Respectful maternity care: Disconnect between perspectives and practices of midwives from a referral hospital in Kampala, Uganda.

Monicah Andru
Muni University
Connie Olwit
Makerere University College of Health Sciences
Charles Peter Osingada
Makerere University College of Health Sciences
Allen Nabisere
Makerere University College of Health Sciences
Elizabeth Ayebare
Makerere University College of Health Sciences
Scovia Nalugo Mbalinda (snmbalinda@gmail.com)
Makerere University https://orcid.org/0000-0002-4945-130X

Research article

Keywords: Respectful Maternity Care, Maternity Services, Midwives, Perspectives, Practices

Posted Date: November 9th, 2020

DOI: https://doi.org/10.21203/rs.3.rs-103170/v1

Abstract

Introduction: Disrespectful and undignified care during childbirth is a global challenge, particularly in less developed countries. Despite the increase in health facility births, women continue to suffer from disrespect and abuse during childbirth. This practice counters the efforts to encourage women to deliver in health facilities by a skilled birth attendant as a strategy to reduce maternal and neonatal mortality. The purpose of the study was to explore midwives' understanding of respectful maternity care and observe how their practice conforms to this concept.

Methods: We conducted a qualitative study combining one-on-one interviews and observation methods of data collection. In-depth interviews were conducted with 17 midwives and 20 observations were done. Audio-recorded data were later transcribed verbatim and analyzed using the content analysis method. Observation data was summarized into a table 2 below.

Results: Midwives understood respectful maternity care (RMC) as treating women with respect, dignity, politeness, providing information to clients, and ensuring privacy and confidentiality. However, there was a discrepancy between their understanding of RMC and what they practiced. They also lacked an in-depth understanding of the domains of RMC.

Conclusion: There is a need to strengthen midwife's knowledge and skills to enable them to provide respectful maternity services. We recommend in-service training and mentoring to equip midwives with knowledge and skills to offer RMC. Also, RMC should be integrated into pre-service curricula for midwifery and nursing training in Uganda. Furthermore, efforts should be put in to strengthen health systems, and support healthcare providers to provide RMC. More research is needed into locally relevant solutions to promote respectful maternity care.

Introduction

Globally, maternal mortality declined by 35% from 2000 to 2017[1]. However, Sub-Saharan Africa and Southern Asia continue to be the most affected regions contributing about 86% of the global maternal deaths in 2017 [1]. The above global reduction in maternal mortality is partly due to the increase in skilled birth attendance, mostly from low-income countries [2–4]. Despite this impressive progress, in both high income and low resources settings, pregnant women continue to suffer from disrespect and abuse during childbirth, and this is countering efforts to encourage pregnant women to give birth in health facilities under the care of a skilled birth attendant [5–7]. The World Health Organization recommends respectful maternity care (RMC) 'which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth [8]. Respectful maternity care is an essential dimension of quality of health care that ensures practice that aligns with international human rights standards [9] and the universal rights of women and new-borns as outlined in the respectful maternity care charter [10].

In the past decade, disrespect and abuse during childbirth have attracted a lot of scholarly interest globally. Several studies have described various forms of disrespectful and abusive care experienced by women during childbirth. These include physical and verbal abuse [11–14], stigma and discrimination[15], and neglect and abandonment [16]. Most studies in this field focused on experiences and perspectives of women, their partners, community members, and health providers [11, 17–22]. Recently a few observational studies [7, 23–25] have been conducted to examine the practice of health professionals concerning RMC.

While Uganda has made significant progress in maternal health care, with 73% deliveries occurring in a health facility and 74% birth being attended by a skilled person, there is certainly room for more improvement[26]. Previous studies report that fear of being neglected or maltreated by health workers [27], high level of verbal abuse and poor communication [28] are some of the barriers that deter women from attending public health facilities in Uganda and this negatively impact access to skilled birth attendance. To address these challenges and start the journey to a positive childbirth experience [8] for Ugandan women, it is vital to examine midwives' understanding of RMC. The purpose of the study was to explore midwives' understating of respectful maternity care and observe how their practice conforms to this concept.

Methods

Study design

This was a qualitative study combining one-on-one interviews and observation methods of data collection.

