Nurse's attitudes towards work attendance and punctuality was another issue that was raised by participants. Some nurses do not come in time for the shift or remain absent. As staff wait for their colleagues, they may neglect the mother in labor.

> Sometimes when the other staff do not come quickly, the staff on duty becomes uneasy while the women are laboring their mind is no longer in the ward. Like the staff wants to go quickly now and they will leave the laboring mother for the other shift (Mikewes).

These accounts present power dynamics between the healthcare workers, the doctor and nurses/midwives and nurses/midwife and CHWs. McDonald et al. (2012) in a study in Australia found the practice of power is related to who has authority, which goes beyond understanding of the professional role boundaries between professional groups.

Workload

All healthcare workers raised the issue of the limited number of human resources for health and high workload. Apparently, this has contributed to the attitude of nurses and midwives towards the women during childbirth. Mikewes accepted nurses' behavior since they have high workloads and "sometimes

when we have an increase flow of mothers, staff are pressured and when the mothers do not listen then the staff will get cross with the mothers".

Nonga Base Hospital is the referral hospital and women from the province are referred to this hospital. Teemes, a male midwife, reported a high workload but limited number of healthcare workers. When faced with staff absenteeism the situation is even worse.
When a gynecologist is not available, midwives have to manage emergencies on the labor unit.

> At this time, we don't have an O&G specialist, it's one of the challenging issues, so we midwives are handling everything (GeeKay).

Dr Jaytee connected the staff ratio with the attitude of healthcare workers, which again has an effect on the work performance. Limited number of staff working in the labor unit, according him contributes to frustration of the health personnel and to the negative attitude towards women in labor.

Resource constrains
Two healthcare worker mentioned inadequate infrastructure and lack of basic equipment that adds to frustrations.

> Stress arises when a health work force encounters scarcity in logistics such as the unavailability of proper equipment and instruments, which are needed for the provision of healthcare service to the women (Dr Jaytee).

Teemes mentioned the infrastructure of the labor wards, with its limited space to accommodate all admitted women to give birth. He also pointed out the limited support from the hospital management for purchasing needed items.

> In regards to support from the management, they are not really giving us what we really need like purchase of …we place orders, but we don't receive those things on time.

Healthcare workers face considerable constrains in terms of available human resources for health, equipment and medical supply and infrastructure issues. They justify the abuse and maltreatment of women due to these issues. In a similar study, Miltenburg et al. (2016) found organizational issues in facilities such as lack of staff, insufficient space and poor resource allocation contributing to the disrespect and abuse by healthcare workers. Izugbara & Wekesah (2018) identified lack of basic infrastructure as a barrier to quality maternal care. Further, the right of health care workers to decent working conditions are not respected, which drives a culture of disrespect and poses a risk to mothers in labor (Cohen & Ezer, 2013). This study illustrates systemic issues contributing to disrespectful and abusive treatment of women in the two health facilities.

Conclusion
The study indicates that women are mistreated, abused and their human rights are violated during childbirth. Healthcare workers use their expert knowledge to exercise power over women without consideration of physiological and psychological needs of the women. Women internalize the situation by blaming themselves or others for their behavior during childbirth. The consequences of abuse on women causes trauma, affects the progress of labor and leads to further complications to women and the newborn. In listening to the women's accounts of received care during childbirth, it speaks to the need for compassionate, kind, respectful and dignified care (Wilson et al., 2020).

On the other hand, healthcare providers externalize the situation as being out of their control and attribute their behavior to high workload and resource constraints. Their right for a conducive working environment calls for immediate attention by the hospital management to strengthen the health system and protect human rights of women and healthcare worker.

The results of the study are a call to action. The hospital authorities need to develop a supervisory structure so that human rights violations will have disciplinary consequences for the workforce of both facilities. Policy makers such as the PNG midwifery and nurses' association has the responsibility to

develop and implement a concrete policy that will not tolerate disrespectful and abusive treatment of women. This should include the serious consequences of losing accreditation of the nursing and midwifery license. Further research is needed to explore the extent of human right abuses of women during childbirth in PNG. This will provide evidence as a foundation to develop effective strategies with the potential to put an end to the abuse on women during of childbirth.

References

Andrew, E. V. W., Pell, C., Angwin, A., Auwun, A., Daniels, J., Mueller, I., Phuanukoonnon, S., & Pool, R. (2014). Factors affecting attendance at and timing of formal antenatal care: Results from a qualitative study in Madang, Papua New Guinea. *PLoS ONE*, *9*(5). https://doi.org/10.1371/journal.pone.0093025.

Arnold, R., van Teijlingen, E., Ryan, K., & Holloway, I. (2018). Parallel worlds: An ethnography of care in an Afghan maternity hospital. *Social Science and Medicine*, *216*(September), 33–40. https://doi.org/10.1016/j.socscimed.2018.09.010.

Aziato, L., Acheampong, A. K., & Umoar, K. L. (2017). Labor pain experiences and perceptions: A qualitative study among post-partum women in Ghana. *BMC Pregnancy and Childbirth*, *17*(1), 1–9. https://doi.org/10.1186/s12884-017-1248-1.

