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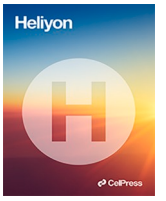

Research article

Midwifery service managers' readiness for prevention of obstetric violence in Nigeria: A community readiness model

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ABSTRACT

Obstetric violence is a public health problem that needs to be prevented at all levels to improve maternal and newborn health outcomes. The midwifery service managers, as custodians of patient care in maternity centres are in a prime position to develop and implement effective obstetric violence prevention interventions. This study explored the midwifery service managers' level of readiness for the prevention of Obstetric Violence in three maternity centres at three separate hospitals in Oyo State, Nigeria. Data was collected from six midwifery service managers as midwifery community leaders, using the adapted Community Readiness Model as a data collection tool. The Community Readiness Model scoring guide was used to score the six dimensions of community readiness. In addition, a thematic analysis was used to analyze the qualitative data from their views on each of the six dimensions of the Community Readiness Model. The findings revealed an overall level of readiness for the prevention of obstetric violence among midwifery service managers was at level five which is the preparatory level. This means that the community has a modest readiness for Obstetric violence prevention, and it would be easier to develop sustainable prevention interventions for obstetric violence. Understanding the midwifery service managers' level of readiness for the prevention of obstetric violence is important for governments and other stakeholders intending to develop obstetric violence prevention interventions that are contextually appropriate and acceptable to communities.

1. Introduction

Obstetric Violence (OV) is a public health problem that is linked to poor maternal and infant health outcomes [1–4]. It is an obstacle to quality maternal and newborn health and therefore needs to be addressed urgently [5,6]. OV includes physical, sexual, and verbal abuse; non-consented care such as conducting procedures like episiotomy, conducting cesarean section, and augmentation of labor without women's consent; non-dignified care such as humiliation; non-confidential care such as staying in a room together with other women during pregnancy and delivery; discrimination based on specific patient attributes; abandonment of care; detention in facilities and failure to meet the professional standard of care [5–9].

About 42 % of women experience OV globally [10]. The prevalence of OV in Nigeria is high, ranging between 11 % and 71 % [11]. In Oyo state in Nigeria, the state where the current study was conducted, a prevalence of 93.2 % OV has been reported [12]. These statistics may not be a true reflection of the prevalence of OV in Nigeria because most Nigerian women accept OV as part of the

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childbirth process experienced in health settings. They do not recognize it as a violation of their basic human rights and therefore do not report it [13,14].

In Nigeria, where this study was conducted, the literature reviewed identified the following additional typical types of OV reported by women during pregnancy and childbirth include the poor or hostile health providers' attitude, physical abuse such as slapping, physical restraint to a delivery bed, detainment in the hospital when unable to pay bills, neglect of care, non-confidential care and verbal abuse (such as shouting and threatening women) women giving birth to their babies on the floor with no one attending to them [11,15–20].

OV by obstetricians and other health workers in maternity settings, particularly midwives who spend the most time with pregnant women and women in labor has been reported in Nigeria, Sweden, Ethiopia, Brazil, Ghana, and Tanzania [15,21–25]. For this reason, our research focused on the midwifery health service managers as midwifery community leaders and custodians of midwifery health care services.

A number of strategies for the prevention of OV have been implemented globally. These included enacting and implementing laws against OV in countries like Latin American Venezuela, Argentina, Bolivia, Panama, and Mexico City [26] and the launch of a global campaign for the Respectful Maternal Care Charter by the White Ribbon Alliance (WRA) in 2011 for promoting respectful maternity care [27]. In Nigeria, the Respectful Maternal Care Charter was implemented in Kwara State, Nigeria to promote respectful maternity care in 2013. The WRA further worked with the Nigerian Ministry of Health to adopt the Respectful Maternity Care Charter as the standard of practice and to include respectful maternity care in the training of maternity health workers [27].

The high current statistics on women experiencing OV in Nigeria despite different interventions show that these interventions are not effective in curbing OV in Nigeria [11,12,15,16,18]. For prevention interventions like OV to be successful, it is important to conduct a community intervention and to involve stakeholders such as midwifery service managers in the prevention of OV, according to the World Health Organization [28]. It is paramount to first identify the level at which the community is ready to tackle such a problem [29]. For this reason, we used the Community Readiness Model (CRM) as a research tool for determining the midwifery service managers' level of readiness to prevent OV in Oyo State, Nigeria.

The CRM is a research tool that was developed by the Tri-ethnic Centre for Prevention Research as an appropriate research tool to determine the community's level of readiness for the development of appropriate prevention interventions [30–35]. In line with the CRM, we focused on the midwifery service managers as community leaders and key informants because of the positions they hold in the identified maternity centres. Furthermore, the World Health Organization advocates for the inclusion of managers as important stakeholders in eradicating OV [36], thus supporting us in identifying the midwifery service managers as a target population for the prevention of obstetric violence in maternity centres in Oyo State, Nigeria.

The findings of this study would help in the reduction of OV by identifying the midwifery service managers readiness to implement preventive measures, thereby fostering a supportive environment for respectful maternity care. This approach, combined with the enforcement of the Respectful Maternity Care Charter, addresses key factors needed to ultimately improve maternal and newborn health outcomes in Oyo State, Nigeria.

2. The aim of the study

The study aimed to explore and describe midwifery service managers' readiness for the prevention of obstetric violence in Nigeria using a Community Readiness Model.

3. Methodology

3.1. Research design and settings

This was a qualitative research study, using the adapted Community Readiness Model (CRM) [32] as a research tool to collect data from midwifery service managers in three maternity centres at the three selected Hospitals in Oyo State, Nigeria. These maternity centres were conveniently selected because of the high prevalence of OV incidents in the Oyo state and the fact that these maternity centres are in the main cities, and are easily accessible and affordable to patients.