Study setting

The study was conducted in in a referral hospital in central Uganda. According to the Human Resource records of the hospital in 2019, the hospital employed a total of 280 midwives working in different areas of maternity care. Twenty-eight midwives were allocated in the public labor ward where the study was conducted. This labor ward has an average of 50 births daily. .

Study population

The participants were midwives working in the labor ward at the time of the study. Midwives working in the labor ward who were either on leave during data collection or did not consent were excluded from the study.

Sample size

Twenty-five midwives were approached and 20 of them agreed to participate in the study. Data saturation was achieved after interviewing 17 midwives and therefore three of those who consented were not interviewed. For the observations, all the 20 midwives who consented were observed providing care to women during labour and childbirth.

Data collection process

We used convenience sampling to select study participants who were available and could describe their perspectives. A list of midwives working in the labour ward and their contacts, cadres, and years of experience was obtained. The midwives were called by phone and invited for a meeting to talk about the study. During the meeting, the midwives were given details regarding the study and written informed consent was obtained from 20 midwives who were willing to participate in the study. After consent, an interview date and time was scheduled according to participant's convenience. All interviews were conducted by M.A. in English using an in-depth interview guide. Interviews were conducted in a quiet room at the facility and audio recorded. The interview guide contained closed-ended questions that were used to collect sociodemographic characteristics, and open-ended questions to assess; 1) understanding of RMC (What does respectful maternity care mean to you?), 2) enablers (In your unit, what things help you to provide RMC to women during childbirth?) and 3) barriers (What things hinder midwives from providing respectful maternity care as you have described above?) to RMC provision. Probes were used to generate more in-depth information from the participants on specific issues of interest.
An observational checklist was developed from the RMC typology as described by Bowser and Hill [30]. This framework has seven domains of RMC namely; 1)non- abusive care, 2) consented care, 3) dignified care, 4) confidential care, 5) non-discriminative, 6) continuity of care and 7) non-detention at the health facility due to lack of funds.. The domain of non-detention at the health facility was not included because the study was conducted in a public health facility where care is free of charge.

The observers were two midwives working at a different unit within the hospital. The observers were trained to use the observational checklist and encouraged to write field notes of actions that were not captured to give a clear picture of events. The participants were observed providing care to one mother from the time of admission until childbirth. The observer did not participate in any of the caregiving activities. During the initial assessment of the mother, some of the actions observed included; whether the midwife greeted the woman in a respectful manner, encouraged her to have a support person present, explained procedures before proceeding, informed woman of findings, and asked if she had any questions. While during labour and child birth, observers looked to see if; the midwife explained what would happen during labor to the woman, encouraged the woman to consume food or drinks, encouraged or assisted the client to ambulate and assume different positions, and supported the woman in a friendly way and draped her during delivery. At the end of each observation, observers recorded open-ended comments about the quality of care observed and any other important observation to enhance the understanding of some of the answers in the checklist.

Data management and analysis

Data analysis began from the point of data collection and followed a detailed process. The audio-recorded interviews were transcribed verbatim. The transcripts were checked against audio recordings to ensure no information was missed out during transcription. The interview transcripts were printed out for ease of analysis. Transcripts and audio versions of the data were stored on a password-protected computer and were available to only the research team members. Content analysis by Shannon, 2005

[29] was used to analyse data from the in-depth interviews manually. The interview transcripts were read and re-read by the first four authors to independently come up with codes. There was constant comparison of codes among the four authors. Where there was disagreement, the coders re-read transcripts, reflected on the meaning units to agree on the codes. The codes were then categorized according to their similarities and differences. Bowser and Hill RMC typology was used to arrange the categories into themes[30].

For the observations, both the checklist observations and the written notes were mapped onto the thematic areas of RMC from the interviews.

Ethical considerations

Ethical approval to conduct the study was obtained from Makerere University, School of Health Sciences, Research and Ethics Committee (SHSREC: 2018-051). Administrative clearance was obtained from the Research Ethics Committee of the referral hospital (MHREC: 1550) and the hospital. Permission was also sought from the ward in-charge of the public labor ward for data collection. Written informed consent was obtained from the mothers and the midwives. Participation was voluntary and all the interviews were conducted in private settings to ensure participant's confidentiality and using serial numbers as identifiers for the transcripts and observations

Results

Socio-demographic characteristics of participants

The average age for the study participants was 34 years. Nine participants were Anglicans by religion and Baganda by the tribe. More than half of the participants had a diploma in midwifery qualification. The average years of experience were 11 years. Details of sociodemographic characteristics are presented in Table 1 below.

