

Perceptions and Expectations of Providers on Maternity Rights of Parturients

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Abstract

Introduction: This study aimed to understand the perception of providers of the Mama Mosalisi health and maternity center perceive the rights of parturients and to explore their expectations. **Method:** We conducted a descriptive qualitative exploratory phenomenological study, the data collection was done through individual face-to-face interviews with 10 providers of the Maman Mosalisi Health Center (nurses, laboratory technicians, doctors, midwives), worker in the maternity ward. **Results:** Providers generally have a positive perception, characterized by the recognition of the rights of parturients. They affirm that it is important to respect the rights of the parturients because this respect makes it possible to avoid the bad course of the childbirth; to gain the confidence of parturients; to increase the clientele and the receipts in the structure; leads to conscientious work; and contributes to the reduction of mortality. In their experiences, service providers encounter several difficulties in the exercise of their profession; but they also recognize their failure to respect the rights of parturients, they feel this in the form of guilt. Finally, they expect managers to improve working conditions in their structure, provide for self-assessment sessions, that the State take charge of them in everything, that the organizations involved strengthen their capacities through continuous training, that researchers sensitize the public in general and parturients in particular on their rights which they are unaware of, in order to be able to claim them and reframe the practices of providers. **Conclusion:** These results plead in favor of concerted interventions between political and health decision-makers, the partners involved and the providers for the promotion of respectful maternity care in order to contribute to the reduction of maternal and infant mortality.

Keywords: Perception, Expectation, Provider, Rights, Parturient.

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INTRODUCTION

Pregnancy, labor and delivery are physiological processes that change the lives of most women and their families and require collaboration among health professionals providing maternity care. Childbirth can be uneventful for the majority of women and children, and maternity care should be supportive,

individualized, and value-based (International Federation of Gynecology and Obstetrics, 2015).

However, a growing body of evidence shows that women face disrespectful and violent treatment at the hands of maternal care providers.

FIGO, together with colleagues from the International Confederation of Midwives, the White

Ribbon Alliance, the International Pediatric Association and the World Health Organization (WHO), launched the Initiative Childbirth International, to promote the active engagement of professional associations, governments, non-governmental organizations and civil society to improve the quality of care and reduce abuse, neglect and extortion of pregnant women in institutions. But, despite all these provisions already taken in the texts, their implementation in the practice of the various service providers still remains absurd; This is the reason why the relationship between health personnel and patients in general, and between the maternity staff and parturients in particular, deserves special attention, because, despite the importance and complexity of the issue, it does not seem to be of great concern to the various health actors in our country (International Federation of Gynecology and Obstetrics, 2015).

A growing body of evidence shows that women face disrespectful and violent treatment at the hands of maternal care providers. In addition to psychological harm, this type of behavior can deter women from using health facilities for maternal care, and can ultimately lead to preventable death and disability (Abuya *et al.*, 2015; Bohren *et al.*, 2015). *et al.*, 2015; Bowser & Hill, 2010; Center for Reproductive Rights & International Federation of Women Lawyers, 2007; Freedman & Kruk, 2014; Perrotte *et al.*, 2020). This kind of treatment not only violates their rights to respectful care, but it also threatens their rights to life, health, physical integrity and freedom from discrimination.” (World Health Organization, 2014).

According to FIGO (International Federation of Gynecology and Obstetrics, 2015), in its study on the 7 dimensions of disrespectful care, aspect Inappropriate behaviors in the delivery room, 71 women out of 619 or 11% reported having witnessed at least one inappropriate behavior occurring in the delivery room in one of the 7 dimensions.

The abuses suffered by pregnant women around the world fall into several categories, namely: physical violence, lack of consent, lack of confidentiality, lack of dignity, discrimination on the basis of a particular attribute or abandonment or lack of care imprisonment (Bowser & Hill, 2010; Ueda, 2013).

A study conducted in Mexico on experiences of obstetrical violence that, Of 1793 eligible women, 1149 (64.1%) responded. They said they experienced their childbirth well on the physical (89.8%) and psychological (93.4%) levels. On the other hand, 506 women (44%) declared at least one Obstetric Violence. The incidence of verbal (2.3%) or physical (0.4%) violence or discrimination (2.1%) was marginal. Obstetric Violence was expressed by a lack of research and/or respect for consent (21.5%), unsatisfactory information for at least one gesture (14.4%), a breach of

good care practices (24, 2%) or a failure in the caregiving relationship (11.1%). When childbirth was very badly experienced physically, at least one violence was reported in 80% of cases ($p < 0.01$) (El Kotni & Faya Robles, 2018).

In a longitudinal study of 499 women conducted four to six weeks after giving birth, conclude that 33% of women mentioned having experienced "traumatic" events during childbirth. These women had at least three symptoms of the PTSD syndrome. A total of 28 out of 499 women, or more than 5.6%, met the DSM-IV criteria for a diagnosis of PTSD (Labrecque, 2018).

However, many studies testify to the serious consequences that the negative experience of childbirth can have. And there they reveal that whatever the nature of these, the repercussions are real and can be permanent. Moreover, a negative experience can have consequences on multiple facets of a woman's life (Denis & Callahan, 2009).

Not only can a negative childbirth experience have a negative impact on a woman's physical, sexual health and self-esteem, but it can also have a detrimental effect on the bond of attachment between mother and child. (Chabbert & Wendland, 2016; Labrecque, 2018).

In Tanzania, a study reveals that women who say they have suffered abuse and lack of respect during childbirth have less satisfaction, a lower perception of the quality of care; and have half the intention of returning to give birth in the same place (Kujawski *et al.*, 2015).