3.2. The population of the study

The study population was all midwifery service managers working in the maternity centres of the three selected Hospitals in Oyo State, Nigeria. These were considered midwifery community leaders and Key informants, in line with the CRM. CRM recommends using Key informants to be interviewed because of their adequate insights information, facts, and understanding of issues affecting their communities [32].

3.3. Sampling method and sample size

Purposive sampling was employed in recruiting six key informants, a technique in which participants are selected based on specific characteristics relevant to the research [37]. In this study, key informants were midwifery service managers who held managerial or supervisory positions within midwifery services, had at least five years of professional experience in maternal and child healthcare, were directly involved in policy-making or program implementation related to obstetric care, and had firsthand experience or

knowledge of efforts aimed at preventing obstetric violence within their facilities. These characteristics ensured that the participants were well-positioned to provide insights into the readiness of midwifery services for the prevention of obstetric violence. Two were recruited from each of the participating maternity centres to participate in the study. This sample size was considered appropriate and is recommended in CRM where four to six key Informants are required to accurately evaluate the community's readiness for the prevention of a public health problem [32,38].

3.4. Inclusion and exclusion criteria

To be included in the study, participants had to be midwifery service managers registered by the Nursing and Midwifery Council of Nigeria as midwives, and employed as managers for no less than five years in the maternity centres of the participating hospitals. This criterion was set to ensure that participants had a deep understanding of OV cases reported in their respective centres. Exclusion criteria applied to midwifery service managers who had a history of involvement in obstetric violence or were facing disciplinary hearings related to OV.

Out of an initial pool of fifteen midwifery service managers, two were excluded due to previous involvement in obstetric violence or ongoing disciplinary actions, which accounted for 13.3 % of the total pool. The purposive sampling was then applied to choose two midwifery service managers who met the inclusion criteria from each maternity centres of the participating hospitals.

3.5. Recruitment

Meetings were held with the Hospital Management Team of each of the three selected hospitals to explain the purpose of the study and obtain permission to conduct the study in their respective hospitals. The midwifery service managers who met the inclusion criteria were then identified for recruitment to participate in the study. Each identified midwifery health service manager was approached by the first author in their place of work physically and informed about the study and asked to participate. Those who agreed were given the verbal information and information sheet about the study and encouraged to seek clarification before signing the informed consent form. Arrangement for individual interview sessions was made with each identified midwifery service manager who was willing and consented to participate as a key informant in the study.

3.6. Data collection instrument

An adapted CRM instrument was used as a research tool for data collection in line with the purpose of the study [32]. Section A of the adapted CRM instrument contained the demographics of the participants. Section B contained questions related to the six dimensions of CRM, including (A) The community efforts about the prevention of OV; (B) The community knowledge of efforts about prevention of OV; (C) Leadership involvement in the prevention of OV; (D) Community climate of OV prevention, (E) Knowledge of about OV prevention, and (F) Resources for prevention efforts about OV for both scoring and interview purposes.

3.7. Pilot study

Two midwifery service managers were recruited from a non-participating maternity centre for the pilot study. The pilot study was conducted to identify and rephrase problematic questions of the adapted CRM tool. The pilot participants completed the first section of the CRM and were interviewed accordingly. They were then asked to indicate if there were questions on the six dimensions that were difficult to understand or respond to. All questions were clear and in line with the study objectives.

3.8. Data collection process

Each participant completed the sociodemographic questions before the interviews. The individual interviews were held in English, the formal language used in the Nigerian health sector using the adapted CRM tool as a guide for questioning from dimension A to dimension F in sequential order. The first author facilitated the interview sessions and recorded field notes on observations made during the interviews. A digital audio recorder was used for recording each interview session. Data collected were transcribed by the first author within 24–48 h of collecting the data while the information was still fresh in her mind, and she could recall all that was said and observed as field notes.

3.9. Data management

Data collected were stored electronically in a Word document and Excel format on the researcher's personal computer with a password, using the Hospital names in alphabetical order for filing. The data was also saved and backed up in the cloud to prevent the loss of data. The data will be discarded later based on the policy of the University of KwaZulu-Natal.

3.10. Data analysis

Data analysis started with the scoring of the transcribed data from each participant using an adapted CRM scoring sheet, to determine the overall level of readiness scores. An independent researcher, who has MSc in Nursing, and is a qualitative researcher was

employed to score the same data together with the first author. An adapted CRM scoring sheet was used to conduct Case–by–case and across-case scoring of data of the 6 midwifery service managers [39]. The scoring sheet has a maximum of nine points per dimension from level 1(no awareness) to level 9 (high level of community ownership). In scoring the transcribed data, each scorer (i.e the first author and the independent researcher appointed for this purpose) read each transcript from the beginning to the end to get general impressions from the interview after which a score was given systematically for each of the 6 dimensions proceeding from dimensions one to six according to the CMR tool. Then, the two co-scorers met to discuss how they each reached the score given. Different scores were discussed until a consensus score on each row per transcript was reached after which the total score for each dimension was summed up and divided by the six interviews held. These scores were further submitted to and confirmed by the senior author who is an experienced qualitative researcher. To determine the overall stage of readiness of the community, the total of all calculated scores was divided by the number of dimensions which is six. In CRM, the score must be rounded down not rounded up [32]. For instance, a score between 3.0 and 3.99 is at stage 3. The final calculated score of 5 was identified as the appropriate level of community readiness to prevent OV.

