Scientific Research Publishing

Open Journal of Obstetrics and Gynecology, 2025, 15(9), 1510-1532
https://www.scirp.org/journal/ojog
ISSN Online: 2160-8806
ISSN Print: 2160-8792

Patients' Rights Charter and Hospitalizations in Maternity Wards: Status Report across Sixteen (16) Maternity Wards in Burkina Faso, Ouagadougou

Ouattara Adama[1,2*], Nsahlai J. F. Christiane[3], Makoyo Komba Opheelia[4], Sawadogo Yobi Alexi[1,2], Kiemtoré Sibraogo[1,5], Ouédraogo Charlemagne[1,2]

[1]Department of Gynecology and Obstetrics, Joseph KI ZERBO University, Ouagadougou, Burkina Faso
[2]Department of Gynecology and Obstetrics, University Teaching Hospital of Bogodogo (UTH-B), Ouagadougou, Burkina Faso
[3]Department of Obstetrics and Gynecology, Faculty of Medicine and Biomedical Sciences, University of Yaoundé I, Yaoundé, Cameroon
[4]Department of Gynecology and Obstetrics, Mother and Child University Teaching Hospital Jeanne Ebori, Libreville, Gabon
[5]Department of Gynecology and Obstetrics, University Teaching Hospital of Yalgado Ouedraogo (UTH-YO), Ouagadougou, Burkina Faso
Email: *ouattzangaadama@yahoo.fr

How to cite this paper: Adama, O., Christiane, N.J.F., Opheelia, M.K., Alexi, S.Y., Sibraogo, K. and Charlemagne, O. (2025) Patients' Rights Charter and Hospitalizations in Maternity Wards: Status Report across Sixteen (16) Maternity Wards in Burkina Faso, Ouagadougou. *Open Journal of Obstetrics and Gynecology*, **15**, 1510-1532.
https://doi.org/10.4236/ojog.2025.159126

Received: August 19, 2025
Accepted: September 19, 2025
Published: September 22, 2025

Abstract

Objective: To assess the implementation status of the patients' rights to respectful care charter and hospitalizations in sixteen maternity wards in Burkina Faso from July 1, 2020, to September 30, 2020. **Patients and Methods:** We conducted a cross-sectional, descriptive, and analytical survey of 1,947 women about their in-patient experiences in sixteen maternity units. We conducted the survey in two phases: in person at the time of discharge from the maternity unit, and on the forty-fifth day postpartum. **Results:** One thousand nine hundred and forty-seven (1947) women discharged from the maternity wards and 1937 women seen on the forty-fifth day postpartum participated in our study. Sixteen health facilities, including three private and thirteen public, participated in the survey. The distribution of these health facilities based on the Burkina Faso health pyramid was: twelve level 1 facilities, 02 level 2 facilities, and 02 level 3 facilities. The average age was 27.21 years, and the age group most represented among women who had given birth was 20 to 24 years. Most women who had given birth were satisfied with their reception (96.3%) and their stay (93.8%). Except for articles 5 and 7, the articles of the Charter of Universal Rights of Women and Newborns were not respected in the provision of care in the sixteen maternity wards included in the study. **Conclusion:**

Maternity ward conditions and respect for the universal rights of women and newborns are especially important for quality care. In our context, the hospitalization conditions were satisfactory; however, much work is needed to ensure respect for universal women's rights.

Keywords

Quality of Care, Patient's Rights Charter, Maternity, Ouagadougou

1. Introduction

Health authorities worldwide are concerned about the quality of care in maternity wards. It is of undeniable importance in promoting safe motherhood [1] [2], based on the universal rights of women during the perinatal period. Thus, numerous initiatives have been taken in Burkina Faso to improve the quality of care in maternity wards, namely:

1) Improving financial accessibility through the subsidy or free provision of Emergency Obstetric and Neonatal Care (EmONC) [3].

2) Increasing human resources to make EmONC available at the most peripheral level [4].

3) Cost-free obstetrical and child care for ages 0 to 5 years [5].

These initiatives have improved access to care, with a probable increase in the workload for nursing staff. Nevertheless, an increase in workload could impact the quality of care provision, especially with regard to the degree to which the charter of universal rights in maternities is respected [6]. However, nowadays it is indisputable that patient satisfaction is a major indicator of quality of care [7]. Patient satisfaction should therefore be a constant concern for health professionals and managers. Therefore, within maternity care, it is essential to assess and evaluate both the quality of services provided and the satisfaction levels of mothers receiving care. Patient satisfaction is one of the complementary aspects of quality of care and also one of the indicators of psychosocial morbidity [8].

Several studies carried out in certain maternity units have assessed the level of patient satisfaction with the quality of services, particularly regarding abortion [9] and childbirth [10]. Unfortunately, these studies did not consider the specific case of the charter of universal rights in maternities.

We found it valuable to conduct a situational analysis of the quality of care and practices in maternity wards in Burkina Faso, guided by the standards outlined in the Charter of Universal Rights of Women and Newborns. We sought to hear from women and collect their feedback on the conditions during hospitalization. To begin our study, we chose sixteen health facilities located in Ouagadougou and its neighboring regions.

2. Patients and Method

2.1. Study Framework

This study was carried out in the maternity wards and obstetrics and gynecology departments of sixteen health facilities in Burkina Faso. The facilities were in the following health regions: Center, Center West, Center East, Central Plateau, and Hauts Bassins, and included twelve (12) primary health facilities, two (02) secondary health facilities, and two (2) tertiary health facilities.

2.2. Type and Period of Study

This study was a multicentric, cross-sectional survey designed for both descriptive and analytical purposes, with data collected over a three-month period from July 1 to September 30, 2020.