Improving the quality and safety of care requires a thorough analysis of what happened and the implementation of corrective measures. This is an effective levé for improving medical practices. While in our country, the Democratic Republic of Congo, although the literature abounds on health research, the observation is that that on the caregiver-patient relationship in maternities in general and on respect for the rights of women who give birth seems rare. This is why this study is justified.

This work is carried out with the aim of understanding the perception of the providers of the Mama Mosalisi maternity hospital with regard to the rights of the parturients in their care and their expectations regarding this in their practices.

METHOD

2.1 Research quote

We conducted a qualitative study of the exploratory descriptive type, the phenomenological approach was used to understand the perception and expectations of providers on the rights of parturients to

maternity. We preferred this approach, because it allowed us to understand the meaning that health actors (providers) attribute to the rights of parturients in the exercise of their profession.

2.2 Study environment

This study is conducted at the mama Mosalisi health and maternity center (CSMM) located at No. 45/55 Avenue By-pass, Quartier Masanga Mbila, in the commune of Mont Ngafula, city province of Kinshasa.

2.3 Target Population, Sampling and Sample Size

The target population of our study is made up of health care providers, working in the maternity ward in this structure, regardless of their titles or qualifications (doctors, nurses, midwives, laboratory technicians).

Given that this is a naturalistic study, we used the non-probability sampling technique of the theoretical sample type, constituted gradually according to the degree of saturation observed as the collection evolved and data analysis. This type is more preferred because the participants were selected according to the need of the researcher and the study. We used primary selection, that is to say, we only selected people who hold the information useful to the study, who have experienced the phenomenon under study.

In the qualitative approach, the number of participants is not determined a priori. Thus, in this study, this number is dictated by the saturation of the information collected (Friedrich-Ebert-Stiftung, 2021). We interviewed participants until the answers became repetitive and added nothing new to the interest of the study. Thus, we interviewed a total of 10 service providers of different categories (doctor, nurse, midwife, laboratory technician) for the Mama Mosalisi Health Center and Maternity Hospital.

2.4 Data collection method and technique

We used the survey method and the individual interview as a data collection technique in this study, in order to collect information from a group of individuals (providers and users of maternity care), who have lived

experiments on the respect of the rights of parturients in their services.

2.5 Data processing and analysis

Data collected from the recording was transcribed. The method of analysis retained for this study is the thematic content analysis of the interviews, aiming to bring out the hidden meanings inherent in the meanings that the interviewees made on the phenomenon studied, that is to say, we used thematic and categorical analysis starting with the verbatim, categories, sub-themes and themes.

In the “results” section, the verbatim are referenced as follows: R1 for the first interviewee, R2 for the second and so on.

However, the information recorded during the interviews was transcribed in verbatim form according to the following procedure:

- Listen completely to the elements recorded in the telephone memo and read them in order to give them a meaning,
- Highlight the characteristic elements of the understanding of subjects in relation to the rights of parturients
- Extract the data under their themes,
- Eliminate redundancies and regroup the main themes,
- Identify the sub-themes related to the themes,
- Group the meanings for each of the elements or expressions selected into central themes,
- Integrate the results of the analysis into a description related to the objectives of the study.
- Formulate a summary of the results obtained
- Confront or compare the results with the theoretical results of the literature review,
- Submit general descriptions to a few interviewees for validation of results.

RESULTS

3.1 Presentation of the identification elements of the interviewees

Table-1: Socio-demographic and professional characteristics of providers

Sex Female: 05 Male: 05	Age ≤25 years: 01 >26 years: 09	Marital status Single: 02 Married: 06 Widow: 01 Divorced: 01
Study level A2:05 A1:03 L2: 02	Occupation Nurse: 06 Midwife (SF): 02 Doctor: 02	Years of experience ≤20 years: 06 >21 years and over: 04

Legend: A2 (State diploma); (A1: Graduated); (L2: Licensed).

Reading this table reveals that the subjects of both sexes were equally represented (5 men and 5

women), 9/10 were over 26 years old, 6/10 were married, 5/10 were A2, 6/10 were nurses and 5/10 had a

professional experience of 20 years or less, and 5/10 had more than 21 years.

3.2 Results of the qualitative analysis

The results presented in this part of the chapter are obtained after careful analysis of the responses of 10 services providers transcribed after interviews with them. They are presented in a box of four columns according to the selected sub-themes.

The central theme chosen is: "Perception and expectations of service providers on the rights of parturients at the Mama Mosalisi health and maternity center".

From this central theme retained after thematic analysis, derive the sub-themes below:

1. Perception of providers on the rights of parturients
2. Importance of respecting the rights of parturients according to the providers
3. Experiences of service providers on the rights of parturients according to their answers
4. Perceptions of service providers in the face of non-respect of the rights of parturients
5. Expectations of providers on the rights of parturients

3.2.1 Perception of providers on the rights of parturients

Reading the verbatim on this sub-theme reveals that providers have a positive perception, characterized by the recognition of the Rights of parturients: right to life and to good health, to good collaboration, to satisfaction of needs, appropriate care, and freedom. Only one respondent expressed a negative perception, explaining that the context of the Democratic Republic of Congo does not allow him to grant all these rights to the parturient.

