



Humanised care and a change in practice in a hospital in Benin[☆]

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ABSTRACT

Objective: to describe the process of introduction and implementation of humanised care (humanised childbirth); to determine how the practice of humanised care affects midwives, obstetricians, and other service providers in the hospital; and to determine the factors influencing the change in practice.

Design: a qualitative study with grounded theory approach. A semi-structured, in-depth individual interview was conducted for data collection with open coding and a constant comparative analysis until the saturation of concepts.

Setting: mothers' and children's hospital functioning as a top referral centre in Benin.

Participants: 16 hospital staff, including 6 midwives.

Findings: humanised care was initiated by midwives with hesitation and difficulties. Midwives and obstetricians learned that a supportive environment for women could produce a positive birth outcome without medication. Communication between the midwives and women and their families improved with a higher level of appreciation of the care provided by the midwives among the women and their families. Humanised care appears to affect the professional value of midwives, their levels of job satisfaction, and their personal motivation for work towards improving their performance. A positive influence on obstetricians and other staff was observed. These individuals were inspired to make changes in hospital culture to improve care, to avoid unnecessary interventions, and to improve communication. Important factors in achieving favourable results were the leadership and commitment of the hospital management team and the recognition and support they extended towards the hospital staff, especially the midwives.

Key conclusions and implications for practice: a system of humanised care that stresses improved communication between the women giving birth, their families, and care providers, based on respect for women's dignity and liberty, and avoidance of unnecessary intervention can be promoted with proper managerial support. This system can promote favourable changes in hospital practice, which are helpful in motivating midwives in resource-limited settings.

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Introduction

Humanised care

Humanised care, or humanised childbirth, has the following attributes: fulfilling and empowering both to women and to their care providers; promoting the active participation and decision making of women in all aspects of their own care; provided by

physicians and non-physicians working together as equals; using evidence-based care, including evidence-based technology; to be located within a decentralised system of birth attendants and institutions that give high priority to community-based primary care; and be financially feasible (Misago et al., 1999). The concept of humanised care is essentially based on a profound respect for the dignity and liberty of women. It values a woman's role as a conductor of her own birth process and recognises that it is her choice of where, how, and with whom to give birth (Wagner, 2001). The status and roles of midwives are different in each country, but midwifery care is an essential component of humanised care (Page, 2001). Literature has shown beneficial physiological and psychological outcomes for women who experienced care provided by midwives during pregnancy and childbirth (Hunter, 2002; Barger, 2005).

[☆] Authors' contributions: NF, XRP, and YS prepared the draught. NF, YM, and SU prepared the questionnaire, and conducted interviews. All authors contributed to analysing the results. YS oversaw the study. All authors read and approved the final manuscript.

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There have been arguments about the efficacy of the existing regime of hospital-based, systematic, and medicalised maternal and newborn care. Hospital-based care played a role in the reduction of maternal and perinatal mortality through necessary medical interventions in the 20th century. However, the rate of unnecessary medical intervention increased partly because of defensive obstetrics caused by medicolegal pressure (Johanson et al., 2002; Walsh and Downe, 2004). Problems related to social and economic deprivation or access to effective maternal care remain (Page, 2001). Such systematic care often does not adequately meet the needs of women and their families. This causes some women to prefer to give birth in midwife-led birthing homes in high-income countries (Coyle et al., 2001; Walsh, 2006; Jimenez et al., 2010; Dahlen et al., 2011). A review of evidence by Bowser and Hill (2010) on disrespect and abuse in facility-based childbirth in low- and middle-income countries suggested that disrespectful care may often serve as a more powerful deterrent to choosing skilled birth care than other more commonly recognised deterrents such as geographic or financial obstacles. This abuse is exacerbated for women who are HIV-positive and suffered from cultural stigma. In Kenya, it was reported that coercive practices by health-care providers and violation of informed consent and breach of confidentiality in testing HIV can diminish the confidence of women in the health-care system and prevent them from seeking necessary care during pregnancy, childbirth, and postpartum, including prevention of mother-to-child transmission of HIV (Centre for Reproductive Rights and Federation of Women Lawyers—Kenya, 2008). The concept of humanised care can be seriously considered for use in low- and middle-income countries. Access to effective maternal health services by skilled birth attendants is a key to decreasing maternal mortality and morbidity and improving women's health (WHO, 2005). Moreover, in middle-income countries, the rate of caesarean sections tend to be higher and can reach 50% among women seeking care in the private sector (Sreevidya and Sathiyasekaran, 2003; Agencia Nacional de Saúde, 2004; Arrieta, 2011). Unnecessary caesarean sections or medical interventions carry a greater risk for the mother and the child (Bastos and Diniz, 2007).