In addition, the first author further used the seven steps of thematic data analysis by Collaizi's (1978) manually to qualitatively analyze participants' views on each of the six dimensions to explain each score in line with the objectives of the study [40]. This was done to further enhance the trustworthiness and dependability of the findings of the study [40]. The first author started by familiarising herself with data from individual interviews by carefully reading and re-reading transcript by transcript and across transcripts to acquaint herself with the data. Significant statements related to OV prevention from participants' explanations were identified, extracted, and recorded separately on a sheet, taking note of their pages and line numbers. Meanings were later formulated from the statement identified earlier and it was given a label about data on OV prevention. The collections of the meanings were organized into clusters of themes by grouping labels with similar meanings into categories. An exhaustive description of OV prevention was developed from the clusters of themes. The fundamental structure was produced by summarizing the exhaustive description into a brief and intense statement that focuses on the aspects considered to be important to the structure of OV prevention. A similar process was used by the independent researcher and an intercoder. The senior author who is an experienced qualitative researcher confirmed that the themes developed were in line with the raw data, verified all other processes of data analysis, and confirmed that it was done correctly. Lastly, verification of the fundamental structure was done by conducting member checking to validate the developed themes with all six participants. Member checking refers to sharing the summary or whole study with the participants to confirm the accuracy of the data [41]. The participants confirmed the author's analysis as a true reflection of their views.

5. The scientific rigor of the study

The authors ensured the credibility, dependability, and conformability of the findings of this study. Credibility means having the assurance of the reliability or truthfulness of the study [42–44]. For credibility, the co-scorer who scored the adapted CRM instrument also became an intercoder for themes, and the senior author ensured and confirmed that the analysed data and interpretations were accurate. Member checking was done and the participants confirmed that the analysed data was a reflection of their views. Dependability means steadiness of data over a while and dissimilar circumstances and situations; that is, a similar outcome will be arrived at if the same study were conducted, with the same participant, and the same method was used [42–44]. For dependability, the detail of the methodology used for the study which includes the method of recruitment of participants, method of data collection, and method of data analysis was explained by the first author. Conformability means the extent to which the findings or outcome of a study are based on data obtained from participants and not on the researcher's bias, motives, or preferences [42–44]. For conformability, bracketing was done to abate the impact of presumptions that may affect the study while for transferability, a detailed process of the study was written in an accurate, coherent, and logical manner for any reader to understand for easy transferability.

6. Findings

A total number of six [6] Midwifery service managers, aged between 43 and 59 years of age participated in the study. The Midwifery service managers were all women, married, qualified, and registered as Midwives with the Nigeria Nursing Council. Their working experience ranged between 19 and 31 years. Three of them had a Bachelor of Nursing Science as an additional qualification to their diploma in nursing and midwifery certificate.

Table 1
Showing the Overall score of Midwifery service managers' levels of readiness for the prevention of OV in maternity centres in Oyo State, Nigeria.

The Overall score of Midwifery service managers' levels of readiness for the prevention of OV in maternity centres in Oyo State, Nigeria.									
Dimensions	1	2	3	4	5	6	Mean score	Readiness Level	Readiness Stage
A: Community efforts about prevention of OV	3.9	6.0	5.9	5.5	–	–	5.3	5	Preparation
B: Community knowledge of efforts about prevention OV.	5.2	6.2	6.3	6	5.9	4.7	5.7	5	Preparation
C: Leadership involvement in prevention of OV	5.3	6.4	–	–	–	–	5.9	5	Preparation
D: Community Climate	5	4.6	5.9	–	–	–	5.2	5	Preparation
E: Knowledge of Midwives about OV prevention	4.9	5	5.8	–	–	–	5.2	5	Preparation
F: Resources for prevention efforts about OV	4.8	4.5	4.9	5.1	4.8	5.4	4.9	4	Pre-planning
Final Score							5.4	5	Preparation

The Midwifery Service Managers' Levels of Readiness for the Prevention of OV in Maternity Centres In Oyo State, Nigeria.

Table 1 shows the overall score of Midwifery service managers' level of readiness for the prevention of OV in maternity centres in midwifery settings, in Oyo State, Nigeria. The overall mean score of the three midwifery settings in the state hospital Oyo state for dimension A which is Community efforts about prevention of OV was 5.3, for Dimension B which is Community knowledge of efforts about prevention of OV, the mean score was 5.7. For Dimension C which is Leadership involvement in the prevention of OV, the mean score was 5.9. For Dimension D which assesses Community Climate, the mean score was 5.2. Dimension E assessed the Knowledge of Midwives about OV prevention, the mean score was 5.2. On dimension F which assessed Resources for prevention efforts about OV, the community mean score was 4.9. Using the rule of rounding down in the CRM, this shows that the overall level of readiness of 5 cuts across dimensions A to E while only dimension F was at the pre-planning stage of level 4.

The analysed data on the participants' views of the six dimensions is presented below with related quotes.

7. Dimension a: community efforts to prevention OF OV

Two themes were generated from the analysed data on the participants' views on Community efforts to the prevention of OV. These are (i) formal efforts for the prevention of OV and (ii) informal efforts for the prevention of OV.

Formal efforts on the prevention of OV: five sub-themes were generated from this theme and included formal training on the prevention of OV, involvement of the public in reporting OV, involvement of patients in their care in OV prevention, punitive measures against those responsible for OV to prevent OV, and scheduled meetings on OV prevention.

Formal training on the Prevention of OV: Analysed data revealed prevention of OV was formally taught as professional ethics during pre-service nursing training and in workshops and seminars as in-service education and training on OV prevention as indicated in the following quotes:

> "… we have the professional ethics that midwives were taught during their training in nursing educational institutions, and midwives are expected to bring that knowledge into their practice in this hospital. In as much as we adhere to this ethics, OV can be prevented" (Anjola, 46 years old, 23 years work experience, maternity 1).