Category 1: positive perception

As for the positive perception, the service providers responding to the study express themselves below on the different Rights that a parturient must have:

- **Right to life and good health**

R1: "first of all, a parturient is someone who comes to wait for her delivery, ... she has the right to go out with her baby, herself to go out alive and in good health. Health and with a baby of quality and good health»

- **Right to good collaboration with providers**

R2: "Silence...it is a right that can be exercised in collaboration between the parturient during childbirth or labor, the nurse must talk about the things she has to do...the The parturient is free to do what the service provider tells her in collaboration,..." **R5:** "... seeing only the parturient, you have to collaborate very well, speak well with her, you have to know her pain, you have to put yourself in her place... if there is no

collaboration there will always be disagreements, maybe she can reject me"

- **Right to the satisfaction of needs**

R3: "the rights of parturients? in a way, this is what we must do to satisfy all the parturients who come to us, the goods done, the satisfactory acts, which are at the request of the parturient, and when we do it the parturients are satisfied, the requests are satisfied, that's it at least, ..."

- **Right to appropriate care**

R5: "*silence...right to assist her during childbirth, privacy, appropriate care ...*" **R8:** "*...she has the rights, we have the right to provide her with quality care, ...* »

- **Right to freedom**

R2: "The parturient who comes to give birth is not a slave, the parturient is free to do what the provider tells her,..." **R8:** "Hmmm, in my opinion the rights of parturients, that means that the patient, the parturient is free to express himself, he has the free choice to ask whom he wants to confide in to benefit from the care, therefore, he has his rights, he is to be respected like any other person, he has his rights and freedom " **R9:** "... that is to say freedom, she is free, she is free to speak, to converse, to do whatever she wants, to shout, so everything she is entitled to, she wants to give birth on the floor, in any position... "

Category 2: Negative perception

Only one respondent expressed a negative perception, explaining that the context of the Democratic Republic of Congo does not allow him to grant these rights to the patient. Here is how he expresses this: **R4:** " in our conditions, we have not yet reached the maturity that the others have reached, we decide taking into account the clinical data of the CPN, or the work of childbirth instead of the woman".

3.2.2 Importance of respecting the rights of parturients according to the providers

With regard to this sub-theme, it appears that our participants affirm that it is important to respect the rights of parturients because this respect makes it possible to avoid the bad course of the childbirth; to gain the confidence of parturients; to increase the clientele and the receipts in the structure; leads to conscientious work; and contributes to the reduction of mortality.

Here is how they express themselves on the different importance of respecting the rights of the parturient:

- **Respect for rights avoids poor workflow**

R3: "Really the law is very crucial for any woman who happens to us because it puts you, it also plays a big role in the progress of childbirth... you know that everything happens with the brain, so if the woman

is stressed, there will also be a blockage, or disruption in the progress of the work... if the rights are not respected, the progress will not be so good,... you know that everything happens with the brain, so if the woman is stressed, there is also a blockage in the labor of childbirth, therefore, there may be disruption in the progress of labor, which is why the woman must have her rights and we have a duty to respect these rights here to ensure a smooth running of the work...".

R7: "A woman who has been made comfortable, her labor flow can go well, she can deliver well, but when she has been contracted, made uncomfortable, labor will be prolonged".

- **Respect for rights leads to conscientious work**

R9: "yes, her rights there are good, ... you can receive a woman who arrives on her own, she walks all that, all the vital signs are normal, ... while she is giving birth, she can go into shock, she can succumb, but if the member of the family was there from the start, he assists us, you see that even if a problem were to arise, in any case it is this member of the family who will still defend the midwife who is there, ... but if we do it ourselves, ... well, there are mistakes that happen, but we avoid these mistakes, I call someone who comes to help us, I don't know, I have to work with all caution, I really have to avoid mistakes, .. it's like I just said the assistance of the person inside it also helps the midwives in many things, ..."

- **Respect for rights Contributes to the reduction of mortality**

R4: "... and that will reduce mortality... we know that a woman who has to give birth should not lose her life, but under our conditions, she must benefit from these rights, if not, there is a risk that the delivery does not take place in good conditions to lose either the child or the mother because of nosocomial infections"

- **Respect for rights gives the parturient confidence**

R3: "really it is important to respect the rights, the first thing, it gives the woman confidence, it reassures her of something, let two, it also contributes to the smooth running of her confidence, she gains confidence in us and we trust her."

- **Respect for rights increases clientele and revenue in the structure**

R6: "it is our duty to respect rights, because if the mothers refuse to come here, what are we going to do, if we are here it is because of these mothers, ... that we also the nursing bodies we are nice to the moms and the moms when they go to see that seeing that you are nice, they will start to come".

R7: "when they trust us they will always continue to come and the service will be well used".

R10: "another advantage also that allows you to have a good aura in the city, if you treat people badly, you will not also have a good number that attends, and therefore, you will not also have a good recipe, that is to say that there is the personal humanitarian aspect and also there is the pecuniary or financial aspect, the more we treat women well, the more we receive them well ».

3.2.3 Experience of providers on the rights of parturients

In their experience, service providers encounter several difficulties in the exercise of their profession, which constitute obstacles to respect for the rights of parturients; they cite the bad behavior of the parturients, their non-observance of the instructions given by the providers, the ignorance of the personnel on the rights of the parturients, the insufficiency of the personnel, the bad organization of the service, the overload of work.

Here are their statements below

- **Bad behavior of parturients**

P1: "...sometimes it gets angry,... there are some women you tell her stories her phone rings, she prefers to take her phone and put it in her ear, everything you tell her there, she will ask you again" 'olobaki nini he? (what were you saying?) " all that sometimes makes us angry... there are women when she comes, she starts to disrespect you,... she thinks you're the one who's there, but she starts asking another person: "mom mususu wana aza té? (the other mom isn't there?)", sometimes it's the little things that get on your nerves... there are some women, me I received two women who threw saliva on me".

R10: "At 90% we respect these rights, but in the extreme don't forget we are human, there are women who are too undisciplined, too insolent, which means that sometimes we are forced to become a not very rigorous, a little hard with them to snatch from their collaboration, there is insolence, there is also incongruity".