Most studies on humanised care have focused on the perceptions of women who received care at birth centres and hospitals (Coyle et al., 2001; Walsh, 2006; Jamas et al., 2010; Jimenez et al., 2010). The results of these studies generally indicate that the satisfaction of the women and their families was much higher with humanised care provided at birth centres by professional midwives than with systematic hospital-based care. On the other hand, very few studies have been conducted for investigating the experiences of the service providers, especially in resource-limited settings.

Study site situation

Benin is a country in Western Africa with a population of 8.9 million. The latest demographic data shows that the maternal mortality ratio is 397 per 100,000 live births in 2006. This is a high rate of maternal mortality considering that 78% of births occur in public or private facilities (Institut National de la Statistique et de l'Analyse Economique, 2007). The Mothers' and Children's Hospital of Lagune is a tertiary hospital for maternal, newborn, and child health in the capital city. It provides outpatient, emergency, and inpatient care. It has 250 beds and 436 staff, including 22 doctors, 66 midwives, and 89 nurses. In 2009, the hospital carried out 4,688 deliveries, of which 1,935 (41.2%) were caesarean sections. The government budget covers 15% of the hospital running cost, mainly including the salary of the staff. The fees for services paid by hospital clients cover the remainder of the running costs of the hospital.

Humanised care, as defined by Misago et al. (1999), was introduced in this hospital at the beginning of 2008. It has also been emphasised that humanised care should not merely be

applied during pregnancy and childbirth but should cover the entire range of the care of women and children by placing great value on communication and interaction among the women, family, and service providers while attempting as much as possible to meet their individual needs (Fujita et al., 2010). The first, mothers' class was started during antenatal care, and all pregnant women were encouraged to enrol. Midwives explained the preparations for childbirth to groups of pregnant women and occasionally to husbands. A physiotherapist initiated consultations and supported the women in terms of their physical preparations for labour and delivery, and counselled them on potential postpartum problems. Second, the labour and delivery rooms were rearranged so that families could stay with the women. Finally, a midwife-in-charge provided care to the women and newborns during labour and delivery, and encouraged the women to give birth in a free-style position, such as squatting, as per the woman's choice (Balaskas, 1992). Obstetricians and midwives discussed and decided the criteria for active birth in a free-style position when women received antenatal care with mothers' class and showed no problems during pregnancy and labour. After the introduction of the criteria, the quality of care was evaluated by a comparative study of 86 women over a period of 1 month. Comparisons were made between women receiving humanised care with free-style vaginal delivery, and those instructed to assume the classical lithotomy birthing position. The results that are obtained showed that in humanised care with free-style vaginal delivery, the duration of labour was slightly shorter with no discernable difference in birth outcome. However, the women's satisfaction was significantly higher (Perrin and Mehoba, 2008, unpublished).

Objective

The objective of this study was to describe the process of introduction and implementation of humanised care and to determine how the practice of humanised care affects the midwives, obstetricians, and other service providers in the hospital. We approached this study with 3 study questions. First, how did midwives and hospital staff understand the concept of humanised care and how did they implement it? Second, does the practice of humanised care change the perceptions of the caregivers (especially midwives) towards their job? Third, what are the factors influencing the change in practice of midwives and other service providers?

Methods

This study is qualitative and descriptive with grounded theory approach by Glaser and Strauss (1967). To determine the change in practice and the factors influencing the changes from the process of implementing humanised care, both access to individual experiences and an ability to move towards generalisation are needed. We selected grounded theory approach, because this approach is inductive and provides explanations of human behaviour based on data.

Participants

A preliminary group discussion was carried out in August 2009 with two of the authors (the first and the third author of this paper) to identify key informants and to prepare the questionnaire for the individual interviews. Hospital managers and hospital staff (midwives, obstetricians, paediatricians, and other co-medical staff) were divided into mixed groups, and they

discussed the process of introduction of humanised care. This discussion indicated that the humanised care was implemented mainly by midwives under the collaboration with obstetricians. Based on theoretical sampling of grounded theory approach, three categories of hospital staff were included as participants of the study. The first category was represented by midwives working actively in antenatal care and conducting free-style delivery. The second category was represented by obstetricians working with the midwives. The third category was represented by the head of each category of professionals and the hospital director.