This was further confirmed by other participants as revealed by the following extract.

> "… we were taught professional ethics in nursing school and how to relate with our patients, so we remind the midwives working with us to uphold that knowledge from their training. All of this training has been helping us in preventing OV" (Angelina, 50 years old, 25 years work experience, maternity 2).

> "… for instance, we nominate ourselves for workshops, and part of what they teach us at the workshop is to give respectful maternity care and to prevent OV" (Mary, 52 years old, 19 years of work experience, maternity 2).

> "Yes, midwives attend seminars on respectful maternity care and when they return from those seminars, they give feedback step-down seminars to others. Then OV prevention forms part of what we discussed during Nurses' seminars," (Angelina, 50 years old, 25 years work experience, maternity 2).

Involvement of the public in reporting OV: Analysed data revealed the involvement of patients and their relatives in reporting instances of OV by calling designated phone numbers anonymously as part of formal efforts used in the prevention of OV in the three maternity centres in Oyo State as demonstrated in the extracts below.

> "Patients can now call phone numbers that were placed in the entrance of the maternity ward to report anyone that misbehaves or engaged in OV to the management, so, everybody is careful not just to behave just anyhow to the pregnant women and their relatives" (Mary, 52 years old, 19 years work experience, maternity 2).

> "… *there are phone numbers that have been placed in strategic places that patients and relatives can call to report if there are cases of OV" (Funmi, 55 years old, 29 years of work experience, maternity 3).*

Their assertion was similar to other respondents from the maternity centre one who affirmed that

> "There are policies even from the government, government do create awareness that involves written documents that has phone numbers that patients and their relatives can call to report to the management of the hospital whenever they experience obstetric violence (Anjola, 46 years old, 23 years work experience, maternity 1).

> "The Ministry of Health publishes designated phone numbers conspicuously in the hospital premises where cases of OV can be reported by women and their relatives" (Anjola, 46 years old, 23 years work experience, maternity 1).

Involvement of patients in their care in OV prevention: Analysed data revealed the involvement of patients in preventing OV by educating pregnant women when they attend antenatal clinics about required information for pregnancy, childbirth, and post-partum stages. The initiative is taken by midwives to educate pregnant women about what they are to expect from midwifery service managers as shown in the following quotes:

> "… *we go to the antenatal clinic to educate pregnant women on what kind of care to expect during pregnancy, labor, and delivery and when to report if such care is not provided by the midwifery service managers (Mary, 52 years old, 19 years work experience, maternity 2).*

"We also address and orient the patients on what they are likely to experience during childbirth like telling them how true labor pains will start and how it will proceed including other signs of labor. The indication for augmentation and episiotomy and other likely procedures are also explained in case there may be a need for such. We do this so that pregnant women are well informed and can cooperate with the midwives during labor and thus OV can be prevented (Bunmi, 43 years old, 23 years work experience, maternity 1).

"We educate pregnant women during the Antenatal period on what to expect at every stage of pregnancy and delivery so that their expectations of the stages are well understood. This has really helped prevent OV because when this is done, most times, the pregnant women comply to all instruction given to them about their care since they have been pre-informed about the process" (Anjola, 46 years old, 23 years work experience, maternity 1).

Punitive measures for those involved in OV to prevent OV: Emerged data showed that all reported cases of unprofessional attitudes among health workers are investigated by a special committee. These unprofessional attitudes reported include OV. The appropriate action is taken depending on whether the midwife is found responsible for OV or not, as demonstrated in the following quotes.

"We have the Hospital disciplinary committee which processes all cases of OV and other unprofessional issues that are reported and the health workers found guilty of OV offenses are disciplined according to the guidelines of the hospital/institution" (Anjola, 46 years old, 23 years work experience, maternity 1).

"if OV is reported by anyone, the issue of OV will be investigated and if the Midwife is found guilty, she will be reprimanded" (Anjola, 46 years old, 23 years work experience, maternity 1).

Other participants also mentioned that:

"The hospital disciplinary committee will act promptly if there is a report of OV by calling the midwife involved in the act of OV. Such will be reported to the head of nursing services in the hospital, who will punish the erring midwives accordingly, for example, canceling the midwife's day off" (Funmi, 55 years old, 29 years work experience, maternity 3).

"The midwife found guilty could be reported to another super authority, she could be issued a written warning" (Eunice, 59 years old, 31 years work experience, maternity 2).

Scheduled meetings on OV prevention: Analysed data indicated that regular meetings are regularly held to address the prevention of OV, thus encouraging the midwives on how to handle pregnant women professionally and to give respectful care as shown in the quotes below.

"Meetings are organized for midwives where issues related to client care are discussed and we also discuss prevention of OV" (Mary, 52 years old, 19 years work experience, maternity 2).

" …. during Nurses' meetings, OV prevention forms part of what we discussed. We also have our meetings on the ward twice a year and respectful maternity care is part of what we discussed" (Angelina, 50 years old, 25 years work experience, maternity 2).

Supporting the statement, other participants also said the following:

"a meeting was held here today and part of what we discussed in the meeting was OV prevention. We discussed that midwives should treat our patients professionally and that we should see our patients as our customers in preventing OV (Bunmi, 43 years old, 23 years work experience, maternity 1).

We scheduled meetings at times once a quarter to discuss and analyze patients' care and as part of the general issues we discuss in our meetings, we also discussed what can be done to prevent OV. At times we have emergency meetings if there are prompting issues to discuss including prevention of OV" (Eunice, 59 years old, 31 years work experience, maternity 2).