Table 1
Sociodemographic information of study participants

No	Tribe/Ethnicity	Age (years)	Experience (years)	Religion	Highest education Attained
01	Muganda	45	17	Protestant	Diploma in Nursing/Midwifery
02	Muganda	37	13	Catholic	Diploma in Midwifery
03	Muganda	23	2	Protestant	Certificate in Midwifery
04	Alur	41	14	Protestant	Diploma in Midwifery
05	Muganda	34	10	Moslem	Diploma in Midwifery
06	Muganda	35	12	Protestant	Diploma in Midwifery
07	Langi	26	2	Catholic	Certificate in Midwifery
08	Musoga	44	20	Catholic	Diploma in Midwifery
09	Muganda	45	22	Protestant	Diploma in Midwifery
10	Lugbara	39	14	Catholic	Diploma in Midwifery
11	Muganda	23	2	Protestant	Certificate in Midwifery
12	Munyankole	42	12	Protestant	Diploma in Midwifery/ BScN
13	Mukiga	23	2	Protestant	Diploma in Midwifery
14	Munyankole	23	2	Protestant	Certificate in Midwifery
15	Munyankole	35	5	Catholic	Diploma in Midwifery
16	Muganda	41	15	Catholic	Diploma in Midwifery/ BScN
17	Muganda	25	4	Catholic	Diploma in Midwifery/ BScN

Theme 1: Midwives' understanding of RMC.

Midwives understood RMC in various ways. They viewed RMC as respectful and ethical interactions or relationships between the woman and the midwife. This relationship was reported to start right from antenatal through labor until the postpartum period.

“I look at respectful maternity care as inter-relationship between mother and midwife in an ethical form where a midwife considers the mother's rights." IDI, participant 13.

"It would mean the relationship and interaction between a midwife and the mother who is pregnant from the time the mother has conceived, during antenatal, during labour, and after delivery." IDI, participant 1.

Non-abusive care

Participants did not regard non-abusive care as part of RMC. In the in-depth interviews, none of the participants articulated non-abusive care as one of the components of RMC. The kind of physical abuse noted during the observation part of the study is, therefore, not surprising. For example, a midwife was observed slapping a woman for not complying with instructions, another midwife sutured a tear without giving lignocaine, and another one performed an episiotomy without local anesthesia. In yet another incident, a midwife was seen piercing a woman's thighs with the suturing needle. These are incidences that indicate abuse of women's right to freedom of harm and ill-treatment during the process of delivery.

Consented care

Participants understood consented care as providing women with information about what was going to be done as well as an explanation of the process of labor. This is evidenced in the quotes below.

"At the same time, you let her introduce herself to you. Then you tell her about what is going to happen, all the process (detailed information)." IDI 12

"Explaining everything to the mother, giving full information about labor process." IDI participant 13

Participants' understanding of consented care was validated during observations as midwives were seen providing information to the clients in an open and friendly way. They also encouraged clients to ask questions. However, consented care, as defined in the literature, is beyond just providing information; it includes aspects such as seeking permission and consent for procedures such as vaginal examinations, episiotomy, cesarean section, and other procedures. The latter conceptualization of consented care was barely observed from the participants of this study (refer to Table 2 for more details).

Table 2
Observations using checklist

Midwives' actions	Frequency (%) N = 20
Greets mother in a respectful manner	7 (25.5)
Encourages client to have a support person	12 (65)
Explains procedures before proceeding	3 (15)
Informs client of finding	4 (20)
Asked woman if she had any questions	1 (10)
Midwife explains what will happen during labour to woman	1 (5)
Midwife encourages woman to consume food and fluids during labour	17 (85)
Midwife encourages or assists mother to ambulate and assume different labour positions	14 (70)
Whether the midwife used a partograph for monitoring labour	0 (0)
Midwife supports mother in a friendly way during labour	7 (35)
Midwife drapes client before delivery	4 (20)
Midwife applies active management of third stage of labour	15 (75)
Midwife applies the immediate essential new born practices	18 (90)
Midwife screens for complications in both mother and baby	18 (90)

Confidential care

The participants in this study had a general understanding of what confidential care is, as illustrated by the quotes below.