Data collection and analysis

An open-ended, semi-structured, in-depth interview was conducted in French in February 2010 by two of the authors (a Japanese obstetrician and midwife, who had an experience of working in Benin and other developing countries). Themes addressed in the interview were the process of introduction of humanised care, the understanding of humanised care, the change in practice, the perception towards the job, and influencing factors for the changes. Participants joined the interview voluntarily. The interviews lasted 45–60 mins and were transcribed with the interviewees' consent. Quotes related to the analytical themes were extracted from the interview data. Key phrases and expressions were coded (open coding) and checked by the authors. Coding results were entered into an analytical worksheet, and categories or key concepts were inductively generated. A constant comparative analysis of mutual similarities and differences between categories and concepts was conducted. The interview was finished when concepts were saturated and no more new categories and concepts were identified.

Quotes, coded key phrases, and expressions were repeatedly reviewed. Categories and concepts were compared, and common themes within the data were analysed based on the principles of data analysis in grounded theory, following the recommendations of Lyn, 2005. A conceptual chart was developed, revised, and finally agreed upon by all authors. To increase the credibility of the study, peer debriefing was conducted. Two Japanese midwives who were not involved in the research reviewed all of the narratives and contents of the themes, tables, and summary findings. These individuals agreed with the final product of the data analysis.

Ethical considerations

At the time of the commencement of this study, the study design was reviewed and approved by the ethical committee of the National Center for Global Health and Medicine in Japan and by the hospital in Benin.

Findings

In all, 16 members of the hospital staff were interviewed (6 midwives, 1 nurse assistant, 4 obstetricians, 1 paediatrician, 1 physiotherapist, 2 other co-medical staff, and 1 hospital director). The midwives ranged in age from 30 to 50 years, and their experience varied from 10 to 30 years. The key concepts emerging from the interviews are shown in Table 1 and are discussed below.

Hesitation and difficulties

In the interviews, midwives described the process of introducing humanised care as learning a new concept brought from abroad. The midwives were initially hesitated to change their practices. Even after they had begun to change their practices,

they had difficulties, especially in assisting the woman during delivery in a non-supine position. Gradually, through training and practice, the midwives were accustomed to assisting deliveries in the position selected by the woman:

In the beginning, we did not have enough skills to assist free-style birthing positions, and some perineal tears resulted. Some midwives had back pain or knee pain. But after learning through watching videos and practicing, the tears have now decreased. (Midwife 5)

Positive birth outcome

Midwives were more actively involved than they had previously been in supporting women during pregnancy, labour, and delivery. Midwives and some of the obstetricians learned that a supportive environment for women during labour eases delivery and results in a positive birth outcome without medication:

Previously, women were left alone and naked in the labor room and could not take a walk, drink or eat. But now, women can drink and eat yogurt if they want to. When women are relaxed during labor, the delivery goes smoothly without complications. (Midwife 2)

Humanized care and free-style delivery shorten the duration of labor, with good APGAR score of the newborn, and no need for medication. (Obstetrician 4)

Improved communication with women and families

Opportunities for communicating with women and families increased when humanised care was introduced in hospitals during antenatal care, labour, and delivery, and a close relationship developed between the midwives and the women and their families:

In the mothers' class, women listen to us very carefully, and try to follow our instructions. We can reduce anaemia when we improve our diet, and we can avoid infection when we know how to avoid it. I am trying to make the mothers' class an opportunity for women to share useful information, make friends and talk to each other. (Midwife 2)

In the case of humanized care, the family can stay with the woman and support her during labor and delivery. The midwife sometimes joins in and asks the woman how she is, and explains to the woman and her family how to deal with labour. (Midwife 1)

Changes in the understanding of humanised care

Through the experience of becoming involved with the introduction of humanised care, midwives and obstetricians realised that the concept of humanised care itself was not actually new. They had been familiar with the principles for a long time and considered them fundamental and necessary in all cases. Practising of humanised care reminded them of the importance of having respect for women and communicating with them and supporting them and their families by sharing their professional knowledge and skill. They expressed a view that the core concept of humanised care is a requirement for effective two-way communication among clients, families, and health staff:

It is nothing difficult or surprising. In the past, we did not have proper communication with women and families. Previously, women just had to listen and follow what we told them to do. Communication was one-way. (Midwife 3)

Midwives and physicians listen to the women more than before, sit side by side and explain to them why this medication is necessary. (Obstetrician 3)

Table 1
Main concepts.