Beck, C. T. (2018). A secondary analysis of mistreatment of women during childbirth in health care facilities. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *47*(1), 94–104. https://doi.org/10.1016/j.jogn.2016.08.015.

Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., Olutayo, A. O., Oyeniran, A. A., Ogunlade, M., Metiboba, L., Osunsan, O. R., Idris, H. A., Alu, F. E., Oladapo, O. T., Gülmezoglu, A. M., & Hindin, M. J. (2016). "By slapping their laps, the patient will know that you truly care for her": A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria. *SSM - Population Health*, *2*, 640–655. https://doi.org/10.1016/j.ssmph.2016.07.003.

Bohren, M. A., Mehrtash, H., Fawole, B., Maung, T. M., Balde, M. D., Maya, E., Thwin, S. S., Aderoba, A. K., Vogel, J. P., Irinyenikan, T. A., Adeyanju, A. O., Mon, N. O., Adu-Bonsaffoh, K., Landoulsi, S., Guure, C., Adanu, R., Diallo, B. A., Gülmezoglu, A. M., Soumah, A. M., … Tunçalp, Ö. (2019). How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. *The Lancet*, *394*(10210), 1750–1763. https://doi.org/10.1016/S0140-6736(19)31992-0.

Childbirth in Human Right (2019). *Submission by human rights in childbirth to the United Nations Special Rapporteur on violenc against women, its causes and consequences*. https://digitallibrary.un.org>files>A_74_137-EN.pdf.

Cohen, J., & Ezer, T. (2013). Human rights in patient care: A theoretical and practical framework. *Health and Human Rights*, *15*(2), 7–19.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Allen & Unwin.

Culda, G. L., Opre, A. N., & Dobrin, A. D. (2018). Victim blaming by women and men who believe the world is a just place. *Cognition, Brain, Behavior. An Interdisciplinary Journal*. 22, 99-110. https://doi.org/10.24193/cbb.2018.22.07.

Creswell, J.W. & Creswell, D. (2018). *Research design: qualitative, quantitive and mixed methods approaches* (5th ed.). SAGE Publications.

D'Ambruoso, L., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health*, *5*, 1–11. https://doi.org/10.1186/1471-2458-5-140.

Davis-Floyd, R., Pascal-Bonaro, D., Davies, R., & Ponce de Leon, R. G. (2010). The international m other baby childbirth initiative: a human rights approach to optimal maternity care. *Midwifery Today*, *94*.

de Savigny, D., & Taghreed Adam, (Eds). (2009). *Systems thinking for health systems strengthening*. Alliance for Health Policy and Systems Research, WHO.

Finlayson, K., & Downe, S. (2013). Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies. *PLoS Medicine, 10*(1). https://doi.org/10.1371/journal.pmed.1001373.

Fiti-Sinclair, R. (2002). Childbirth in Papua New Guinea villages and in Port Moresby Genernal Hospital. In R. Fiti-Sinclair, *Birthing in the Pacific: beyond tradition and modernity*, 57-77. University of Hawaii Press.

Gillieatt, S. J. (2014). Antenatal care in Goroka: issues and perceptions. *PNG Medical Journal*, 47, No 3-4, 202–214.

Hanson, L.W., Allen, B.J., Bourke, R.M., McCarthy, T. J. (2001). *Papua New Guinea Rural Development Handbook*. Department of Human Geography Australian National University.

Hameed, W., & Avan, B. I. (2018). Women's experiences of mistreatment during childbirth: A comparative view of home- and facility-based births in Pakistan. *PLoS ONE, 13*(3), 1–17. https://doi.org/10.1371/journal.pone.0194601.

Hennink, M., Hutter, I., & Bailey, A. (2020). *Qualitative research methods* (2nd ed). SAGE publications.

Hinton, R., & Earnest, J. (2011). Assessing women's understandings of health in rural Papua New Guinea: Implications for health policy and practice. *Asia Pacific Viewpoint, 52*(2), 178–193. https://doi.org/10.1111/j.1467-8373.2011.01449.x.

Hodges, S. (2009). Abuse in hospital-based birth settings? *Journal of Perinatal Education*, *18*(4), 8–11. https://doi.org/10.1624/105812409x474663.

Homer, C. S. E., Friberg, I. K., Dias, M. A. B., Ten Hoope-Bender, P., Sandall, J., Speciale, A. M., & Bartlett, L. A. (2014). The projected effect of scaling up midwifery. *The Lancet*, *384*(9948), 1146–1157. https://doi.org/10.1016/S0140-6736(14)60790-X.

Ith, P., Dawson, A., & Homer, C. (2012). Women's perspective of maternity care in Cambodia. *Women and Birth*, *26*(1), 71-75. https://doi.org/10.1016/j.wombi.2012.05.002.