"If she has come in labor, provide confidentiality, privacy so that she feels comfortable to open up about her issues." IDI participant 12

"A spacious room with privacy enables me to provide respectful maternity care." IDI, participant 10.

However, structural and system factors seemed to impede the provision of confidential care. From the observations, the delivery rooms had no curtains or screens to provide privacy to mothers during labor. Besides, the labor ward set up was in such a way that a midwife would be overheard by others while communicating with a mother, which violates confidentiality.

Dignified Care

Midwives described dignified care as treating clients with respect, humility, and politeness. They believed in building friendly relationships with clients through creating rapport and showing understanding and tolerance while interacting with women, especially during labor. Others described it as making mothers feel comfortable, for example, by providing a bed and reassurance. These descriptions are captured in the quotes below.

"If she has come in labor, welcome her, greet her, and introduce yourself to her and let her introduce herself to you so that she feels comfortable to open up about her issues." IDI, participant 9.

"RMC is the care the midwife gives to a mother that involves respect, humility, and politeness… During labor and delivery, these mothers come in pain; they can say anything or behave in any way, so they need to be understood." IDI, participant 7.

However, during the observations, midwives depicted both positive and negative aspects of dignified care they described above. Some midwives were calm and friendly while interacting with the mothers. They greeted mothers at arrival, listened, and supported them during labor. On the other hand, other midwives were not respectful. They were rude as they scolded, shouted, and ignored mothers when they needed help. In some instances, midwives were not patient and had a negative attitude towards mothers.

"If you do not want to be repaired, I don't care. It is your marriage that will break. (Midwife yelled)" Direct observation 2

"I don't have time to wait for slow people like you, let me leave you to take your time (The midwife called in another client for examination and left the mother waiting)." Direct observation 1

Non-discriminative care

Only one midwife described this domain. She viewed RMC as providing non-discriminatory care, where all mothers can get equal treatment. This is illustrated in her quote below.

"When mothers come in labor, I should not segregate them by tribe, religion, or anything." IDI, participant 15

During the direct observation, mothers were treated on a first-come, first-serve basis. However, when there was a shortage of supplies at the labor ward, the mothers who could not afford to buy the supplies had delayed or did not receive care

Continuity of care

Midwives also viewed RMC as being able to document and monitor mothers and babies during care. The midwives emphasized the importance of being knowledgeable, having tools to monitor mothers, and the

ability to provide timely collaborative care. They pointed out the willingness and availability of other health workers as critical to delivering RMC.

"*….it is proper monitoring of mother and baby's condition during labour using a partograph, and proper documentation; in case of deviation from normal, the doctor is informed timely so that appropriate action can be taken to save the mother and the baby on time." IDI, participant 15.*

As much as midwives mentioned monitoring mothers using partographs during labor, none of them was observed using a partograph. There was also a delay in delivery of care whereby a midwife delayed preparing a mother for cesarean section after a decision had been made and another one delayed to identify the need for resuscitation for a newborn (refer to Table 2).

Theme 2: Barriers to respectful maternity care

Midwives mentioned potential barriers to RMC provision such as; shortage of staff, lack of equipment, sundries, and medicine, inadequate resources, low salaries, client-related factors, knowledge gap, and lack of teamwork. The sshortage of staff, for instance, leads to working for long hours, which compromises their ability to provide RMC.

"Shortage of staff; you find that in our labor ward, midwife to mother ratio is 1midwife: 20 mothers. Remember, we work from 8.00 am to 8.00 pm, this becomes so distressing." IDI, participant 7.

"*When you are exhausted, you cannot be able to give proper care; that is, you will not explain procedures to the mother, and she may refuse to be worked upon." IDI, participant 14.*

Midwives also said that lack of equipment, sundries, and medicine hinders the provision of quality and dignified care.

"….there are no sundries in the hospital, and so I have to ask mothers to provide, and sometimes they do not have money, or they may just keep silent because of pain. This makes the midwife change colors (become angry) and tone of voice due to anger and ends up barking at the mothers." IDI, participant 6.

According to midwives, the health facility did not provide adequate space for private and confidential care.

"… every patient has a right to privacy, but for the case of our labor ward; its setup, it's very difficult for a midwife to maintain privacy." IDI, participant 2.