2.3. Study Population

The target population included all pregnant or postpartum women who utilized these health facilities, whereas the source population comprised all women who had given birth.

2.4. Sampling

We used non-probabilistic sampling for convenience. For practical reasons, health facilities in the city of Ouagadougou and its neighboring areas were prioritized. Sampling of women who had recently given birth was accidental, meaning that only those who had given birth and were discharged from the maternity ward in our presence were interviewed. Women who gave birth were interviewed only on weekday mornings; weekends and on-call hours were not covered. This choice was based on the fact that these are the periods that have the highest attendance for both staff and patients, the other periods being reserved for minimum service.

For each health facility, the sample size was calculated using a multicentric study approach according to the formula $c = \pi\ 2\ ABC\ 2$.

N = sample size; **Z** = standard deviation chosen at a value of 1.96 (which corresponds to a 95% confidence interval); E = margin of error estimated at 0.05; p = estimate of patient satisfaction rate at 50%, as the specific level of satisfaction in maternities is unknown in our context; q = 1 − p.

Applying this formula, we obtained a minimum necessary sample size of 384 patients for all study sites.

Based on data from the statistical yearbooks of the Ministry of Health of Burkina Faso, we rationally established a minimum of 120 patients per health facility to enable independent site-specific analysis. Finally, we conducted the survey with 1,947 patients.

2.5. Inclusion Criteria

All patients who had delivered a live newborn vaginally or by cesarean section were included.

2.6. Non-Inclusion Criteria

1) All patients who had a communication barrier, such as deafness or a mental handicap.

2) Women who had given birth to a malformed or stillborn child.

2.7. Data Collection

Using a pre-established questionnaire and an observation grid of the premises and practices of providers, women's perception of their reception and their stay at the maternity ward were assessed using various variables. The same women were interviewed upon their discharge from the hospital and 45 days' post-partum to evaluate the consistency of their judgment. The questionnaire was tested and validated over a 10-day period from May 1 to 10, 2020.

The study variables were socio-economic characteristics, accessibility, human relations, quality of care, conditions of stay, and the level of implementation of the ten elements of the charter of respectful care in maternities.

To assess patient satisfaction, we proposed a scale from 0 to 100, 0 being the lowest and 100 the highest level of satisfaction. We asked each patient to indicate their level of satisfaction on this scale. We then coded the level of satisfaction into three subgroups:

1) Very satisfactory: score greater than or equal to 75.

2) Fairly satisfactory: score between 50 and 75.

3) Unsatisfactory: score less than 50.

Throughout the survey, researchers assessed the level of compliance with the ten (10) articles of the Charter of Universal Maternity Rights.

1) A score of 0: was given when non-compliance with one of the articles was observed, even for only one day.

2) A score of 1: was given when compliance with the articles was observed throughout the survey period.

The level of compliance with the charter was calculated by creating a fraction whose denominator is all sites surveyed and whose numerator is the number of sites on which the article was respected.

Data entry and analysis were performed on a microcomputer using Microsoft Office Word 2016; Microsoft Office Excel 2016; and Epi Info 7 software. Percentages were used to analyze patient perceptions. Statistical tests used were the Chi-squared and two-tailed Fisher's exact tests, with a significance threshold set at $p \leq 0.05$.

2.8. Ethical Aspects

Before each interview, the women were informed about the purpose of the study and the confidential nature of the interview, and they signed an informed consent form. Collection permits were obtained for all study sites. We have requested and obtained the agreement of the national health ethics committee.

2.9. Description of the Charter

This charter deals with the universal rights of women and newborns and is based on the following points: Protection of integrity-Information and consent-Confidentiality-Dignity and respect-Absence of discrimination-Health care-Liberty and autonomy-Right of the child to remain with his parents or guardian-Right of the child to an identity and a nationality-Right to adequate food and clean water. Thus, the charter consists of ten articles, which are:

Article 1: Every woman has the right to the protection of her integrity without harm or abuse.

Article 2: Every woman has the right to information, informed consent, and respect for her choices and preferences, including those related to her desired companion(s) during maternity care and refusal of medical procedures.

Article 3: Every woman has the right to the protection of her privacy and the confidentiality of information concerning her.

Article 4: Every woman is a full person from the moment of birth and has the right to be treated with dignity and respect.

Article 5: Every woman has the right to equality, freedom from discrimination, and fair care.

Article 6: Every woman has the right to health care and the highest attainable standard of health.

Article 7: Every woman has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention.

Article 8: Every child has the right to be with his or her parents or guardians.

Article 9: Every child has the right, from birth, to an identity and a nationality.

Article 10: Everyone has the right to adequate food and clean water.

3. Results

3.1. General Characteristics

Patients from public sector health facilities accounted for 81.2% of our sample. Of these, 75% came from first-level health facilities. Women from second-and third-level facilities represented one quarter of those who gave birth (Table 1).

Table 1. Distribution of patients by type and level of facility.

	Number of employees N = 16	Percentage (%)
Type		
Private	3	18.8
Public	13	81.2
Level		
Primary	12	75
Secondary	2	12.5
Tertiary	2	12.5

3.2. Sociodemographic Data

The mean age of the patients was 27.21 years (± 5.64 years) with extremes of 15 and 45 years. Married women represented 78.13% of the study population (Table 2).

Table 2. Distribution of patients by sociodemographic data (n = 1947).