7.1. Informal efforts on OV prevention

This theme has two sub-themes which include verbal reminders of midwives about the prevention of OV, and supervision of midwives on OV prevention.

Verbal Reminder on OV prevention: Analysed data revealed that the midwife service managers often give Verbal reminders to remind midwives about preventing OV as another formal effort for prevention of OV as indicated below.

"*… we also remind midwives to have a good interpersonal relationship and put patients into consideration when they are managing them and telling pregnant women to put into practice what they have learned on prevention of OV" (Funmi, 55 years old, 29 years work experience, maternity 3).*

" …. *as a leader, I tell midwives what to do to prevent OV and how to give respectful maternity care and setting a good example myself* "*(Mary, 52 years old, 19 years work experience, maternity 2).*

" I inform midwives to uphold professional ethics and to give respectful maternity care. A verbal warning is given to staff who violates patients depending on the severity of the OV. I tell midwives that it is important to treat our patients professionally and

that we should see our patients as our customers and that obstetric violence must be prevented at all costs" (Bunmi, 43 years old, 23 years work experience, maternity 1).

Supervision by midwifery service managers on OV prevention: Analysed data indicated that supervision of midwives by midwifery service managers in the care of pregnant women is another informal effort for preventing OV as shown in the quotes below.

"*… as the head of the department, we meet with midwives working with us to supervise them. Then also, the supervisors on each shift move around to supervise midwives" (Funmi, 55 years old, 29 years work experience, maternity 3).*

"I supervise *and orient newly appointed midwives on how to relate with patients to prevent OV" (Anjola, 46 years old, 23 years work experience, maternity 1).*

Similar to the above points, two other participants also expressed that

"I am always on the ward to supervise and if there is anything that can portray OV to patients, I stand up to attend to it and prevent it. I also go around to supervise and ensure the midwives do the right thing. And anyone found wanting, I correct such" (Funmi, 55 years old, 29 years work experience, maternity 3).

" As a leader, as I supervise, I do tell my midwives what to do and how to give respectful maternity care to prevent OV. I make sure I supervise and stand by midwives when they attend to the patients to correct when necessary to prevent OV and other unethical behaviors" (Mary, 52 years old, 19 years work experience, maternity 2).

8. Dimension B: community knowledge of efforts about prevention OF OV

One theme emerged under this dimension i.e. Satisfactory knowledge of efforts on OV and its prevention.

Satisfactory knowledge of efforts on OV and its prevention: The analysed data revealed that the participants were able to identify with ease the existing efforts that have been put into place for OV prevention, including attending meetings, seminars, and the involvement of social workers. This can be seen in the quotes below:

"We know about the existing programs for OV prevention because we attend meetings and seminars where issues like these are discussed and how to prevent them. We implement that accordingly" (Bunmi, 43 years old, 23 years work experience, maternity 1).

"We know some efforts for preventing OV and we make use of it. We involve the social workers for indigent patients, we conduct meetings where we discuss how to prevent unprofessional practices including OV, we give prenatal education, so we are all aware of those efforts "(Eunice, 59 years old, 31 years work experience, maternity 2).

"They know the existing program for OV prevention, the majority are aware because we are always together in the meeting where we discuss issues including OV prevention" (Funmi, 55 years old, 29 years work experience, maternity 3).

9. Dimension C: Leadership involvement in the prevention OF OV

Analysed data in this dimension generated one theme which is the development and implementation of OV prevention strategies.

Development and implementation of OV prevention strategies: The analysed data showed that the participants were involved in the development and implementation of policies for OV as demonstrated in the following quotes:

"When we have the Head of Departments meetings, I get involved in policy development in different aspects of care including OV prevention, I come back to my ward to disseminate the information to the midwives" (Angelina, 50 years old, 25 years work experience, maternity 2).

"I am very well involved in policy development and implementation as it relates to management and the care of patients in which OV prevention is not an exception. For instance, the Head of the department takes me along as the officer in charge of where policies will be developed, she always involves me in the OV prevention strategies that we develop. She makes sure that we work together towards implementing the policies" (Bunmi, 43 years old, 23 years work experience, maternity 1).

"As a Manager, I am involved in the development and implementation of strategies to prevent OV by gathering midwives for meetings, we discuss different issues including OV and its prevention then I use that information to develop …." (Eunice, 59 years old, 31 years work experience, maternity 2).

Likewise, other respondents further confirmed this in the following excerpt.

"When I resumed here as the nurse manager, I observed that midwives did not have meetings, so I started to have scheduled meetings to improve the standard of care and we also discuss the issue of OV and its prevention. I participate in follow-up, supervise, and monitor midwives to ensure all those policies formulated are implemented including that of OV prevention" (Anjola, 46 years old, 23 years work experience, maternity 1).

"I get involved directly in implementation; I serve as a role model to other midwives by getting involved in the procedures done on the ward. I ensure everything needed to work with like equipment is available to prevent burn-out that may lead to OV" (Angelina, 50 years old, 25 years work experience, maternity 2).

10. Dimension D: community climate

One theme emerged from this dimension i.e. Positive Attitudes of midwifery service managers to the prevention of OV.

Positive Attitudes of midwifery service managers to the Prevention of OV: The analysed data revealed that the participants adopted a positive attitude to OV prevention and discharging their duties as expected of women as demonstrated in the following quotes.

"*There are about 70% of midwives that have a positive attitude towards preventing OV. I know this because there was positive feedback from patients and relatives survey conducted recently*" *(Bunmi, 43 years old, 23 years work experience, maternity 1).*

Midwives are all working towards the implementation of OV prevention as evidenced by the better way they discharge their duty" (Angelina, 50 years old, 25 years work experience, maternity 2).