Low salaries also demotivate midwives, which compels them to get other jobs. So that by the time they report for duty, they are exhausted and may not be able to provide RMC.

"*…due to the little salary, you may opt to get a part-time job so that you increase on your income, by the time you come from the part-time job you are already tired, which will make you have a bad attitude towards the mothers." IDI, participant 15.*

The other barrier cited by participants was the inability to communicate to clients due to challenges such as language, deafness, and mental illness.

"At times, it could be due to language barrier or physical impairment such as the deaf and the dumb who cannot speak hindering midwives from offering RMC. Sometimes midwives receive mentally ill women who cannot understand any explanations hence becoming uncooperative." IDI, participant 16.

Some participants stated that negative attitudes of clients towards midwives make them uncooperative, which hinders the provision of RMC.

"*Some of the clients themselves have a poor attitude towards the midwives, and this makes them uncooperative. When a mother is biased on a midwife, she will do the opposite of what you instruct her to do." IDI, participant 12.*

Midwives cited the knowledge gap as a barrier to providing RMC. According to the participants, the lack of continuous professional development has contributed to the knowledge gap on the current standard of practice.

"..., lack of Continuing Medical Education (CME), because if we had CMEs, they would keep on reminding us of what to do; we could not forget what we are supposed to do. However, you find that it takes too long to have them, and when they plan for them, very few people attend because if we are three on duty, how will we separate ourselves, and yet we have four stations in the labor ward." IDI, participant 6.

Findings from the observational checklist

Findings from the observational checklist were tabulated with frequency and percentage and are presented in Table 2 below. The actions of respectful maternity care performed by majority of participants were; encouraging the mother to have a support person (12/20), encouraging mothers to consume foods and drinks (17/20) and assisting the mother to ambulate or assume different positions during labor (14/20). On the contrary, use of the partograph to monitor the progress of labor (0/20), explaining what will happen in labor to the mother (1/20), asking the mother if she has questions (1/20), and explaining procedures before performing them were least done by the participants (3/20).

Discussion

The aim of this study was to assess the perspectives and practices of midwives concerning respectful maternity care (RMC). We found that participants in this study did not have a solid understanding of the concept of RMC. Findings from in-depth interviews reflected a shallow understanding of the various domains of RMC, as presented by Bowser and Hill[30]. In several domains, there was a disconnect between what the participant mentioned and the observed practice. Moreover, analysis of the interviews did yield content that reflected participants' understanding of non-abusive care as a domain of RMC.

From interviews, midwives described consented care as giving detailed information to mothers in a friendly way, explaining each procedure performed, and providing feedback. However, during the

observations, only a few participants were seen doing what they had stated in the interviews. It was observed that most midwives did not seek consent before performing procedures such as episiotomies and vaginal examinations. This finding is consistent with what has been observed in other studies. For example, Bohren and colleagues found that many women had not consented to episiotomies and cesarean section despite receiving the procedure[7]. In another study conducted in Tanzania, many participants narrated experiences of forceful vaginal examinations which were conducted without seeking consent[31]. These findings highlight practice that is inconsistent with the human rights approach that requires effective and proper application of informed consent during childbirth, there is a need to change practice to respectful and acceptable ways[32].

In this study, non-abusive care as a domain of RMC did not emerge from the analysis of the interviews conducted. It was, therefore, not surprising that some of the participants were observed verbally and physically abusing women during childbirth. Some midwives were seen suturing women without lignocaine, slapping, or piercing a woman's thighs. In other cases, participants were rude to patients, and others scolded or shouted at the women. These findings confirm reports from earlier studies conducted in Uganda[14, 28]. Similar instance of poor communication between health providers and women, as well physical abuse, are common occurrences in other African countries [7, 23, 33, 34]. The widespread nature of the phenomenon of disrespect and abuse of women during childbirth does seem to suggest deep-rooted structural and socio-cultural challenges inherent in many societies. Thus, remedying it may require examining what Sen and colleagues call the drivers of disrespect and abuse in childbirth, which are intersecting social and economic inequality, and the institutional structures and processes that frame health practice[35].