Features	Number	Frequency
Age		
[15 - 20]	199	10.2
[20 - 25]	539	27.7
[25 - 30]	530	27.2
[30 - 35]	397	20.4
[35 - 40]	224	11.5
[40 - 45]	58	3
Level of education		
Not in school	565	29
Primary	448	23
Secondary	701	36
Tertiary	235	12
Mother's profession		
Housewife	921	47.3
Informal sector	520	26.7
Pupil/Student	280	14.4
Civil servant	226	11.6
Marital status		
Married	1520	78.1
Concubine	347	17.8
Bachelor	74	3.8
Divorced	06	0.3
Widow	00	00
Obstetrical profile		
Primiparous	672	34.5
Pauciparous	784	40.3
Multiparous	491	25.2
Delivery route		
Vaginal delivery	1552	79.7
Caesarean section	395	20.3

3.3. Women's Perception of their Welcome

Sixty-one percent (61%) of patients reported at hospital discharge and day 45 post-partum (D45) that they were already familiar with the reception area. Upon arrival at the maternity ward, 80% of women at discharge and at D45 had been seen by state-approved female and male midwives in 58.2% and 59.5% of cases, respectively. For 83% of women at discharge and at D45, the health worker who welcomed them was courteous. They identified long waiting times as a point for improvement in 17.4% of cases at discharge and 18% at D45 (Table 3).

Table 3. Patients' perception of their reception. On leaving the hospital (n = 1947) and at D45 postnatal (n = 1937).

Perception of reception	At Exit n = 1947		At D45, n = 1937	
	N	%	N	%
Awareness of reception area (n = 1947)				
I already knew the room.	1190	61.1	1191	61.5
As advised by a person present at the health facility	466	23.92	422	21.8
The paramedic took me there.	267	13.8	289	14.9
My companion/relative knew	24	1.2	35	1.8
Time to first contact (n = 1947)				
Fewer than 5 minutes	1597	82	1569	81
5 - 15 minutes	187	9.6	186	9.6
15 - 30 minutes	86	4.4	101	5.2
30 minutes - 1 hour	50	2.6	48	2.5
Greater than 1 hour	27	1.4	33	1.7
Qualification of the welcoming agent (n = 1947)				
Doctor	177	9.1	180	9.3
STOG	2	0.1	2	0.1
Midwife (female and male)	1133	58.2	1153	59.5
Waitress	12	0.6	6	0.3
I don't know	623	32	596	30.8
Attitude of the welcoming agent (n = 1947)				
Courteous	1631	83.8	1612	83.2
Empathetic	236	12.1	236	12.2
Disinterested	74	3.8	87	4.5
I don't know	6	0.3	2	0.1
Other best practices				
Warm welcome	1188	61	1199	61.9

Continued

Respectful attitude	693	35.6	686	35.4
Communication/encouragement	506	26	480	24.8
Prompt care	487	25	345	17.8
Room cleanliness	232	11.9	439	11.7
Negative points at reception				
Long wait	724	19.1	370	19.1
Unruly behavior of housekeeping	300	15.4	298	15.4
No chair	86	4.4	85	4.4
Threats/insults	169	8.7	169	8.7
Unsanitary conditions	10	0.5	10	0.5
Lack of privacy/too many trainees	35	1.8	35	1.8

Note: STOG: Senior Technician in Obstetrics and Gynecology.

3.4. Overall Satisfaction with Reception

Over half the patients (51.5% at discharge and 51.3% at D45) were very satisfied with their reception; see Figure 1.

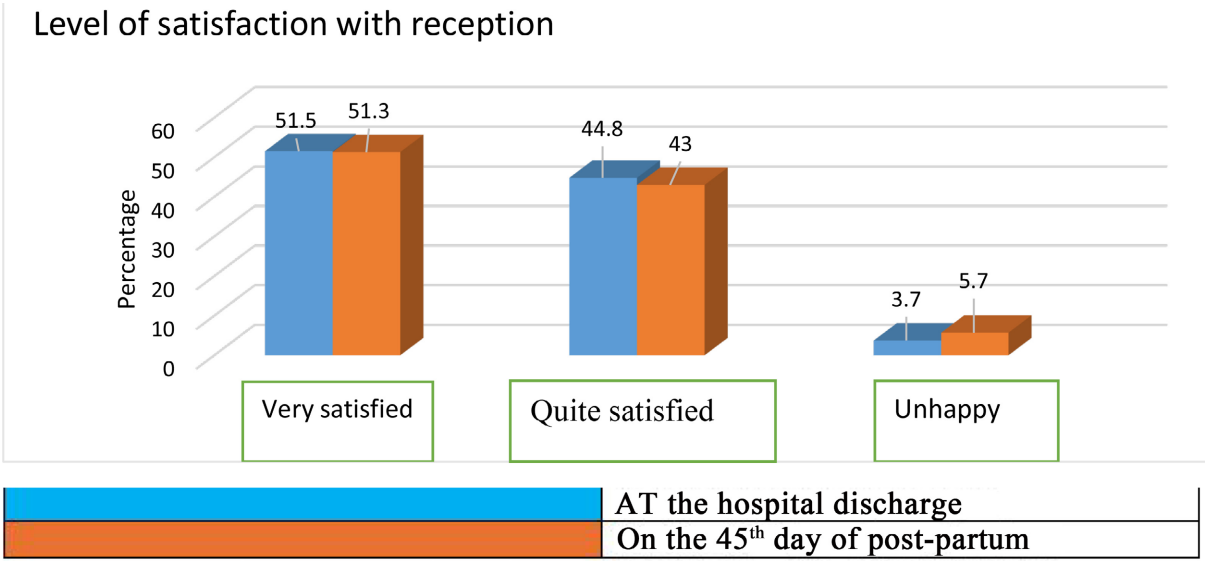

Figure 1. Overall level of satisfaction with reception (n = 1947 at exit and n = 1937 at D45).