- **Non-compliance with provider instructions**

P1: "there are women when she comes to the CPN, you chat, you tell her everything, what to bring, especially when the woman reaches term, ... what she will bring the day she will come to give birth, but the day she is going to give birth you see her come with nothing, and you go to touch her, you find that she is complete, now what are you going to do?... stories that irritate...".

P2: "well, for the rights there for me I myself I think that, if a woman who has respected the ANC, at that time we will not in any case, ... we will respect because he too has respected what we told each other, ... but if you didn't respect, it's like a woman who fled the CPN since July, she comes today with the genital

haemorrhage, ... we told her transferred, not even the ultrasound, not even well followed the CPN, **BOTAWU!** it's reciprocal all the same, arrow go-arrow return!

- **Overwork and understaffing**

P1: "... now you nurse, you are going to leave a complete woman, and especially since we always work with only one person in the service, you are still going to go out to ask for clothes from the women who are in the service, ... well, we manage, when you are alone, sometimes you have 4 wives, we manage because there are days when you have 6 wives too, you have 6 wives, you do the guard, you lead 7.8, there are days when we have managed 9 deliveries, it has happened to us already, you will know how to manage your time, and sometimes God helps us too..."

R3: "really, no, the team is insufficient, so I can stay alone as for the moment I am alone, I had a woman in labor, there are others who have contractions, you have to see the other, and the other, however I am unable to respect their rights normally, because I see myself that I do not respond in due time to the needs of one and the other, it is at the minus that, ... the team is minimal, there are not enough of us, sometimes we find ourselves with only one person who is on call with many women, only one person who does the day with the CPN, all that, ... »

R7: "Hmm, well, ... with the multitude of tasks for example I am in the ANC room, at a given moment, there is a parturient who arrives, you see that the fact of occupying two services at the same time being alone, not going to make me wait for the woman to really give me her approval, consent, and everything, so you have to move quickly, it gives me time to go and do the other work in the CPN room, there is an overload of work..."

R8: "That's the organization of the hierarchy, we won't be able to put two people together, but we can't work alone at the birth table, you have to be accompanied, but the financial means are expensive for the taking care of the staff, and it's difficult to put two people, and I'm going to force myself to be alone, and being alone, there are six or seven parturients, what am I going to do? it's the organization"

R9: "...we always ask for help, we have our nursing colleagues who are at the dispensary, we have the doctors, I always make recourse... to say that I can manage 2, 3 deliveries myself at the same time and the women who want to give birth, at the same time, in any case even if you are a robot, you will not know, "

- **Non-collaborating parturients**

R5: "... if she found you to be mean, unwelcoming, maybe you talk too much, maybe she is afraid of you, you talk nonsense"

R6: "... when the woman does not collaborate in any case, so that you do not come to a problem, you have to refer her because if there is a problem the fault will come back to you"

R10: "sometimes what can prevent it is when you come up against a problem, they don't collaborate, it doesn't work, or he has a family that doesn't collaborate, it doesn't work, there we no longer respect their rights, otherwise it won't work".

- **Staff ignorant**

R3: "...perhaps there is also a lack of information,...perhaps we also don't have information on the merits of rights, other women's rights that we don't know, it's is also a problem.

R4: "in our conditions, we have not yet reached the maturity that the others have, we decide taking into account the clinical data of the CPN or the labor of childbirth in place of the woman, we also see it in Kinshasa here, the midwives thunder at the woman, you don't know how to give birth, nor push,..."

R7: "... obviously, frankly when we don't know, when I don't know that it's a right for a person I can't respects it... well, the first element is ourselves, if we don't has not mastered that it is a right that must be respected".

R8: "Hmm, in the years when I started here with colleagues, I started first as an A2 nurse, my experience is very bad, why? since the parturients who came were taken as if they were prisoners, and when they were on the table to give birth, they were slapped, they were traumatized psychologically and physically and morally, ... but currently advancing with the experience, with the training that we are beginning to see that we were really making a big mistake, that we should now make the effort to change this attitude, the past experience ourselves with disagreements with certain parturients, some fled from us so that 'they come to give birth to us'.

- **Fears of companions/visitors**

R4: "first reason is culture, we came to find people who worked who didn't accept non-medical people, we adopted; secondly, when the husband is allowed to enter, the women have whims; thirdly, another case, the caregivers also reserve, if there is a non-medical person who comes in, and there is a small problem, and he has seen everything, you will not be able to defend yourself, to avoid that we are brought to justice; he also becomes a supervisor and witness of the service provider, and in the event of an error, he can expose it; and the obstetrician also prefers to be alone so that if there is a problem, he stays there; some can't bear to bring in the non-medical because he won't bear what he's going to see".

R10: "but know that we are in the delivery room where we also keep babies in certain rooms which must also be in good shape, there are also cases of baby theft in our context, when we do not know control, each other, there are thefts of babies and goods, which is why o is obliged to filter the accompanying persons a little ».

- **Poor organization of the service (hierarchy and work environment)**

R8: "Madam, the major obstacle is the regulation first of all of the structure, that's what hinders us, the rights that are really abolished are the visits and the accompanying, the woman does not is not really accompanied".

R3: "well, it also depends on the organization, it depends on the hierarchy, there is also the first thing there is the fear of the hierarchy, we are only at the maternity ward, but there is also the people who direct us, from there, we had forbidden that there are no people in the delivery room, ... we do not have a maternity ward where each woman must be isolated in her pavilion what, ...".

R9: "in any case for that, as there are 2, 3, 4 of them, I don't think we can bring in the family members, ... in any case if they are all mixed up there, it's difficult, yes, that is a barrier".