	Midwives	Obstetricians	Other staff	Manager team
Introduction stage	<ul style="list-style-type: none"> ● Hesitation ● Difficulties ● Positive birth outcome 	<ul style="list-style-type: none"> ● Involvement ● Positive birth outcome 	<ul style="list-style-type: none"> ● Indifference 	<ul style="list-style-type: none"> ● Initiatives ● Commitment ● Managerial support ● Improvement of work environment ● Training opportunities
Implementation stage	<ul style="list-style-type: none"> ● Improved communication ● Women and family's satisfaction ● Reflection on their own attitude ● Increased self-esteem ● Self-confidence ● Professional value ● Moral satisfaction 	<ul style="list-style-type: none"> ● Understanding of unnecessary intervention ● Reflection on their own attitude ● Recognition towards midwives' activities 	<ul style="list-style-type: none"> ● Influence from midwives' activities ● Reflection on their own attitude 	<ul style="list-style-type: none"> ● Recognition and appreciation towards midwives' activities ● Continuous support
Future	<ul style="list-style-type: none"> ● Motivation for work ● Willingness for continuation ● Challenges for continuation 	<ul style="list-style-type: none"> ● Humanised care for all clients 	<ul style="list-style-type: none"> ● Humanised care for all clients 	<ul style="list-style-type: none"> ● Continuous support

Satisfaction of the women and their families

Midwives are highly appreciated by women and their families when they provide humanised care. Midwives and other hospital staff noticed that increased satisfaction is achieved when family members can be present and participate during labour and delivery. Increased satisfaction is also obtained by improved communication. In addition, all interviewees considered financial issues to be important. The cost burden on the family is less when unnecessary medication is not administered:

In the case of humanized care, the family can stay with the woman and support her during labor and delivery. The woman is very happy to have someone beside her. (Midwife 1)
With humanized care, the financial burden on the family becomes less because we do not provide unnecessary medication. Women and their families look happy with such natural and cost-free delivery. (Obstetrician 1)

Professional value

Experience of humanised care gives midwives a chance to reflect on their professional roles and value:

When a woman has enough information about herself during pregnancy or delivery, she can make appropriate decisions. Our job is to help women understand themselves, and empower themselves. (Midwife 2)
Humanized care means women-centered care. Midwives need to love the women and to get to know them by looking at their situation and that of their families, not just the condition of pregnancy and labor. The women trust the midwives. (Midwife 1)

Increased self-esteem

The practice of humanised care and appreciation by the family can give midwives high levels of professional self-esteem:

Humanized care is just a clear expression of what we have been doing at the hospital. It gives me high self-esteem and

confidence in myself as a professional. It helps me to conceptualize my responsibilities and makes it easy for me to explain them to others. (Midwife 3)

I am like the mama of mamas. The woman and her family trust me and ask me to attend a future delivery or tell me that they will introduce me to their friends. I am so proud of this. (Midwife 4)

Support from the hospital management team

The hospital management team took the initiative to introduce humanised care and supported midwives who began to practice humanised care as a way of improving hospital management. The management team positively recognised the activities of midwives practising humanised care:

I wanted to bring about a change in my hospital... We can start with those (midwives) who are willing... Humanized care is implemented within the discipline of the hospital. (When we started humanized care), midwives requested "training," "improvements in the work environment," and "financial motivation." I supported training, prepared materials and renovated the labor room. But I did not agree to provide financial incentives for midwives, because it is not an extra job. (Hospital Director)

After introducing humanized care through free-style delivery, I delegated some responsibilities to midwives in the labor and delivery room. (Obstetrician 2)

Job satisfaction ('moral satisfaction')

Appreciation by women and the family, and recognition and support by obstetricians and the management team, and increased self-esteem by recognition of their professional expertise were reported by all of the midwives. The midwives expressed that they obtained 'moral satisfaction' from their work:

I feel happy to see a happy woman and her family after she gives birth. Women and their families rely on me and appreciate me. I feel like I am integrated into the family as a result of accomplishing my task. 100% satisfaction. (Midwife 4)