3.5. Patients' Perceptions of their Stay

The delivery room and toilets were clean for 94.5% and 76.7% of women, respectively. They also stated in 94.6% of cases that their privacy had been respected. Regarding areas for improvement, they noted several elements, including the presence of mosquitoes in health facilities and unsanitary conditions of toilets, with a prevalence of 23.8% and 18.2%, respectively (Table 4).

Table 4. Patients' perception of their stay upon discharge after childbirth and at postnatal consultation (n = 1947 upon discharge and n = 1937 at D45).

Perception of their stay	At Exit n =1947		At D45, n =1937	
	N	%	N	%
Delivery room cleanliness				
Clean	1839	94.5	1788	92.3
Dirty	104	5.3	147	7.6
I don't know	4	0.2	2	0.1
Toilets cleanliness				
Clean	1493	76.7	1416	73.1
Dirty	454	23.3	521	26.9
Respect for privacy				
Respected	1842	94.6	1813	93.6
Not respected	105	5.4	124	6.4
Availability of health workers				
Available in the morning.	1854	95.2	1844	95.2
Available at night	1721	88.4	1699	87.7
Available on non-working days	1612	82.8	1590	82.1
Patient assessment of bedding				
Comfortable	1624	83.4	1582	81.7
Not comfortable	323	16.6	355	18.3
Level of satisfaction with patient/caregiver communication				
Very satisfactory	786	40.4	715	36.9
Satisfactory	855	43.9	856	44.2
Unsatisfactory	306	15.7	366	18.9
Availability of prescription drugs at the pharmaceutical depot				
Available	1036	53.2	992	51.2
Not available	781	40.1	786	40.6
Not available at all	130	6.7	159	8.2
Availability of paraclinical examinations				
Available	1330	68.3	1191	61.5
Limited availability	144	7.4	248	12.8
Not available at all	473	24.3	498	25.7
Catering				
Quality	1497	76.9	829	42.8
Quantity	1554	79.8	864	44.6
Hygiene	1530	78.6	856	44.2

Continued

Other good practices during your stay				
Availability/dynamism of staff	876	45	872	45
Courteous/respectful staff	654	33.6	651	33.6
Good quality of care	586	30.1	583	30.1
Free healthcare	439	22.54	437	22.54
Warm welcome	352	18.1	351	18.1
Qualified personnel	271	13.9	269	13.9
Cleanliness of the premises	257	13.2	256	13.2
Effective communication	158	8.1	157	8.1
Comfortable room	74	3.8	74	3.8
Regular inpatient care	51	2.6	50	2.6
Psychological support	14	0.7	14	0.7
None	6	0.3	00	0
Practices to improve during the stay				
Too many mosquitoes	463	23.8	525	27.1
Dirty/Pay Toilets	354	18.2	364	18.8
GEM rupture	134	6.9	213	11
Presence of animals/cats	14	0.7	4	0.2
Lack of privacy/Too many trainees	78	4	27	1.4
Lack of food catering	97	5	97	5
Lack of a bed	56	2.9	76	3.9
Long queues at checkout	282	14.5	240	12.4
Noisy premises	14	0.7	14	0.7
Dirty premises	125	6.4	161	8.3
Complexity of procedures	95	4.9	17	0.9
Insufficient communication	214	11	110	5.7
Lack of compassion and respect	84	4.3	273	14.1
None	14	0.7	10	0.5

Note: GEM: Generic essential medicines (GEM).

3.6. Level of Satisfaction

At discharge, 41.1% and 37.7% on the 45th day postpartum said they were very satisfied with their stay in the maternity ward, as shown in **Figure 2**.

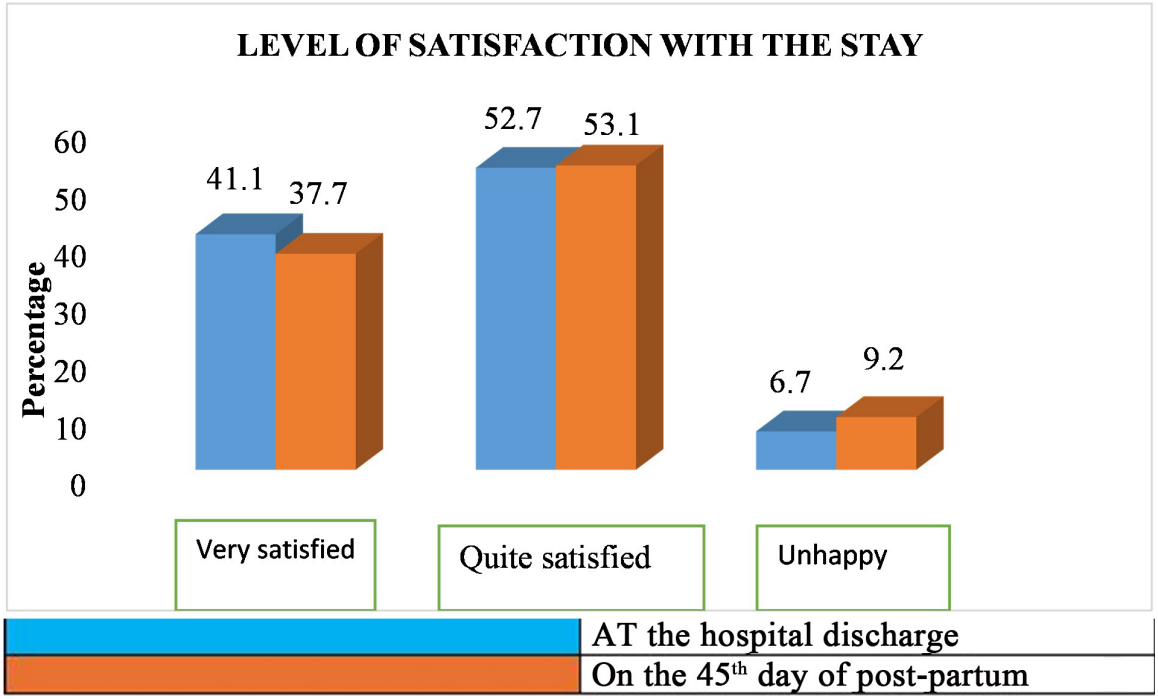

Figure 2. Overall level of satisfaction with the maternity stay (n = 1947 at discharge and n = 1937 at D45).