3.2.4 Providers' feelings about non-respect of the rights of parturients

Providers recognize their failure to respect the rights of parturients, they feel this in the form of guilt, for this they sometimes apologize or do nothing, they only minimize. This is what they say in these stories:

- **Guilt (reproach)**

R3: "well, we are aware that we have not respected but with a little argument also that I told you, between us the medical staff, the service providers, it is not but if not, we can't say in front of the woman that it's not good because, well, we've never changed maybe if you can make a change about that, I don't know, with convincing elements we can also change ... between us we have reproaches but as is our habit too, we are used to not doing it, we run away..."

3.2.5 Expectations of service providers respecting the rights of parturients

Providers expect managers to improve working conditions in their structure, to provide self-assessment sessions, for the State to take full responsibility for them, for organizations to strengthen their capacities through ongoing training, for researchers educate the public in general and parturients in particular about their rights, which they are unaware of, in order to be able to claim them and reframe the practices of service providers.

They themselves speak about it.

- **Improve working conditions**

R1: "Firstly...these rights are respected, but for it to be 100% respected, first in the workplace, where you do the working conditions must be at least good, at most it's too much, but... in the service, being two people is a relief first... having several people in the team where you work is good and then... we have the sheets that we don't put on the beds at cause of Covid-19, it is among the conditions that do not put women at ease".

R10: "another thing is that the State can see the working conditions of the staff since when they are well paid they are strong morally, mentally, they will respect them well".

- **Build the capacity of a large number of providers for continuing education on respectful maternity care**

P1: "... with competent personnel, ... if the State can also think about private centres, if it can also take charge of private centres, ... if possible also take care of personnel in all contexts, ... despite the fact that we are trained by BDOM, the training is really important on maternity, care, resuscitation of the newborn".

R3: "...every time you can also do small seminars at any time which can do what, where you need to add, you add to strengthen capacities, and also, it also requires meetings with the hierarchy because, ... they can also respond to our needs, so that we can achieve desired standards in motherhood, ... so that the woman feels truly respected in all her rights".

R10: "our expectations are that people can be sufficiently trained and informed about rights and respect for rights".

- **Increase the number of competent service providers**

P1: "... we were told when we were studying that childbirth is always directed to two, take the example of our current system of GATPA, as soon as the child comes out we must give the injection of oxytocin, but for us, it's a bit difficult, you're alone, you take the child, sometimes it's a child who has swallowed the liquids, ... and the time for this injection is already passing, you see? But when there are two of you, ... and the second person can already provide care there, ... you can share the tasks.

R2: "... the State has a lot to do for people mum, the nurses don't even have a salary, not even a risk premium, ... there are old people who can take their pension, what is the State waiting for? to take these people out and pick up the young girls and boys who have just finished..."

- **That the State and the organizations involved can equip the structure with sufficient and good quality equipment**

P1: "...and then have the necessities, the minimum kit for deliveries, if all that is organised, I think that there are many things that can be avoided, complete kit, ... complete delivery kits, in any case, we must avoid certain tensions... if the State can also think of private centers, if it can also take charge of private centers,... first of all by starting by reinforcing the hospital with equipment, with drugs".

R2: "we also have difficulties, maybe in the maternity ward, we don't have an incubator, ... that's a neighborhood center, it's the government that can put their eyes here to even give their contribution, there are the poor who come here, ... there are not even people of the means who come to give birth in our center, ...".

- **That parturients respect the instructions of providers**

R2: "for the women who come to give birth here with us, that they respect our obligations, compared to those who come, transferred them from outside there, that always poses a problem for us, and then when she comes to give birth there really so it is regrettable, ... that is why I only wish, even for women who do not follow the CPN here, that they come in time, to start another CPN here like the new cases, like the others, not only to come with the card there from the city, without hiding, without signature, without anything and nothing, there we are not going to accept women from like that, ...".

- **That researchers can inform, educate and communicate the general population on their rights and particularly parturients**

R4: "Awareness is needed, people are not informed, we know, but the majority of populations do not know how to ask for them and the midwife also prefers to be alone so that even if there is a problem, it stays there".

R8: "In our opinion, if we go in depth, the parturients who come here do not first know their rights, to you the researchers as you come you can also make them aware that they recognize their rights, as we prohibit them not to move around during work, there we are hindering their rights, and we refuse that people do not come to his side when they are in labor, I am alone, I will not be by his side, there we are blocking his rights...".

- **That service providers regularly organize self-assessment sessions and exchange experiences**

R3: "Hmm! a good question, the first thing, you have to do the self-assessment first each time, when you work you finish you have to assess yourself first,

see there are a few difficulties that you can improve, ... ».

R5: "we need exchanges of experiences, meetings when we find ourselves among ourselves, we can talk to each other, where there are errors, correct ourselves together".

4. DISCUSSION

4.1. Results in relation to the socio-demographic and professional characteristics of providers

It is observed in this study that the subjects of both sexes were fairly represented (5 men and 5 women), a proportion parallel to the popular opinion stipulating that the nursing profession is a profession of women in our circles. These results are in constant contradiction with those of several studies in this context. This can be justified by the fact that in this study, we interviewed all health providers without distinction of their categories or their qualifications.

The feminization of the medical profession began at the end of the 19th century and Swiss universities were pioneers in the training of women. The growing feminization of the medical profession only seems to worry economic and political decision-makers when they detect potential effects on the organization, quality or cost of the supply of medical care in the medium or long term (Lapeyre & Le Feuvre, 2005).

From the point of view of research on gender relations, this phenomenon arouses a completely different interest. The feminization of elite professions in general and of the medical profession in particular is part of a debate which is gradually imposing itself on all of the social sciences, that of the mechanisms of sexuation in contemporary societies.