We have a cleaning day, once a month, when all of hospital staff clean their work places. I had never considered that clean and tidy work environment makes it easy to work and makes us satisfied with our work. (Midwife 1)

Normal labor and delivery is our job. When a cesarean is needed or a complication happens, we work together with obstetricians. We trust obstetricians and have no problems with our relationship. (Midwife 3)

Motivation for work

The results that are obtained indicate that personal satisfaction, the attainment of professional expertise, and self-esteem motivate midwives to continue providing humanised care. This might contribute to their retention, even if the working conditions are not optimal. The positive factors that lead to higher motivation of midwives are identified as improved communication with women and their families, appreciation of the women and families, and support extended by hospital managers, including training, improvements in work environment, recognition, and appreciation:

I wanted to be a doctor and did not want to work as a midwife, but now I feel it is my profession. Babies are the God's will, and to assist women in giving birth is really a wonderful job. ... Even if the hospital is undergoing a strike, women come to the hospital to consult me. That's why I will work here. (Midwife 6)

My salary is insufficient, but I will still work here. This hospital has an in-service training program, and teaching what I learned is also a good opportunity for me to improve myself. (Midwife 1)

Influences on the other staff

Humanised care was initiated mainly by midwives in antenatal care and in the labour room. The introduction of the concept of humanised care provided the other hospital staff an opportunity to reflect on their routine activities and their manner of communication with clients and their families. A change in hospital culture with respect to the service provision slowly expanded to

other staff and services. Improvements were noted in communication between clients and their families and hospital staff:

Humanized care means communicating enough with women and families, explaining medical intervention if needed, and listening to the women. It can be applied to all of our services, not just normal delivery. (Obstetrician 2, physiotherapist, co-medical staff 1)

Previously, we carried out cesarean sections because women wanted them, but I now know the criteria for making a decision based on the evidence. I learned that there was unnecessary intervention. (Obstetrician 3)

Humanized care gave me an idea for a solution to what was not working well in my hospital. It is said that we need three H's in our profession; heart (attitude), hands (skill), and head (knowledge), and that of the three, we need more heart or love for our work. We should explain this to our staff, especially the younger staff.... Now, some staff members communicate more with families and provide more explanations to them. When staff members are friendly, women and families also become friendlier. (Pediatrician 1)

Conceptual chart: the cycle of humanised care (Fig. 1)

Through the practice of humanised care for women who are not at risk, starting from hesitation and difficulties, midwives had an opportunity to reflect on the ways to deal with normal pregnancy and childbirth. While practising what they had learned, they found that they had achieved improved communication with women and their families, and that they benefited from being aware of their appreciation. They realised their professional value and were empowered with high self-esteem. This motivated them and initiated a highly positive cycle for those practising humanised care. This cycle of humanised care positively influences other staff and may bring about a change in the services provided at the hospital. A conceptual chart that represents the cycle of humanised care is shown in Fig. 1.

Recognition by the managerial team and the delegation of responsibilities by the chief obstetrician were the major factors

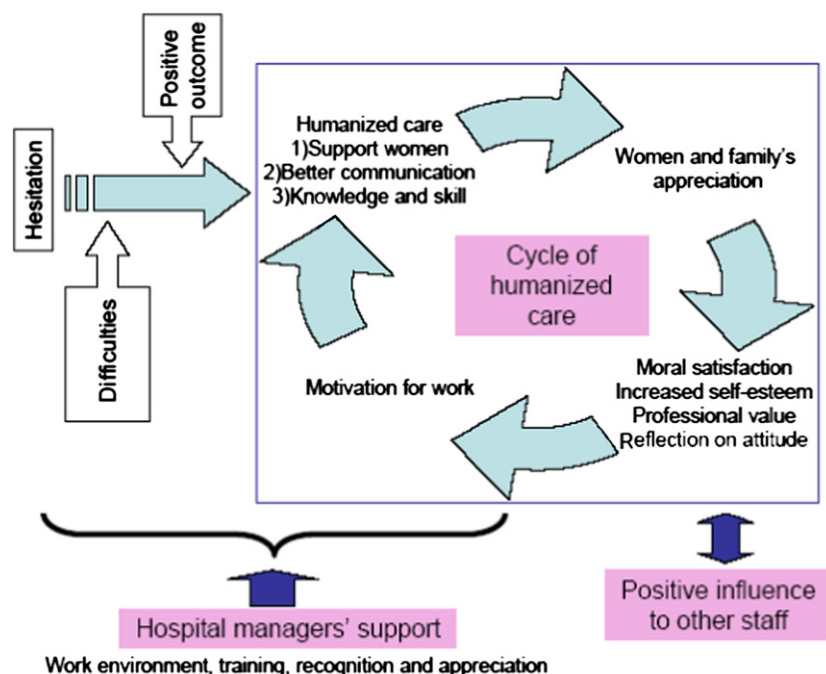


Fig. 1. Cycle of humanised care.