3.7. Assessment of the Articles of the Charter by the Investigator

Articles 5 and 7 of the Charter of Universal Rights of Women and Newborns were respected at all study sites (Table 5).

Table 5. Evaluation of the articles of the charter of universal rights of women and newborns in the study sites (n = 16).

Article	Number of respected sites	Compliance rate (%)
1	12	75
2	1	6.5
3	9	56.3
4	0	0
5	16	100
6	11	68.7
7	16	100
8	15	93.7
9	13	81.2
10	5	31.1

3.8. Acts of Non-Compliance with Charter Articles

1374 patients reported no access to food and water: Table 6.

Table 6. Breakdown of acts of non-compliance with the articles of the charter of universal rights of women and newborns in maternities.

ACT OF NON-COMPLIANCE	Number
Article 1	
Strikes	7
Slaps	5
Article 2	
Non-consensual care	32
Lack of information	107
Article 3	
No respect for privacy	118
Non-confidentiality of care	242
No respect for dignity	0
Article 4	
Yelling	52
Insults	15
Article 5	
Discrimination	0
Article 6	
Abandon	0
Refusal to provide care	14
Article 7	
Detention	0
Article 8	
Separation of the baby and its mother	3
Article 9	
Lack of identification	0
Lack of information on the chart	4
Civil status nonfunctional	53
Article 10	
No access to food and water	1347
Lack of nutritional advice	0

3.9. Factors Associated with the Level of Satisfaction with the Reception of Women Who Had Given Birth

A statistically significant relationship was found between the type of facility and the level of satisfaction with reception ($p < 0.001$), as well as between the facility level and the level of satisfaction with reception ($p < 0.001$); Table 7.

Table 7. Analysis of factors associated with the level of satisfaction of women who gave birth regarding their reception (n = 1947).

Factors	Level of satisfaction with the stay (%)			
	Unsatisfactory	Quite satisfactory	Very satisfactory	p-value
Age (years)				**0.34**
<35	70.18	71.41	75	
≥35	9.82	28.59	25	
Gravidity				**0.58**
Primigravidae	23.7	23.41	23.41	
Paucigravidae	51.49	53.03	49.62	
Multigravidae	24.81	23.56	73.02	
Employment				**0.35**
Yes	7.81	24.64	16.66	
No	92.19	75.36	83.34	
Level of education				**0.47**
Not in school	16.42	33.95	25.92	
Schooled	83.58	66.05	674.08	
Facility				**p < 0.001**
Private	2.72	16.35	80.93	
Public	4.18	51.08	44.75	
Facility level				**p < 0.001**
Level 1 (HSPC/District Hospital)	3.82	38.24	57.94	
Level 2 (RHC)	5.42	47.08	47.50	
Level 3 (UHC)	2.92	80.42	16.67	

Note: HSPC-Health and Social Promotion Center RHC-regional health center UHC-university health center.

3.10. Factors Associated with the Level of Satisfaction of Women Who Had Given Birth with Their Stay

A statistically significant relationship was found between the type of facility and the level of satisfaction during the stay ($p < 0.001$), as well as between the facility level and the level of satisfaction during the stay ($p < 0.001$); Table 8.

Table 8. Analysis of factors associated with the level of satisfaction of women who had given birth regarding their stay (n = 1947).

Factors	Level of satisfaction with the stay n (%)			
	Unsatisfactory	Quite satisfactory	Very satisfactory	p-value
Age (years)				**0.5**
<35	56.39	75.18	62.08	
≥35	43.61	24.82	37.92	
Gravidity				**0.6**
Primigravidae	41.7	30.3	41.7	
Paucigravidae	25	42.1	36.1	
Multigravidae	33.3	27.6	22.2	
Employment				**0.36**
Employee	21.19	26.04	19.22	
Self-employed	78.81	73.96	80.78	
Level of education				**0.36**
Not in school	12.28	36.89	31.65	
Schooled	87.72	63.11	68.35	
Facility				**p < 0.001**
Private	5.45	23.98	70.57	
Public	6.34	59.32	34.35	
Structural level				**p < 0.001**
Level 1 (HSPC/ District Hospital)	6.21	48.74	45.05	
Level 2 (RHC)	5.42	56.25	38.33	
Level 3 (UHC)	6.67	72.92	20.42	

Note: HSPC-Health and Social Promotion Center RHC-regional health center UHC-university health center.

3.11. Advice to New Mothers

Most patients received advice on postnatal consultation and breastfeeding, 85.3% and 57.2% of women, respectively; see Figure 3.