"The respect patients give us as midwives outside the hospital has increased lately and the patient always says we have improved in our relationship with them and we take care of them respectfully (Angelina, 50 years old, 25 years work experience, maternity 2).

11. Dimension E. knowledge of midwives about OV prevention

Two themes emerged in this dimension which is the developmental level of Knowledge of OV and appreciation of OV as a problem.

Developmental Level of Knowledge of OV: Analysed data revealed that the participants' knowledge about OV was still at the developmental level because they could not identify some practices as OV such as scolding patients so that she can cooperate to prevent complications during labor and therefore were not working towards preventing them as OV. This is demonstrated in the quotes below.

"We only know OV like verbal and physical abuse (beating). It is only recently that we know that there are some other things we have been doing that constitute OV from what you (the researcher) told us. We did not know its OV, so we did not pay more attention to it" (Anjola, 46 years old, 23 years work experience, maternity 1).

"There are some midwives that felt that some actions that are referred to as OV is not necessarily OV, for instance scolding the patients so that she can cooperate to prevent complication is not a form of OV. Some of the midwives claim it is a way of assisting the patients to have a positive outcome". It's only when you explained it that even some of us take this seriously (Eunice, 59 years old, 31 years work experience, maternity 2).

"Most of the things that midwives do to women in labor, they do not know that these are OV, midwives think that they are helping the patient, or they want to avoid negative health outcomes. So I can say their knowledge is average" (Bunmi, 43 years old, 23 years work experience, maternity 1).

11.1. Acceptance of OV as a problem

Analysed data shows that participants confirmed that they accept OV as a problem that occurs in health facilities as few are still engaging in it. This is shown in the quotes below;

"*Few are still practicing OV. There are some unavoidable circumstances you cannot avoid like when a patient is not cooperating, you are forced to raise your voice which is seen as physical abuse" (Angelina, 50 years old, 25 years work experience, maternity 2).*

"*Some do not see some of their actions as OV. For example, some will say if I did not slap the patient on the lap, how would she open her lap when she is not ready to open her lap? Do I need to inform her again if I want to give an episiotomy? She will not want me to do that, hence, most time, I may not tell the woman" (Bunmi, 43 years old, 23 years work experience, maternity 1).*

"Well, let me say that even till now, some of us still feel that most of these things we identified as OV are done to assist the woman. We felt it was not done out of hatred nor to harm the patient, but we wanted the woman to deliver a live baby and for the woman to be alive, and we are gradually getting there. Initially, as a midwife, I used to think AH! AH! For example, if I want to deliver a patient with her baby in the second stage of labor and she is not opening up her lap, how does she want the head of her baby to be? If the patient is not responding to persuasion, you want to use other means like scolding that will assist the patient. So, when you say all manner of things to the patient, you still feel you are just trying to help the patient. So, Midwives do not have that feeling that we are creating a form of violence for the woman or seeing it as if it is OV" (Anjola, 46 years old, 23 years work experience, maternity 1).

12. Dimension F. resources for prevention efforts about OV

Analysed data in this dimension generated two themes which are a shortage of human resources for the prevention of OV and inaccessible funding for the prevention of OV.

Shortage of human resources for prevention of OV: Analysed data showed that there were insufficiently qualified midwives, and this was causing an increased workload that may militate against OV prevention. This is shown in the quotes below:

> "We do not have enough midwives to provide quality midwifery care. In this maternity section, there are five units, hence one midwife can be caring for like fifteen patients at a time, at times when the workload is much, unconsciously, you may raise your voice at the pregnant woman and scold her if she is not complying to what you ask her to do" (Bunmi, 43 years old, 23 years work experience, maternity 1).

> "… You can hardly have two midwives on a shift. It's worsened when people are on leave. There are times when one single midwife will be on duty in this maternity, she will be the one to attend to women in labor, take delivery, attend to post-natal patients on the ward, and also go to the theatre. This can lead to OV in the forms of verbal, and physical abuse or given non-dignified care which could be termed as OV when she cannot cope with the workload on duty" (Anjola, 46 years old, 23 years work experience, maternity 1).

> *"Midwives are not enough to carry out expected care for our patients, the nurse may be overworked and may unconsciously act unprofessionally which may be termed as OV. How can someone be at her best when the workload is much?" (Eunice, 59 years old, 31 years work experience, maternity 2).*

Inaccessible funding for the prevention of OV: Analysed data revealed that there is funding though not easily accessible and not enough for OV prevention as indicated by complaints from the management that there is no money for the recruitment of more midwives, sponsoring midwives for attending seminars on OV and its prevention, and insufficient funds to meet up with payment for indigent patients who cannot pay their hospital bill as demonstrated in the following extracts from data.

> "The funding needed to prevent detaining patients in the hospital which is another form of OV is not easily accessible. Although hospital administrators are trying their best, most times, it may not be adequate to meet the needs of the number of patients that may require the money" (Funmi, 55 years old, 29 years work experience, maternity 3).

> "… funding to assist indigent patients who are not able to pay the hospital bill that sometimes leads to OV in the form of detaining the woman on the ward is not easily accessible. There are times that indigent patients will be detained on the ward for months when the social worker is finding it difficult to raise funds for the patients" (Bunmi, 43 years old, 23 years work experience, maternity 1).

Some of the related responses generated from other respondents are seen in the excerpt below:

> "Sometimes, when we request for employment of more midwives to ease the workload that may lead to OV. The hospital management always refers to the fact that there is not enough fund to employ nurses presently but always promises to do something that is not always forthcoming. The funds are not easily accessible for OV prevention" LAUGHING(Mary, 52 years old, 19 years work experience, maternity 2).