influencing the cycle. Hospital managers consider that such efforts, both on the administrative and the technical side, are necessary for positive effects on midwives' activities:

When our work environment improves, our workload decreases, the staff are satisfied, the clients are also satisfied, and a very positive cycle begins. Satisfied staff will accept clients more in a friendly manner, explain more, and women and their families will join in the decision making process at the hospital. This means providing humanized care. (Obstetrician 2)

Challenges to the cycle of humanised care

All of the midwives expressed their willingness to continue humanised care, not only for women whose pregnancy and birth were normal but also for women with complications. Their main concern was their workload, i.e., the number of clients. However, the management team still shows a strong commitment towards continuing humanised care:

When we practice humanized care, we are close to the women and families, and talk to them. I am happy to do that. But if there are too many women in the labour room, it is difficult. I understand that we should provide humanized care in any case, to any women. (Midwife 5)

Nowadays, a core team of active midwives is established inside the hospital. I hope that this team's activities (implementation of humanized care by active midwives) can be expanded. We are preparing non-financial incentives for active midwives along with awards and further training opportunities. (Hospital Director)

Discussion

Our findings suggest a positive relationship between the practice of humanised care and the professional value and self-esteem of a midwife. Our result supports the results of a study by Misago et al. (2001) that indicated that health professionals gained increased self-esteem, showed a greater commitment to their work, and showed improved teamwork skills through the training and practice of humanised care in secondary hospitals in Brazil. The midwife's original scope of work consisted of taking care of normal pregnancy and providing intrapartum, postpartum, and newborn care. However, in resource-limited countries, major efforts for improving maternal and newborn health have focused on facility-based care. In particular, this involves training of professionals for midwifery skills, ensuring that emergency services function at the referral level, and improving access to the facilities through community involvement (WHO, 2005). The quality of care mainly focuses on the systematic introduction of a clinical standard at facilities of all levels (WHO, 2005; Ekman et al., 2008). Because of the shortage of health personnel and the necessity to scale up effective interventions to reduce maternal and newborn deaths, task shifting is common in developing countries. For example, midwives have to work as a substitute for a physician. Training and support are often focused on the abnormal side of pregnancy when emergency care is needed (Fauveau et al., 2008). There are opportunities to learn the ways to handle emergency cases, but there are very a few opportunities to learn the normal course of pregnancy, labour, and delivery. Practice of humanised care provides good opportunities to midwives in resource-limited countries to refresh their knowledge and skill in providing care during normal pregnancy and delivery, and to reflect on their professional value, described by Barger (2005) as 'an authentic guardian of birth as a natural and physiological phenomenon of women's life.'

Walsh (2006) showed that professionals who provide humanised birth care had more job satisfaction at a birth centre in the UK. The fact that the work was not restricted to the accomplishment of standard care procedures was the main justification for professional satisfaction. Hundley et al. (1995) showed that being able to maintain their autonomy and their continuity in the role of caregivers is one of the best predictors of midwife satisfaction in a midwife-managed delivery unit in a hospital in the UK. We could not find any references describing job satisfaction for midwives in African countries. No midwives in our study mentioned autonomy. They were more interested in gaining the appreciation of the women and their families and gaining recognition by hospital managers and obstetricians. Further insight is needed, but this may well be a result of the difference in cultures or social norms.