Izugbara, C. O., & Wekesah, F. (2018). What does quality maternity care mean in a context of medical pluralism? Perspectives of women in Nigeria. *Health Policy and Planning*, *33*(1), 1–8. https://doi.org/10.1093/heapol/czx131.

Jason, K., & Turgeon, B. (2021). Victim-blaming in disguise? Supervisors' accounts in healthcare delivery. *Qualitative Sociology*, *44*, 253-270.

Kabakian-Khasholian, T., Campbell, O., Shediac-Rizkallah, M., & Ghorayeb, F. (2000). Women's experiences of maternity care: satisfaction or passivity? *Social Science and Medicine*, *51*(1), 103–113. https://doi.org/10.1016/S0277-9536(99)00443-8.

Mays, N., & Pope, C. (1995). Qualitative research: rigour and qualitative research. *British Medical Journal*, *311*, 109–112.

Mukhopadhyay, A., & Yeung, C.W.M. (2010). Building character: effects of lay theories of self control on the selection of products for children. *Journal Market Research, 47*(2), 240-250. https://doi.org//10.1509/jmkr.47.2.24.

McDonald, J., Jayasuriya, R., & Harris, M. F. (2012). The influence of power dynamics and trust on multidisciplinary collaboration: A qualitative case study of type 2 diabetes mellitus. *BMC Health Services Research*, 12(1), 63. https://doi.org/10.1186/1472-6963-12-63.

Mola, G., & Kirby, B. (2013). Discrepancies between national maternal mortality data and international estimates: The experience of Papua New Guinea. *Reproductive Health Matters*, *21*(42), 191–202. https://doi.org/10.1016/S0968-8080(13)42725-8.

Miltenburg, S. A., Lambermon, F., Hamelink, C., & Meguid, T. (2016). Maternity care and human rights: what do women think? *BMC International Health and Human Rights*, *16*(1), 1–10. https://doi.org/10.1186/s12914-016-0091-1.

Neill, A., Homer, C., Rumsey, M. & Kililo, M. (2016). PNG maternal and child health initiative phase 2: *Mid- term Summary Report.* World Health Organization Collaborating Centre for Nursing, Midwifery and Health, University of Technology, Sydney.

Orpin, J., Puthussery, S., Davidson, R., & Burden, B. (2018). Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. *BMC Pregnancy and Childbirth*, *18*(1), 1–9. https://doi.org/10.1186/s12884-018-1847-5.

Parry, D. C. (2008). "We wanted a birth experience, not a medical experience": exploring Canadian women's use of midwifery. *Health Care for Women International*, *29*(8–9), 784–806. https://doi.org/10.1080/07399330802269451.

Sochas, L. (2019). Women who break the rules: social exclusion and inequities in pregnancy and childbirth experiences in Zambia. *Social Science and Medicine*, *232*(May), 278–288. https://doi.org/10.1016/j.socscimed.2019.05.013.

UNDP (2014). United Nations Development Program, Report on MDGs. Retrieved June 12, 2020 from: http://www.pg.undp.org/content/dam/papua_new_guinea/docs/MDG/UNDP_PG_MDG%20Comprehensive%20Report%202010.pdf.

Vallely, L. M., Homiehombo, P., Kelly, A. M., Vallely, A., Homer, C. S. E., & Whittaker, A. (2013). Exploring women's perspectives of access to care during pregnancy and childbirth: a qualitative study from rural Papua New Guinea. *Midwifery*, 1–8. https://doi.org/10.1016/j.midw.2013.03.011.

World Health Organization. (2018). Human rights and health. Retrieved November 8, 2020 from https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

Wilson, A. N., Spotswood, N., Hayman, G. S., Vogel, J. P., Narasia, J., Elijah, A., Morgan, C., Morgan, A., Beeson, J., & Homer, C. S. E. (2020). Improving the quality of maternal and newborn care in the Pacific region: A scoping review. *The Lancet Regional Health - Western Pacific*, *3*, 100028. https://doi.org/10.1016/j.lanwpc.2020.100028.

Yakong, V. N., Rush, K. L., Bassett-Smith, J., Bottorff, J. L., & Robinson, C. (2010). Women's experiences of seeking reproductive health care in rural Ghana: challenges for maternal health service utilization. *Journal of Advanced Nursing*, *66*(11), 2431–2441. https://doi.org/10.1111/j.1365-2648.2010.05404.x.

Authors

Eva Piniau Tenanga is a senior midwifery tutor, clinical coordinator and is lecturing in the Midwifery Program, St Mary's School of Nursing (SMSON), Department of Nursing, Faculty of Medicine and Health Science (FMHS), Divine Word University, Rabaul campus. She holds a Master's Degree in Public Health from the Divine Word University, PNG.

Elisabeth Schuele is the Head of the Department Public Health Leadership and Training at the Faculty of Medicine and Health Sciences (FMHS), Divine Word University (DWU) and the research coordinator of FMHS. She holds a Doctorate of Public Health from Flinders University, Australia and MSc Health Services Management from the London School of Hygiene and Tropical Medicine, UK.

---oo0oo---