> "… funding needed for OV prevention is not easily accessible in this hospital. Employing more midwives to work to reduce the workload that may lead to OV prevention is also a challenge due to poor funding" (Angelina, 50 years old, 25 years work experience, maternity 2).

> "The seminars and workshops where issues for improving patient care including OV prevention are discussed are not easily accessible. The hospital management will always be complaining that there is no fund to sponsor us to attend these workshops" (Eunice, 59 years old, 31 years work experience, maternity 2).

13. Discussion

This study explored and described the midwifery service managers' level of readiness for the prevention of obstetric violence in maternity centres in Oyo State, Nigeria. The preparatory level at which the midwifery service managers were indicates that midwifery service managers have begun planning in earnest and that the community offers modest support for their efforts for OV prevention [32]. It also shows that the majority of midwifery service managers have at least heard of local efforts to prevent OV and that the midwifery service managers are actively supportive of maintaining current efforts, enhancing existing ones, or developing new ones in the prevention of OV. It also demonstrates that the midwifery service managers had a fairly positive attitude and concern about OV prevention. It means midwifery service managers have a modest interest in OV prevention and that some measures have already been taken toward the prevention of OV. This finding suggests that it would be easier to work with these midwifery service managers to develop sustainable prevention interventions for OV.

Our findings are different from other previous studies that utilized CRM to explore and determine the community level's readiness for the prevention of different public health problems [30,45–47]. Most of such studies reported an overall readiness level of less than 5, thus making it difficult to develop and implement appropriate prevention interventions for identified public health issues. For

instance, a study conducted in American Indian reservation communities on readiness for prevention of Childhood Obesity was found to be on stage overall readiness level stage 2 which means denial and resistance to prevention planning for childhood obesity for American Indians [30]. The team had to create corresponding initiatives to raise awareness because of the low preparedness scores. The readiness level of another study conducted in Astana, Kazakhstan, on increasing physical inactivity among older adults was at level three which was the stage of vague awareness [47]. This necessitated the researcher to propose that older adults must engage in more physical activity, according to community-specific measures, to reduce the burden of diseases brought on by aging and increase life expectancy. Another study in Pakistan showed the readiness level for implementing school-based sexual education to be at stage two which was the denial and resistance level [46]. Another study conducted in two cities of Ghana for preventing overweight and obesity shows overall readiness levels of 3 and 2 which corresponds to "vague awareness", denial, or resistance stages, respectively. A Diet counseling and keeping fit program was proposed [45]. Although all these studies revealed low levels of readiness, they helped the researchers to make a level-appropriate intervention suited for each study.

This present study also identified formal efforts in OV prevention in the form of formal training on the prevention of OV (workshops, seminars, training in health institutions). In line with the outcome of this study, a Kenyan study identified training of health workers as one of the ways to prevent OV(53). Similar steps were identified to prevent OV and promote respectful maternity care in another study, including raising educational and training initiatives, and legal strategies as outlined in another study [48]. Training in the form of seminars could help in preventing OV as evidenced in another study conducted in Spain which shows improvement in the perception of participants about OV after the participants were exposed to training [49]. Academic training was also suggested as a solution to addressing the prevention of OV [6]. The current study identified putting into place punitive measures to prevent OV by enacting laws. An earlier systematic review in Nigeria identified a lack of legal redress as a factor that contributes to the occurrence of OV [11]. Our findings show that Nigeria is moving towards addressing this challenge of OV. Supervision of midwives by midwifery service managers is another formal effort for OV prevention identified in this current study is similar to the findings in a systematic review in Nigeria that identified poor supervision, as one of the factors contributing to the occurrence of OV [11]. OV can be prevented when adequate supervision is done by midwifery service managers.

Coincidentally with the outcome of this study, studies conducted in Ghana identify the importance of leaders' participation and active roles in OV prevention [50,51]. Most of the community leaders in this study have at least heard about local efforts for OV prevention and they are actively supporting the current efforts for OV prevention, including attending meetings where OV prevention is discussed, attending seminars that focus on OV prevention and the involvement of social workers that search for funds to pay for indigents patients who are unable to pay up their hospital bill. This may come from the efforts of the implementation of the Respectful Maternal Care Charter in Nigeria to promote respectful maternity care as far back as 2013 and the White Ribbon Alliance that worked with the Nigerian Ministry of Health to adopt the Respectful Maternity Care Charter as the standard of practice and to include respectful maternity care in the training of maternity health workers [27]. This will make it easy to develop interventions for OV prevention in moving the community from level five to the highest level of CRM which is level nine.

Contrary to the outcome of a scoping review of studies in Chile where healthcare professionals have an unwillingness attitude to acknowledge women's complaints of OV [52], the midwifery service managers in this study have a positive attitude toward OV prevention. They were involved in the development and implementation of OV prevention through the development of policies for OV prevention during their meetings, and implementation of the policies developed on the ward by telling other midwives working with them and monitoring them while they also serve as a model. The implication of this is that Nigerian midwifery health services are already in alignment with the World Health Organization's call for the inclusion of managers as important stakeholders in eradicating the OV [36]. This will probably make it easier to further develop prevention interventions for OV that are contextually appropriate. The midwifery service managers in Oyo State Nigeria are more positive towards preventing OV and have a better attitude towards the prevention of OV.