Nine out of ten providers were over 26 years old, which means that in our study environment, our respondents are already advanced in age and even sometimes tired by the weight of the profession, but by the fact that they are called to be in function to survive according to the context of the country, living without salary nor bonus of the State, they disregard and continue in spite of the complaints. On this subject, it has been demonstrated that in France among doctors, the average age is falling due to a large number of retirements and the entry into activity of more numerous generations of doctors due to the loosening of numerous constraints in the 2000s (Gonon, 2003).

This average age, 49.3 years, whereas it was 50.7 years in 2012. But this rejuvenation is deceptive, the age pyramid being in fact distorted by the arrival more young generations. The departures, even less numerous, of the oldest doctors, still weigh on access to care and may even accentuate the difficulties of replacing those who practice in unattractive areas (rural

and underprivileged), accentuating in fact the territorial inequalities. All this justifies confirming that age is one of the classic determinants of human behavior (Adjiwanou & LeGrand, 2014).

The study again reveals that 6/10 were married, these results seem to approach those found by several authors in a sense, stipulating that married women are no longer too preoccupied with housework.

With regard to their level of education, the study reveals that most of the respondents were at secondary level (6/10 were A2 nurses). Authors such as (Bellerose-Langlois, 2015) consider the level of education to be one of the main explanatory factors of human behavior because it offers them a greater availability of means, a better ability to understand the health-related issues, as well as the opportunity to participate in family decision-making.

In this context, the level of education promotes the development of a sense of humanism in the exercise of the profession. However, in our study environment, the majority are made up of those at level A2.

5/10 had a professional experience of 20 years or less, and 5/10 had more than 21 years.

4.2 Results relating to the themes and sub-themes of the study

We recall that 5 sub-themes emerged from the main theme, which is the perception and expectations of service providers on the rights of parturients. These sub-themes are: the perception of the rights of parturients, the importance of respecting these rights, the feelings of providers in the event of non-respect of these rights, the obstacles to respecting these rights, their expectations in favor of these rights.

4.2.1 Understanding of the rights of parturients

The results of this study reveal that providers perceive the rights of parturients in five ways: The right of the parturient is perceived as the fact that the woman who comes to give birth at their maternity ward leaves there alive, with a living baby of good quality, that it is necessary to collaborate with the parturients to allow this, to satisfy their needs, provide them with appropriate care, leave them free and put them at ease.

Provision of respectful and dignified health care is a fundamental right for every pregnant woman, leading to a positive childbirth experience delivered by compassionate and skilled providers. Recent evidence suggests that exposure to disrespectful, abusive, or coercive service by skilled maternity care providers, which results in actual or perceived poor quality of care, is *both* directly and indirectly associated with maternal and neonatal outcomes. unfavorable (Bhutta *et al.*, 2014; Bohren *et al.*, 2015; Datson *et al.*, 2014; Wagaarachchi & Fernando, 2002).

Indeed, a parturient should not be subject to inhuman treatment, as one respondent stipulates in these terms: “ **R4**: “ It seems to be complex! When the woman is in the maternity ward, she has her rights, elsewhere they are respected, but here with us,... in other places, she has the right to choose the birthing voice and also as a human being, she keeps her rights. of respect we must not thunder, we must not type ».

The term “obstetric violence” was coined to reflect “professional” shortcomings in the provision of health care to pregnant women (Gray *et al.*, 2019).

Obstetrical violence is defined as "the appropriation of women's bodies and reproductive processes by health personnel, which manifests itself in the form of dehumanized treatment, abuse of drugs and the conversion of natural processes into pathological processes, leading to a loss of autonomy and the ability to decide freely about their bodies and their sexuality, which has a negative impact on women's quality of life (Bohren *et al.*, 2015).

On this, we also believe that parturients have the right to quality care as stipulated (MUNDYO *et al.*, 2016), in their study on the quality of emergency obstetric care and maternal mortality in the province of South Kivu (DRC) that in 2012, for a population of 5,869,250 inhabitants, 191,152 births were attended by qualified health personnel (81.4%).

One respondent wanted babies born in their maternity unit to come out alive; which is in line with the results of the thesis of (HASNA IGORMAN, 2018) on the Evaluation of the satisfaction of parturients after childbirth in the obstetrics gynecology department CHU Mohamed VI in Marrakech. According to the latter, 87.5% of newborns were alive in good condition, while 25 cases had a complicated delivery, which corresponded to 12.5% of cases.

4.2.2. Importance of respecting the rights of parturients according to the providers

In this study, our participants affirm that it is important to respect the rights of parturients because they are human beings, because they give life, to preserve their life, to avoid the bad course of the childbirth, to build their confidence, to increase clientele and revenue, to encourage parturients, because it leads to quality care and reduces mortality. However, as for their actions and reactions observed, nothing testifies to their knowledge of the advantages of respecting the rights of parturients as they mentioned above nor to their sense of humanism in the exercise of their profession.

Verbal abuse is encountered more frequently and is perceptible in the way in which certain service providers address parturients/given birth and those

accompanying them. This violence goes from moralizations to remonstrances. But it seems to us that most of them have as their source, on the one hand, the stress of the service providers in the face of the many requests, the lack of medico-technical materials and, on the other hand, the behavior or reactions of the mothers themselves. It is also not excluded, the difficult, clean personality of some providers.

The exorbitant workload also leads to the deviant behavior observed among care providers; it would therefore be advisable to plan for at least two service providers and if the number of cases increases, it is imperative to review the agents on duty because most births are supervised during the night. This is one of the negative points encountered in our study environment.