We found that the participants from this study generally appreciated the need to provide confidential and private care as a requirement for RMC. However, structural and system factors such as lack of screens and curtains impeded their ability to provide RMC. This finding resonates with those from a study conducted in Iran[36] agrees with what has been reported in other African countries[21]. Indeed, several studies have pointed out the lack of adequate supplies, poor staff remuneration and shortages, and structural and institutional bottlenecks as majors challenges that hamper the provision of respectful maternal care[7, 27, 33, 37, 38]. Therefore, addressing disrespect and abuse will require system-wide efforts that support healthcare providers to deliver RMC. There is a need to structure health systems in a way that promotes respectful maternity care[39], and this will require enormous investment.

Only one participant mentioned non-discriminatory care as an important aspect of RMC. However, we observed that clients were treated on a first-come-first-served basis. Nevertheless, there were incidences when care was delayed or missed because the patient was unable to provide the supplies that she was required to buy. This system related problem may result in discrimination based on financial grounds, which undermines trust and provision of quality care. The study site was a government-aided facility that provides services free of charge, and most clients come expecting free services. Therefore, being asked to buy what you expect to find in the health facility is psychologically distressing and discourages future visits to public health facilities.

Study limitations

The midwives were aware that they were being observed, and some could have modified their interaction with women according to what is expected. However, efforts were put in to reduce modification of behavior for example, midwives were not aware of what topics and items were on the checklists, and observers were recruited from other units other than general labor ward to minimize the effect of personal and professional relationships. This study reports both respectful and non-respectful maternity care which requires change and maintaining some elements for quality delivery of maternity services.

Conclusions And Recommendations

Midwives understood respectful maternity care (RMC) as treating women with respect, dignity, politeness, providing information to clients, and ensuring privacy and confidentiality while providing care. However, there was a discrepancy between their understanding of RMC and what they practiced. They also lacked an in-depth understanding of the domains of RMC. We recommend in-service training and mentoring to equip midwives with knowledge and skills to provide RMC. Also, RMC should be integrated into pre-service curricula for midwifery and nursing training in Uganda. Also, efforts should be taken to strengthen health systems, and healthcare providers should be supported to provide respectful maternity care. More research is needed for locally relevant solutions to promote respectful maternity care.

Abbreviations

D&A: Disrespect & Abuse

EM: Enrolled Midwife

IDI: In-depth Interviews

ICM: International Confederation of Midwives

PMTCT: Prevention of Mother to Child Transmission of HIV

PNC: Postnatal care

RM: Registered Midwife

RMC: Respectful Maternity Care

SBA: Skilled Birth Attendant

UNFPA: United Nations Fund for Population Activities

UNICEF: United Nations Children Fund

WHO: World Health Organization

WRA: White Ribbon Alliance

Declarations

Ethics approval and consent to participate

Ethical approval to conduct the study was obtained from Makerere University, School of Health Sciences, Research and Ethics Committee (SHSREC: 2018-051). Administrative clearance was obtained from the Research Ethics Committee of the referral hospital (MHREC: 1550) and the hospital. Permission was also sought from the ward in-charge of the public labor ward for data collection. Written informed consent was obtained from the mothers and the midwives. Participation was voluntary and all the interviews were conducted in private settings to ensure participant's confidentiality and using serial numbers as identifiers for the transcripts and observations

Consent for Publication

Not applicable

Availability of data and material

The datasets used and /or analyzed during the current study are not publicly available due to some privacy reason, but are available from the corresponding author on reasonable request.

Competing interests

The author(s) declare that they have no competing interests.

Funding

The work was supported by Grant Number D43TW010132 supported by Office of the Director, National Institutes of Health (OD), National Institute Of Dental & Craniofacial Research (NIDCR), National Institute Of Neurological Disorders And Stroke (NINDS), National Heart, Lung, And Blood Institute (NHLBI), Fogarty International Center (FIC), National Institute On Minority Health And Health Disparities (NIMHD). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the supporting offices.

Research reported in this publication was supported by the Fogarty International Center of the National Institutes of Health under Award Number 1R25TW011213. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Authors' contributions

MO designed the study, collected and analysed the data, drafted the paper; CO contributed to the design of the study, analysed the data, drafted the paper and reviewed the paper. CPO contributed to the design of the study, analysed the data, drafted the paper and reviewed the paper; AN contributed to the analysis and reviewed the paper; EA contributed to the reviewed the paper and SNM drafted the paper and reviewed the paper.