Like other similar studies in Ghana and Nigeria where midwives were giving justification for involvement in OV and the knowledge of midwives giving respectful maternity care for preventing OV was reported to be a little above average [53,54], the midwifery service managers' readiness level for OV prevention in this study were at the developmental level of knowledge and acceptance of OV as a problem. They do not know that some activities they are involved in are categorized as OV. Some defended practices that are categorized as OV in literature, saying these are not done out of wickedness but to enhance the positive outcome of the labor. This finding corroborates another study conducted in Spain where midwives did not see OV solely as professional malpractice [55]. Midwives will benefit from training that could make them understand professional malpractices that constitute OV.

This study identified that the resources for the prevention efforts of OV were insufficient. There was a shortage of human resources overall in maternity settings in these facilities. If there is too great of a midwife-to-patient ratio, midwives cannot perform their jobs properly. In this case, OV may be a result of a workforce stretched too thin. This finding was consistent with findings from different studies in Nigeria, Tanzania, and Kenya that documented inadequate human resources in terms of inadequate staffing as an impediment to preventing OV [56,57,58]. Another study in India also supported that inadequate staffing of health facilities can facilitate OV [59]. To facilitate the prevention of OV, recruitment of human resources is required. The finding of this current study also revealed that there was inadequate funding for OV prevention. This corroborates the outcome of studies in Africa, India, and Niger where inadequate funding has been identified as a factor in preventing OV in studies [59–61]. To prevent OV, adequate funding is needed for the recruitment of staff, training of midwives, buying of medicines, supplies, and consumables, providing quality infrastructure, and other things needed to provide professional care in preventing OV.

The midwifery service managers' preparedness was at stage five which is the preparatory level of prevention of OV and thus this means they are fairly ready for the development and implementation of OV prevention. The current level of readiness suggests that it would be easier for the government, and other stakeholders to develop and implement OV prevention interventions. Hence, strategies

should be put in place by the state government in collaboration with the Ministry of Health in Oyo State to prevent OV in all hospitals across the state. This can be possible by working together with the midwifery service managers in Oyo State in OV prevention, reviewing the existing efforts for OV, and making improvements where there is a need. There should be a recruitment of more human resources to work in the midwifery settings to help in the prevention of OV and improvement in efforts for funding OV prevention in hospitals and the fund should be made accessible.

14. Practical implication of the study

Healthcare institutions and organizations should develop and implement training programs that focus on OV prevention to enhance the readiness of midwifery service managers. Policymakers can use the findings to advocate for and strengthen the implementation of policies that prevent OV. Quality improvement programs which include continuous monitoring and evaluation to assess the progress of OV should be put in place while necessary adjustments should be made where needed. Researchers and organizations can further explore the readiness of healthcare providers in different regions of Nigeria and continue to use the Community Readiness Model as a framework for assessment. This can help identify regional variations and track improvements over time. Advocacy groups and organizations can use the manuscript's findings to garner support and resources for initiatives that address obstetric violence. This includes securing funding for training, awareness campaigns, and policy implementation on obstetric violence.

15. Strength of the study

The Community Readiness Model used for the study approach aligns with the community-based nature of midwifery services and obstetric care and it allows for the consideration of local nuances that might influence midwifery service managers' readiness in OV prevention. This has helped to comprehensively assess multiple dimensions of readiness which provide a more nuanced understanding of the challenges and strengths of OV prevention. This has helped to identify where improvement is needed and will facilitate the development of public health intervention in the context of obstetric violence prevention. The input of stakeholders like midwifery service managers has provided a more comprehensive perspective that will drive a practical change in healthcare practices and policies in OV prevention.

16. Limitations of the study

Findings from a specific region or a limited sample of midwifery service managers may not be representative of the entire country. Nigeria is a diverse country with significant regional variations in healthcare infrastructure, resources, and cultural practices, hence, the readiness of midwifery service managers may differ significantly between regions, so there may be challenges in generalizing findings to the entire country.

17. Conclusion

The study sheds light on the critical issue of obstetric violence and the readiness of midwifery service managers in Nigeria to address it. The CRM used in the study has assisted in identifying the level of readiness of midwifery service managers in the prevention of OV in maternity settings in Oyo State to be at level five out of level nine. It highlights the need for capacity-building, the need for more resources, and community engagement to effectively combat obstetric violence and improve maternal care in the country. The study has offered valuable insight for future research and initiatives aimed at enhancing the readiness of healthcare providers to address OV. Other countries that want to develop and implement OV prevention should also take this pattern to determine the level of readiness in OV prevention while involving the community leaders who will be the key informant because they will have adequate insights information, facts, and understanding of issues affecting their communities. We emphasize the necessity of adequate funding and supportive policies alongside institutional readiness to effectively prevent OV. This holistic approach shows the critical role of both institutional and upstream interventions.

CRediT authorship contribution statement

Adetunmise Oluseyi Olajide: Writing – review & editing, Writing – original draft, Validation, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Sinegugu Evidence Duma:** Writing – review & editing, Writing – original draft, Validation, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Ethical considerations

Ethical approval for the study was obtained from the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu-Natal (BREC/00003411/2021) and the Ethics and Research Committee of the Ministry of Health, Oyo State (AD 13/479/44,134), Nigeria respectively. The permission to conduct the study was also received from the Hospital Management of each of the participating hospitals. Informed consent was signed by participants after they had understood all the information about the study to signify their voluntary participation. No participant was coerced to participate in the study. The participants' information was kept confidential.

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request. For any inquiries related to the data, please contact the corresponding at adetunmiseolajide1@gmail.com.

Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:The authors declare that they have no competing interests or conflicts of interest in relation to this manuscript. All authors have contributed to the work without any financial or personal relationships that could inappropriately influence or bias the content of this paper. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.heliyon.2024.e39813.

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