In fact, speaking of stress, we have witnessed situations where service providers were solicited from all sides, simultaneously by women in labor on delivery tables, those who had already given birth with health problems, those with complaints related to the pregnancy. The tension remained perceptible and sometimes nervousness arose at the level of the service providers.

However, from our interviews with service providers, we retain mixed opinions about their assessments of the workload, although they are all subject to the same pace of work and under the same conditions. Some consider themselves too busy and others find the workload acceptable. However, the service providers are all subject to the same pace of work.

Those who consider themselves burdened argue that this burden negatively influences the delivery of standard care. This observation remains the same as that also made by (KIENYIGA BAYALA, 2017) in his study on the Humanization of childbirth: An evaluation of the work environment and relational practices of providers in a maternity ward of a hospital in district of the commune of Ouagadougou. What we think is true in our sense.

According to the CIANE (Collectif Inter associatif Autour de la Naissance), quoted by (Allemani *et al.*, 2018), which has campaigned since the early 2000s against abuse in perinatal care, "voluntary and manifest abuse or violence by health professionals seem rare". It is therefore so-called "ordinary" violence and abuse in obstetrics and gynecology care (non-respect of consent, modesty, lack of information, failure to take care of pain, etc.) which are then targeted today. Today in the media and by the general public.

In our interviews with our respondents, the majority seemed to demonstrate fairly sufficient knowledge of the rights that must be respected for any

parturient who happens to her during the exercise of her profession. However, in our direct observations made during our clinical internship in the same environment, our findings were very alarming, bitter and even revolting; the fact that these parturients could be asphyxiated to the point that some did not even have the possibility of expressing their opinions on the care prescribed and administered to them.

Yet (Manning & Schaaf, 2010), in her work on Respectful Maternal Care and Human Resources for Health, demonstrates that disrespect and abuse represent a breakdown in the accountability of the health system not only towards users but also towards women and men employed as service providers.

The authors went on to say that disrespect and abuse, also referred to as child abuse, obstetric violence and care dehumanized can manifest in various forms, including physical violence; sexual violence; verbal abuse; stigma and discrimination; failure to maintain professional standards; poor relationships between women and providers; and health system constraints.

Although rare during observed births, it seems to us that intentional physical violence is almost non-existent in the delivery room according to the respondents. Sometimes, psychological preparation for childbirth (relaxation technique, pushing, etc.) is not taught, medicinal means are only used to manage pain, in order to promote collaboration and facilitate childbirth. This leads to care given in violence, even if some are not premeditated.

On this subject, during the placental extraction without medical or psychological preparation, and that the woman giving birth did not collaborate by trying to escape, the fact that the Midwife (accoucheur) called someone as a witness to denounce the non-cooperation or failure of the parturient could mean that she does not even realize that her act constituted a violation of the rights of the latter, and that this gesture constituted in itself a humiliation, which also proves to sufficiency a certain failure on the part of this service provider.

In our study, it seems that the majority of these violations are made unconsciously and linked to unfavorable working conditions, which were decried by the majority of interviewees during the interviews. In this context, we join (KIENYIGA BAYALA, 2017; Vadeboncoeur, 2003) who maintained that: "*These are not necessarily forms of intentional or voluntary violence, but they can happen that they are*".

Opinions are still divided on this subject, we judged most of their answers to be facades and subtle, as a protection not to expose their structure, because, on several occasions, they could use one which says "don't do that at you" for certain acts they perform in our

presence, which arouses in us a certain amount of mistrust in their responses.

4.2.3: Experiences of providers on the rights of parturients

It emerges from this study that providers encounter several difficulties in the exercise of their profession, which constitute obstacles to respect for the rights of parturients; they cite the bad behavior of the parturients, their non-observance of the instructions given by the service providers, the ignorance of the personnel about the rights of the parturients, the insufficiency of the personnel, the poor organization of the service, the culture, the fear of the parturients, their fear, their distrust of their companions, the workload.

Some parturients display bad behavior; which sometimes irritates providers. The testimony of this respondent can translate this hypothesis in a concrete way: *PI: "...sometimes it gets angry,... there are some women you tell her stories her phone rings, she prefers to take her phone and put it in her ear, everything what you say to her there, she's going to ask you again "olobaki nini he?" all that time it makes us angry... there are women when she comes, she starts to disrespect you,... she finds you that it's you who are there, but she starts asking another person: "mom mususu wana aza té?" sometimes it's the little things that annoy... there are some women, I received two women who threw saliva on me".*

On this subject (KIENTIGA BAYALA, 2017) states that the concept of relational competence is polysemous depending on the context, but in general terms, relational competence is according to (Camus, 2011), the ability to develop the ability to approach others in an open way, to enter into relationship with them in a flexible way. The same author continues in her same work inspired above, "relational competence is the capacity to enter into contact, to adopt and to adapt, vis-à-vis others and according to the goals that we are fixed, behaviors, aptitudes and effective attitudes in order to maintain satisfactory and fruitful exchanges in a professional context".

This communication can be verbal or non-verbal. For (Aubret *et al.*, 2018), verbal communication constitutes the content of the discourse, and non-verbal communication, the form. Verbal communication is about the choice of words and conveys information data. Non-verbal communication, on the other hand, is the form of speech. It is based on the modulations of the voice, its intensity and the flow of the words, but also on how to position the body and move it. It further conveys the relationship.

So, in our study as in his, it will be about the ability of providers to adapt to enter into a helping relationship based on empathy, to adopt and adapt behavior (respect for the rights of parturients) while aiming for quality childbirth in a friendly atmosphere.

In the testimony of the respondent quoted above, there is a certain inability to recognize the right of the parturient to choose her caregiver as to the fact that she calls it lack of respect by looking for someone else.