Acknowledgments

The authors would like to thank Midwives and the health we collected data and the research assistants and the funders for this work.

References

1. WHO. Trends in maternal mortality: 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization. 2019. https://apps.who.int/iris/handle/10665/327595
2. Moyer CA, Adanu RM, Engmann CM. The relationship between facility-based delivery and maternal and neonatal mortality in Sub-Saharan Africa. Int J Gynecol Obstet. 2013;122:263–5. doi:10.1016/j.ijgo.2013.04.010.
3. Montagu D, Sudhinaraset M, Diamond-Smith N, Campbell O, Gabrysch S, Freedman L, et al. Where women go to deliver: Understanding the changing landscape of childbirth in Africa and Asia. Health Policy Plan. 2017;32:1146–52. https://doi.org/10.1093/heapol/czx060
4. Doctor H V., Nkhana-Salimu S, Abdulsalam-Anibilowo M. Health facility delivery in sub-Saharan Africa: Successes, challenges, and implications for the 2030 development agenda. BMC Public Health. 2018;18:1–12. https://link.springer.com/article/10.1186/s12889-018-5695-z
5. Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Health. 2019;16:1–18. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2?utm_source=miragenews&utm_medium=miragenews&utm_campaign=news
6. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. Int J Gynecol Obstet. 2015;128:110–3. https://doi.org/10.1016/j.ijgo.2014.08.01
7. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. Lancet. 2019;394:1750–63. https://doi.org/10.1016/S0140-6736(19)31992-0
8. WHO. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO. 2018.

9. Khosla R, Zampas C, Vogel JP, Bohren MA, Roseman M, Erdman JN. International human rights and the mistreatment of women during childbirth. Health Hum Rights. 2016;18:131–43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5394989/
10. WRA. Respectful Maternity Care Charter: Universal Rights of Women and Newborns. 2019.https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-019-2189-7
11. McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RNM, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. BMC Pregnancy Childbirth. 2014;14:1–13. https://link.springer.com/article/10.1186/1471-2393-14-268
12. Moyer CA, Adongo PB, Aborigo RA, Hodgson A, Engmann CM. "They treat you like you are not a human being": Maltreatment during labour and delivery in rural northern Ghana. Midwifery. 2014;30:262–8. doi:10.1016/j.midw.2013.05.006.
13. Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D. Exploring inequalities in access to and use of maternal health services in South Africa. BMC Health Serv Res. 2012;12. https://link.springer.com/article/10.1186/1472-6963-12-120
14. Atuyambe L, Mirembe F, Johansson A, Kirumira EK, Faxelid E. Experiences of pregnant adolescents - Voices from Wakiso district, Uganda. Afr Health Sci. 2005;5:304–9. https://www.ajol.info/index.php/ahs/article/view/6969
15. Davies MM, Bath PA. The maternity information concerns of Somali women in the United Kingdom. J Adv Nurs. 2001;36:237–45. https://doi.org/10.1046/j.1365-2648.2001.01964.x
16. Chadwick RJ, Cooper D, Harries J. Narratives of distress about birth in South African public maternity settings: A qualitative study. Midwifery. 2014;30:862–8. doi:10.1016/j.midw.2013.12.014.
17. Bohren MA, Vogel JP, Tunçalp Ö, Fawole B, Titiloye MA, Olutayo AO, et al. "By slapping their laps, the patient will know that you truly care for her": A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria. SSM - Popul Heal. 2016;2:640–55. doi:10.1016/j.ssmph.2016.07.003.
18. Balde MD, Diallo BA, Bangoura A, Sall O, Soumah AM, Vogel JP, et al. Perceptions and experiences of the mistreatment of women during childbirth in health facilities in Guinea: a qualitative study with women and service providers. Reprod Health. 2017;14:1–13. doi:10.1186/s12978-016-0266-1.
19. D-Zomeku VM, Mensah BAB, Nakua EK, Agbadi P, Lori JR, Donkor P. Exploring midwives' understanding of respectful maternal care in Kumasi, Ghana: Qualitative inquiry. PLoS One. 2020;15:e0220538. doi:10.1371/journal.pone.0220538.
20. Bradley S, McCourt C, Rayment J, Parmar D. Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. Reprod Health. 2019;16:1–16.https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0773-y
21. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. BMC Pregnancy