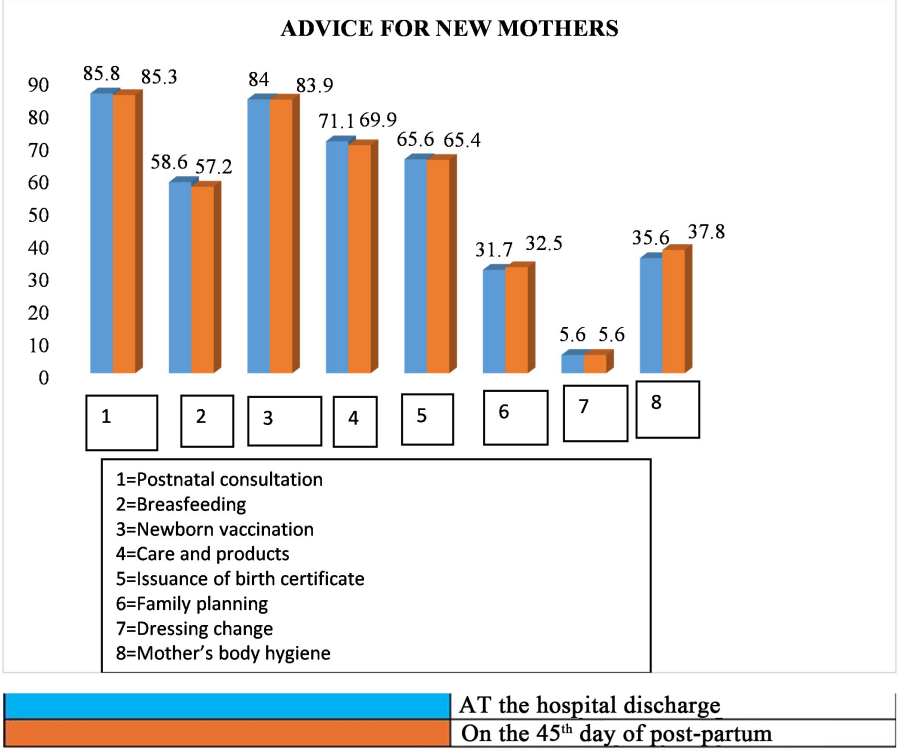

Figure 3. Distribution of advice given by health workers to women who had given birth (n = 1947 at discharge and 1937 at D45).

4. Discussion

4.1. Limits and Biases

Data collection in our study was based on patient self-reporting. The results of such a study should be interpreted considering certain potential biases, namely: interviewer bias, survey timing bias, healthcare provider bias, and the fact that the birth of a live and healthy child, which is a favorable outcome, is likely a major source of satisfaction regardless of other aspects. These may have positively influenced some responses; however, ignorance of patients' rights and responsibilities also influenced other responses.

4.2. Sociodemographic Characteristics

Most health facilities surveyed were first level (CSPS and district hospitals), which could explain why 79.7% of patients gave birth naturally. This result could also be seen as an indicator of good prenatal care. The average age of these patients was 27 years, with extremes of 15 and 45 years. The most represented age group was 20 - 24 years. These were young women, married in 78.1% of cases with a secondary level education, therefore able to answer questions objectively. This average age has not varied over the last ten years. Indeed, Ouedraogo [11] in 2017 already found identical figures over 27 years. It reflects the relatively young Burkinabe population, 77.9% of whom are under 35 years old. Women marry young, thus experiencing motherhood earlier, as described in many developing countries [12].

Pauciparity was noted in 63.5% of the study participants. However, our results are different from those of Matejić in Serbia [13], where primiparous women accounted for 51.2%.

Most of our participants were unemployed housewives, with 47.3% of cases devoting themselves entirely to raising their children. Our average was lower than that of Pathak in Nepal [14], and Bante in Ethiopia [15], who found, respectively, 63.3% and 79.3% of housewives. Our results are consistent with national data [16]. They reflect, on the one hand, the very low level of employability of women in our country, and, on the other hand, it could be a consequence of free health care making it financially accessible to pregnant women of all social classes.

4.3. Patients' Perceptions of Maternity Care

Many of our patients (61.1%) were already familiar with the delivery room. Most women in our study (96.3%) were seen for consultation within 30 minutes of their arrival at the health facility, including 82% immediately upon arrival. This result is higher than that of Ajavon in Togo, [17] which found 86.7% of patients seen within 30 minutes. Our results could be explained by our field of study, which consists of delivery rooms in maternity wards where women in labor constitute most cases in this type of unit. Due to these emergencies, waiting times will be reasonably shorter.

More than half of our patients, or 58.2%, were received by state-approved midwives (SFE). However, 32% of patients said they did not know the profile of the agent who attended them. Doumbia [18] found a lower proportion of 2% of women who said they did not know the profile of the welcoming health agent. In our context, the introduction of staff to women giving birth is often omitted due to the heavy workload. In addition, the absence of an identifying badge for all staff could be the reason. However, knowing who you are dealing with helps humanize care.

Patients positively appreciated the courtesy (83.8%) and empathy (12.1%) of health workers. Indeed, an adequate welcome and positive communication foster the establishment of a bond of trust between health professionals and women, enabling women to have the courage, self-confidence, and strength necessary to give birth normally [19]. On the other hand, Lukpata in Nigeria [20] found a prevalence of courtesy and empathy of health workers at 37.3% and 43.6%, respectively. It is therefore necessary, despite the difficulties and workload, to cultivate this courteous and empathetic attitude in the delivery room for a satisfactory outcome of childbirth.

Long waiting times were the most cited negative point by patients at reception (19.1%). These results can be explained by the "overcrowding" encountered in delivery rooms, especially in referral facilities; it can also be explained by the lack of human resources and infrastructure. Indeed, despite efforts made by the government to improve the quality and accessibility of health care for the population, it must be recognized that Burkina Faso has not yet reached the World Health

Organization (WHO) standards in terms of health personnel and infrastructure [21]. Patients therefore need to be informed verbally of the likely waiting times as soon as they arrive at the emergency room to avoid any confusion.