A change observed in this study by introducing humanised care was the staff's recognition of 'unnecessary medical intervention' in labour and delivery. The concept of evidence-based care was new in Benin, and the idea of 'unnecessary medical intervention' in normal pregnancy and delivery is not yet understood by health care professionals in many resource-limited countries. Midwives in this study work in a tertiary hospital with referral backup by obstetricians and encounter many complicated cases. Medical intervention such as the induction of labour often becomes routine when the women are not carefully observed. Through implementation of humanised care, midwives and obstetricians have learned from the real experience that positive outcomes can be achieved by avoiding unnecessary intervention. Evidence has been established in developed countries that midwifery-led birthing centres integrated with a hospital, as compared to physician-based maternity hospitals, result in similar clinical outcomes for mothers and children and low rates of labour interventions in low-risk women (Jackson et al., 2003; Hodnett et al., 2009). It would be very useful if this study could be followed up by an examination of hospital data on caesarean sections and other forms of medical intervention to confirm the impact of humanised care in the long term. In resource-limited countries, the financial burden of medical intervention is crucial for families. For less wealthy governments, it may be essential to promote the development of a system that avoids unnecessary interventions.

Bowser and Hill (2010) reviewed evidence for disrespect and abuse in facility-based childbirth. There is a relative lack of evidence for respectful care intervention, specifically with regard to childbirth care. Most previously reported interventions were implemented as part of a broader quality improvement approach at health facilities, and potential contributors to respectful care (governance and leadership, service delivery, and providers) have been identified. The term 'respectful care' used in their review corresponds to 'humanised care' in our study, and the result of the review is similar to the situation and results of this study. However, there is a gap and needs for systematic evaluation and analysis on its relative contribution and the areas in which it may contribute.

A challenge for the human resources crisis in developing countries is the low levels of motivation of health-care workers. Systematic reviews have identified major motivational terms: financial rewards, career development, continuing education, hospital infrastructure, resource availability, hospital management, and recognition/appreciation from managers and the community. The above factors are more effective if provided in bundles of interventions rather than in a single intervention (Grimshaw et al., 2001; Lehmann et al., 2008; Willis-Shattuck et al., 2008). There is some evidence to suggest that the initiatives to improve motivation have been effective for retention (Willis-Shattuck et al., 2008). Focusing on nursing and midwifery managers in the US, Canada, UK, and Hong Kong, Lee and Cummings (2008) showed that the key factors influencing motivation are the span of control of managers' organisational support and empowerment. In developing countries, however, financial incentives are often highlighted to influence health workers' behaviour,

especially in rural areas, and less tangible factors such as recognition/appreciation or professional value are not often discussed (Mathauer and Imhoff, 2006; Manongi et al., 2006; Mbindyo et al., 2009).

In this study, humanised care was implemented through the efforts of the hospital management team to create a better work environment, to provide moral support to midwives, and to create opportunities for continuous training. Even under the strong leadership of the hospital management team, strikes are common because of certain situations brought about by the government, such as delayed salary payments and the unstable position of contract staff. This could be one of the reasons that the number of active midwives practising humanised care represents a minority in the hospital. All the 6 midwives who participated in the study expressed satisfaction and indicated that their motivation had improved. Their workloads increase during strikes, and this is the main challenge for continuing humanised care. Our study is qualitative, and generalisations cannot be made based on a study in a single hospital. However, the results suggest that when a cycle of humanised care begins and midwives are empowered by respect for their professional value and gain higher self-esteem, motivation improves without financial incentives under proper managerial support. The cycle of humanised care also has a positive influence on other hospital staff and may bring about a change in hospital culture for many different service providers. Further research is necessary to determine the factors influencing professional value and motivation, and to identify effective interventions to solve the problems of motivation and retention of health professionals in developing countries.

Conclusion

Humanised care introduced in a hospital in Benin brought about changes in the practice of midwifery care. Communication among women, their families, and midwives improved with a higher level of appreciation of midwives by the women and their families. Perception of the midwives themselves towards their jobs also changed as they gained increased self-esteem and the opportunity to engage in reflection on their professional value. This study suggests that midwives can be empowered by providing humanised care and can be motivated for such work, even under difficult working conditions. A positive influence on obstetricians and other staff was observed. These individuals were inspired to make changes in hospital culture to improve care, to avoid unnecessary interventions, and to improve communication. An important factor in achieving such a result without the need to provide additional financial incentives has been the leadership and commitment of the hospital management team and the recognition and support extended to midwives. A system of humanised care, which stresses improved communication between women, their families, and care providers based on respect for women's dignity and liberty and avoidance of unnecessary intervention, can be promoted under proper managerial support. This can bring about a change in hospital practice and help motivate midwives in resource-limited settings.

Competing interests

The authors declare that they have no competing interests.

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