Childbirth. 2017;17:1–14.https://link.springer.com/article/10.1186/s12884-017-1442-1

22. \Rominski SD, Lori J, Nakua E, Dzomeku V, Moyer CA. When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out: Justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. Health Policy Plan. 2017;32:215–24.https://doi.org/10.1093/heapol/czw114
23. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, et al. Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy Childbirth. 2015;15:1–11.https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4?optIn=false
24. Dey A, Shakya HB, Chandurkar D, Kumar S, Das AK, Anthony J, et al. Discordance in self-report and observation data on mistreatment of women by providers during childbirth in Uttar Pradesh, India Prof. Suellen Miller. Reprod Health. 2017;14:1–13.https://link.springer.com/article/10.1186/s12978-017-0409-z
25. Sethi R, Gupta S, Oseni L, Mtimuni A, Rashidi T, Kachale F. The prevalence of disrespect and abuse during facility-based maternity care in Malawi: Evidence from direct observations of labor and delivery. Reprod Health. 2017;14:1–10. https://link.springer.com/article/10.1186/s12978-017-0370-x
26. UBOS & ICF. Uganda Bureau of Statistics (UBOS) and ICF. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF. 2018.https://link.springer.com/article/10.1186/s12936-019-2883-y
27. Anastasi E, Borchert M, Campbell OMR, Sondorp E, Kaducu F, Hill O, et al. Losing women along the path to safe motherhood: Why is there such a gap between women's use of antenatal care and skilled birth attendance? A mixed methods study in northern Uganda. BMC Pregnancy Childbirth. 2015;15:1–15. doi:10.1186/s12884-015-0695-9.
28. Ackers L, Webster H, Mugahi R, Namiiro R. What price a welcome? Understanding structure agency in the delivery of respectful midwifery care in Uganda. Int J Heal Gov. 2018;23:46–59. https://www.emerald.com/insight/content/doi/10.1108/IJHG-11-2017-0061/full/html?fullSc=1&mbSc=1
29. Shannon SE. Three Approaches to Qualitative Content Analysis. 2005;15:1277–88.https://journals.sagepub.com/doi/abs/10.1177/1049732305276687
30. Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a landscape analysis. Washington (District of Columbia); 2010.https://www.ghdonline.org/uploads/Respectful_Care_at_Birth_9-20-101_Final1.pdf
31. Solnes Miltenburg A, van Pelt S, Meguid T, Sundby J. Disrespect and abuse in maternity care: individual consequences of structural violence. Reprod Health Matters. 2018;26:88–106.doi.org/10.1080/09688080.2018.1502023
32. UN. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.

2019.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348458/

33. Mselle LT, Moland KM, Mvungi A, Evjen-Olsen B, Kohi TW. Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania at Comprehensive Community Based Rehabilitation in Tanzania and Temeke hospitals in Dar es Salaam, and Mpwapwa district in Dodoma region. 2013.http://www.biomedcentral.com/1472-6963/13/174.
34. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLoS One. 2017;12:1–17.https://doi.org/10.1371/journal.pone.0174084
35. Sen G, Reddy B, Iyer A. Beyond measurement: the drivers of disrespect and abuse in obstetric care. Reprod Health Matters. 2018;26:6–18.https://doi.org/10.1080/09688080.2018.1508173
36. Moridi M, Pazandeh F, Hajian S, Potrata B. Midwives' perspectives of respectful maternity care during childbirth: A qualitative study. PLoS One. 2020;15:1–12. doi:10.1371/journal.pone.0229941.
37. Mselle LT, Kohi TW, Dol J. Barriers and facilitators to humanizing birth care in Tanzania: Findings from semi-structured interviews with midwives and obstetricians Prof. Suellen Miller. Reprod Health. 2018;15:1–10.https://link.springer.com/article/10.1186/s12978-018-0583-7
38. Rahmani Z, Brekke M. Antenatal and obstetric care in Afghanistan - A qualitative study among health care receivers and health care providers. BMC Health Serv Res. 2013;13.https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-166
39. Bohren MA, Tunçalp Ö, Miller S. Transforming intrapartum care: Respectful maternity care. Best Pract Res Clin Obstet Gynaecol. 2020;67 xxxx:113–26.