4.4. Patients' Perception of Maternity Stay Conditions

Most women found that the delivery room (94.5%) and the toilets (76.7%) were clean. These results are higher than those of Ajavon in Togo [17] and Senarath in Sri Lanka [22], which found a general cleanliness of the environment of 44% and 10.1%, respectively. Housekeepers recruited and paid by the municipalities or management committees (COGES) of the Health Centers are involved in the upkeep of the premises, which explains the overall patient satisfaction, although efforts are still needed to ensure irreproachable cleanliness of our health facilities.

Most patients found that health workers were available in the morning (95.2%), at night (88.4%), and on non-working days (82.8%). Communication with health workers was considered very satisfactory (40.9%) and satisfactory (40.4%). Indeed, the shortage of staff decried in many public facilities is offset by the presence of trainees from the Faculty of Medicine and the National School of Public Health in most of the facilities surveyed. We also note the efforts made by all health facilities in our series to offer continuous health care, even if staffing levels at night and on public holidays are reduced, hence these results. Communication allowed women to learn about their current health status and the results of any prescribed paraclinical examinations. In addition to the information given to the woman about her condition, this interaction with the health worker helped to convey the message about the "postpartum care package" for the mother-child couple. Thus, in our study, the majority of our patients reported receiving information on their diet and breastfeeding (58.58%), vaccination of the baby (84.04%), postnatal consultation (85.79%), care for and products to administer to the newborn (71.1%), the establishment of the baby's birth certificate (65.64%), family planning (31.71%), and dressing changes (5.63%) for women who had undergone cesarean deliveries. Our results are identical to those of Ajavon [17] who found that 70% of women had received information on warning symptoms, postnatal consultation follow-up, and hospitalization costs. Communication is an essential element of a therapeutic relationship.

Medicines were available from the department's pharmaceutical depot in 53.2% of cases. Regarding paraclinical tests, 68.3% of patients found that the tests prescribed during their stay were available. Our results are lower than those of Kanta in Mali [23], where 97.9% of medicines were available. Our results can be explained by the usual shortages of drugs observed in pharmaceutical depots of health facilities, which were likely exacerbated by the COVID-19 pandemic due to production difficulties of major pharmaceutical companies. Also, in terms of complementary examinations, some of the first-level health centers, which account for 75% in our series, do not have a medical laboratory unit.

In our series, 16.6% of women found the bedding uncomfortable, and the presence of mosquitoes and unsanitary toilets were the negative points most frequently mentioned by patients. Kam in Burkina [10] noted that 29% of patients found the bedding uncomfortable. Our results include women who found that their beds were too narrow for them and their babies, and those who, for lack of space, had settled on the floor with their newborns. Free healthcare has made a major contribution to improving the affordability of healthcare in Burkina Faso [24]; however, this high level of use may have accelerated the wear and tear of equipment and materials in health facilities, especially if there are maintenance problems.

Overall, 52.7% and 41.1% of women judged their stay at the maternity ward as satisfactory and very satisfactory respectively, for a total of 93.8%. These results are identical to those of Ajavon [17] who found a proportion of 90% and 4% of patients were respectively satisfied and very satisfied with their stay, for a total of 94%. Our results reflect the overall satisfaction expressed by parturients at reception.

4.5. Assessment of the Articles of the Charter by the Investigator

In our study on the situational analysis of the quality of care in relation to the charter of universal rights of women and newborns, we found that out of the ten (10) articles of the charter, only Articles 5 and 7 were fully implemented at all study sites.

In fact, no cases of discrimination violating Article 5 were observed. Azhar in Pakistan [25] found that 23.6% of women had experienced discrimination and 5.3% of cases of discrimination were observed. Bante [15] in Ethiopia found 87.3% of cases of discrimination. In Rosen's study, out of 9 observations made, a violation of Article 5 of the Charter was noted in all cases [26]. Burkina Faso is made up of several ethnic groups who live in harmony thanks to several social initiatives, including the promotion of "joking kinship", where humor is used to resolve social and inter-community crises, thus preserving social cohesion. This peculiarity of Burkina Faso could explain our results.

No cases of parturients being detained were observed, thus complying with article 7 of the charter. Our results are identical to those of Azhar [25] and Rosen [26]. This result could be seen as an advantage of the policy of free care for women and newborns in public facilities [5]. In private facilities, a deposit is required from clients on admission, and those who cannot pay are redirected to public facilities.

Article 1 was violated, with twelve cases of physical violence (7 cases of hitting and 5 cases of slapping). These findings included physical abuse of women and newborns (spanking for resuscitation). Pathak [14] found significantly higher rates of physical abuse, with 28 cases (18.7%) of slapping and hitting. Our findings could be explained by the effect of the researcher's observation of the provider. Qualitative studies have shown that acts of violence are considered normal by women in labor, who therefore do not consider them a violation of their rights

[27] [28]. Indeed, in Orpin's qualitative study in Nigeria, [28] women who had been victims of physical violence (slapping and hitting) did not get angry, because they considered these actions as necessarily well-intentioned on the part of professionals, in order to save their lives and that of their unborn child. Since childbirth is a painful and complex phenomenon, every woman should be treated gently and kindly, without physical violence, to facilitate her adherence to care and ensure a smooth delivery.