And yet, in its survey on childbirth, respect for wishes and experience of childbirth, the (CIANE, 2012) found that the percentage of women who express, during pregnancy, particular wishes concerning their childbirth is steadily increasing: it went from 36% before 2005 to 57% in 2011. This is accompanied by an increase in birth plans (7% before 2005; 18% since 2009). 63% of women who expressed wishes consider that the team did its best to respect them, 26% that this was only partially the case, and 11% that the team did not do its best better.

He goes on to say that this is very strongly correlated with the experience of childbirth: 90% of women whose wishes were respected experienced their childbirth very well or rather well, whether physically or psychologically, whereas those whose wishes were not respected are only 43% (physical level) and 30% (psychological level) to share this opinion.

97% of the first consider that they have received adequate support from the medical staff, whereas only 16% of the second group consider that. 71% of the latter request exchanges a posteriori with the professionals who accompanied their childbirth (44% for the others): we thus see open a possibility of reparation which should be encouraged in the interest of all.

The main wishes expressed by the women concern their freedom of movement (choice of position, possibility of walking around), personalized support for pain (support for childbirth without an epidural, possibility of choosing the moment and the dosage of the epidural) and the refusal of episiotomy except for serious medical necessity. These demands, which are by no means exorbitant, should be able to be met.

However, too many women are exposed to incomprehension or even refusal by professionals in the face of their requests: lack of listening, rejection, broken promises, even the imposition by force of certain gestures, all these attitudes to which women testify must be banned from birthing rooms.

Finally, efforts must be made to encourage women, especially primiparous women, to work out and express their request: those who have not done so often because they are unaware of the possible choices or because they do not feel authorized to do so expressing regret after the fact; we also observe that they are significantly less satisfied with their delivery than those whose requests were respected.

It concludes that the quality of the support provided to women for childbirth requires the establishment of a dialogue between professionals and women, a dialogue through which they can gradually formulate their expectations and through which professionals can put themselves in a capacity to respond appropriately.

Workload has always been a serious problem in health institutions, especially when the organizers take little interest in it. (KIENIGGA BAYALA, 2017) found the same in these results.

4.2. 4. Providers' feelings about the non-respect of the rights of parturients

The analysis of the results of this study reveals that providers recognize their failure to respect the rights of parturients, for this they sometimes apologize or do nothing, they only minimize.

Indeed, pregnant women have the right to choose their companions as stipulated in the charter in these terms: " the presence during pain and during childbirth, of a person chosen by the parturient, if possible her partner" (Charter of rights of the parturient, 1988).

4.2.5: Expectations of providers on the rights of parturients

In this study, service providers expect managers to improve working conditions, provide for self-assessment sessions, that the State take charge of them in everything, that organizations strengthen their capacities through continuous training, that researchers educate the public (parturients) on their rights, which they are unaware of, in order to be able to claim them and reframe the practices of service providers.

In the study by (KIENIGGA BAYALA, 2017), the providers proposed a multitude of solutions, for the improvement of the quality of the relations between them and the mothers, among which they cited: firstly improving the premises, avoiding ruptures in free healthcare, review the living conditions of the staff because we often think about our problems, Improve the availability of medical technical equipment because pediatrics are often used to resuscitate newborns and afterwards.

In our country, the DR Congo, we have followed in the footsteps of European countries as stipulated in the European charter of the rights of parturients to improve the conditions of the latter (Charte des droits de la parturiente, 1988).

The Charter for Respectful Mothering Care, a normative document that was developed in collaboration with researchers, clinicians, program administrators and activists, outlines a rights-based

approach to many aspects of care. The Charter is based on universally recognized international instruments to which many countries are signatories, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of All Forms of Discrimination against Women.

The seven rights of pregnant women described in this charter are the rights to: protection of physical integrity and against ill-treatment; information, informed consent, and refusal, as well as respect for choices and preferences, including the right to an accompanying person of their choice whenever possible; confidentiality and respect for privacy; dignity and respect; equality, freedom from discrimination and equitable care; timely health care at the highest possible level of health; and freedom, autonomy, self-determination, and freedom from coercion (White Ribbon Alliance, 2011).

CONCLUSION

After the analyses, the results obtained through this study on the perception and expectations of service providers on the rights of parturients show that:

Providers *have* on the one hand a positive perception, characterized by the recognition of the Rights of parturients: right to life and to good health, to good collaboration, to the satisfaction of needs, to appropriate care, and to freedom. Only one respondent expressed a negative perception, explaining that the context of the Democratic Republic of Congo does not allow him to grant all these rights to the parturient.

It appears that our participants affirm that it is important to respect the rights of the parturients because this respect makes it possible to avoid the bad course of the childbirth; to gain the confidence of parturients; to increase the clientele and the receipts in the structure; leads to conscientious work; and contributes to the reduction of mortality.

In their experience, service providers encounter several difficulties in the exercise of their profession, which constitute obstacles to respect for the rights of parturients; they cite the bad behavior of the parturients, their non-observance of the instructions given by the service providers, the ignorance of the staff on the rights of the parturients, the insufficiency of the staff, the poor organization of the service, the overload of work.

Providers recognize their failure to respect the rights of parturients, they feel this in the form of guilt, for this they sometimes apologize or do nothing, they only minimize.

Providers expect managers to improve working conditions in their structure, to provide self-

assessment sessions, for the State to take full responsibility for them, for organizations to strengthen their capacities through ongoing training, for researchers educate the public in general and parturients in particular about their rights, which they are unaware of, in order to be able to claim them and reframe the practices of service providers.

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Conflict of interest

The authors have declared no conflict of interest.

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