Article 2 of the charter was not respected in 139 cases. There were 32 cases of care without consent and 107 cases of patients who had no information about their state of health or that of their newborn. These results are higher than those of Sana [29], which recorded that 62 patients (20%) had no information about their care. In our series, the women were not told about the procedures or the course of their labor and postpartum care. They received no information on the nature of the prescribed paraclinical examinations and were not informed of their results. Some women were cared for without their consent (episiotomy, venipuncture, digital vaginal examination). It is essential to obtain consent from the mother and family during interventions, as well as to take into account the mother's choice and preference, as this helps to empower her, which has a positive influence on her.

Article 3 was not respected in terms of privacy (118 cases) and confidentiality of care (242 cases). Twenty (20) cases (5.2%) of non-confidential care were observed by Ijadunola in Nigeria [30]. Just as in the survey in Ethiopia, most of the women in our series were in common delivery rooms, without curtains to separate them, and without the possibility of private conversations. Questioning and physical examination were therefore carried out in the presence of other women. Non-confidential care constitutes an unacceptable violation of the health care code of ethics [31]. Lack of privacy can also affect breastfeeding. Indeed, after childbirth, if the mother does not enjoy sufficient privacy, skin-to-skin contact will be affected, and she will be nervous and self-conscious. Intimacy provides a favorable environment for the establishment and continuation of breastfeeding. [32]

Women were verbally assaulted in 67 cases, in violation of Article 4 of the Charter. This rate is higher than the series of Pathak [14] who found 32 cases of insults to women. Our results, however, are lower than those of Azhar [25] who reported that 208 women had experienced undignified care in maternity wards. One possible explanation could be the denial of the lack of respect by women interviewed after childbirth, to protect their self-esteem, as emphasized by Freud in his theory of defense mechanisms. Indeed, Freud explains that the normal population, when exposed to anxiety-provoking thoughts, unconsciously protects its ego and self-esteem through a mechanism of denial [33].

Article 7 of the Charter was violated when 14 women were refused care in our study. In the literature, non-compliance with this article mainly concerns cases of abandonment of women by health care providers. Thus, 4% - 5% of women in Tanzania reported giving birth alone (without medical assistance) in a health fa-

cility [26]. In our context, these were women who had not worn protective masks, and women who had consulted directly in second-or third-level health facilities. Out of respect for Burkina Faso's health pyramid, the latter were rejected by the providers. No woman should be refused maternity care for any reason whatsoever, as this could have very serious consequences for her and her unborn child.

Article 8 was not respected for 3 women, whose babies were transferred to the neonatal unit without their knowledge. Separation has a negative impact on the mother, preventing her from establishing early breastfeeding. On the other hand, being with the child after delivery can help establish a bond that stimulates oxytocin and improves breastfeeding [32].

Article 9 was not complied with 57 times: 4 cases of failure to provide information on the establishment of the newborn's birth certificate, and 53 cases where the child's birth certificate could not be established due to the non-functionality of the civil registry. Failure to register birth is a violation of the child's inalienable right to an identity from birth and to be considered a member of society [34]. With a national birth registration rate of 77.8%, Burkina Faso has made considerable progress in recent years. But glaring disparities remain between urban areas, where more than 9 out of 10 children are registered at birth (96.5%), compared to 7 out of 10 (74.7%) in rural areas [35].

Article 10 of the charter was not respected for 1,347 women. Almost all first-level health facilities, except for a few private health facilities, do not offer meals to their clients. The catering services at some health facilities were unable to meet the demand of all patients. As a result, some patients ate food from elsewhere without being able to check its quality. In all cases, nutritional advice was given to postpartum women to ensure a balanced, rich, and varied diet once they returned home.

4.6. Factors Associated with the Level of Patient Satisfaction in Maternity Wards

4.6.1. At Reception

A statistically significant relationship was highlighted between the level of satisfaction with reception and the facility type and level ($p < 0.001$). In fact, 80.93% of patients consulting in the private sector said they were very satisfied with the reception, compared to 44.75% in public establishments. Our results are consistent with those of Okumu in Kenya [36] who found that 63.9% of women were very satisfied with their reception in the private sector compared to 53.2% in the public sector. Lukpata [20] in a qualitative study on "the satisfaction of maternity clients with the client-care provider interaction in public secondary health establishments in Cross River State in Nigeria" concluded that the elements that had a significant impact on good perception of reception by women were politeness, tone of voice, sympathy, and support; however, the lack of respect shown by health care providers in that study was linked to the work overload of health professionals in public health institutions, influenced by cost-free

maternal health services.

The level of satisfaction with reception was inversely proportional to the level of the facility. Thus, the satisfaction rate was 84.66% for the first level, 47.50% for the second, and 16.67% for the third. The workload is inversely proportional to the level of care; moreover, the first level facilities receive complicated cases, with already stressed patients, and this could alter the interpersonal relationship.

4.6.2. During the Stay

A statistically significant relationship was found between the type and level of health facility and level of satisfaction with stay ($p < 0.001$). In our study, 70.57% of women were very satisfied with their stay in private health facilities compared to 34.35% in public facilities. Our results are lower than those of Okumu [36], who found 98% of patients satisfied with their stay in private health centers compared to 96% in public facilities. In addition to the fact that the conditions of stay are often better in private than public facilities, the quality of the interaction between healthcare staff and patients could have had an impact on our observed results. Indeed, the heavy workload and lack of staff in public facilities could have altered the quality of time spent with patients, as well as the patient/caregiver interaction.

5. Conclusion

The majority of patients were satisfied or very satisfied with their stay at the maternity ward. The availability, dynamism, and courtesy of the nursing staff were positively appreciated by women who had just given birth. However, some areas of dissatisfaction were noted, highlighting numerous inadequacies and a significant gap between the healthcare provided in our maternity wards and the Charter of Universal Rights for Women and Newborns.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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