RESPECTFUL MATERNITY CARE AND ASSOCIATED FACTORS AT KITALE COUNTY REFERRAL HOSPITAL, TRANS NZOIA COUNTY, KENYA

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A Research Thesis Submitted in Partial fulfillment of the Requirements for the award of the Degree of Master of Science in Advanced Nursing Practice (Midwifery) of Masinde Muliro University of Science and Technology

October, 2023

DECLARATION AND CERTIFICATION PAGE

This research thesis is my original work prepared with indicated sources and has not been presented elsewhere for a degree or another award.

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Approval by Supervisors

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DEDICATION

I dedicate my work to the Almighty God for health during my study period.

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ABSTRACT

Respectful maternity care (RMC) is an avenue that ensures pregnant women preferences, needs and rights are adhered to when seeking maternity services. It remains a global challenge as most pregnant women seeking maternity services don't receive respectful maternity care. This contributes negatively to maternal and neonatal outcomes. This study aimed at assessing RMC and associated factors at Kitale county referral hospital in Trans Nzoia county. Specifically, it sought to explore perception on RMC among women who have delivered; determine women related factors that influence RMC; assess institutional factors and examine provider factors that influence RMC at Kitale county referral hospital. A cross-sectional study design with mixed method approach was used. Purposive sampling method was used to select the facility while census method was used to arrive at the women and healthcare providers. Data collection tools used were two questionnaires and an interview guide. The postnatal women tool dealt specifically with women who had delivered while the healthcare provider tool addressed healthcare providers (HCP). Postnatal women tool had information on socio-demographic characteristics of women, obstetric features, social support, health system factors and women perspectives on RMC while healthcare provider tool dealt with HCP on RMC. An interview guide was used to explore perceptions among women on RMC. Bivariate analysis was used to recognize variables associated with RMC while multivariate analysis was used to control for confounders. SPSS version 23.0 database was used in this. A p-value of 0.05 was used to determine statistical significance. Inadequate equipment, limited supplies, limited infrastructure, facility management and working environment were institutional factors that influence RMC while Inadequate number of HCP, high workload, motivation and training on RMC were key among HCP. Moreover, marital status, place of residence, employment status, parity, previous birth place, type of delivery and having a complication at birth were significant women related factors that influence RMC. Besides, women felt dignified care and privacy were key challenges as they received care in the unit. The study recommends availability of equipment and adequate supplies in the facility as HCP to continue offering RMC despite the challenges they face. Moreover, women need to be aware of their universal rights, enlightenment on birth positions and pain care. In conclusion, limited supplies and inadequate equipment were the key facility obstacles in RMC care while HCP were faced with inadequate number, high workload and needed trainings on RMC and be motivated. Lastly, women felt that their privacy, dignity and pain relief/comfort in the maternity unit needed to be addressed.

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LIST OF ABREVIATIONS

ANC	Antenatal care
CS	Cesarean section
EMOC	Emergency obstetric care
HCP	Health care provider
HIV/AIDS	Human immune deficiency virus/ Acquired immune-deficiency syndrome
KCRH	Kitale county referral hospital
KNBS	Kenya national bureau of statistics
LMIC	Low and middle income countries
MCHIP	Maternal child health integrated program
MMR	Maternal mortality ratio
RMC	Respectful maternity care
SPSS	Statistical package for social sciences
SVD	Spontaneous vertex delivery
TBA	Traditional birth attendant
UN	United nations
USA	United states of America
USAID	United states agency for international development
WHO	World health organization

OPERATIONAL DEFINITION OF TERMS

Respectful maternity care: is when all the 7 components as envisaged by White Ribbon Alliance were met, that is women answered Yes to the questions on the 20 components asked on RMC. The seven components were adopted in this study and they included:

Consensual care: In this study for one to have received consensual care then the pregnant woman should have been asked for permission for procedures to be done.

Confidential care, privacy: In this study for care to be said to be confidential, the files of pregnant woman should have been kept in lockable cabinets while privacy is said to have been offered when curtains are used as barriers during examinations.

Dignified care, respect: In this study it meant the pregnant woman and companion were spoken to politely by health providers.

Non-abandonment of care: In this study it meant a woman was not left unattended whenever need arose.

Non-discriminative care: - In this study it meant a woman's attribute wasn't used for her to be disrespected like HIV status, socio-economic status, disability etc.

Non-harm care: In this study it meant that the pregnant woman was not harmed either by pinching using instruments or hands, slapping and forceful vaginal examinations.

Non-RMC: In this study it is any form of treatment that violates the seven rights of a pregnant woman as outlined above.

CHAPTER ONE

INTRODUCTION

1.1 Overview

This chapter presents the background of the study, statement of the problem, justification, study objectives, study questions, theoretical framework and the conceptual framework.

1.2 Background

Respectful maternity care (RMC) is an avenue grounded on a person's ethical principles, respect for human rights and encourage practices that perceive women preferences and needs. It is a global human right to all women bearing children in all health systems (Raval et al., 2021) as ''all women have a right to highest attainable standard of health,'' as recognized by the World health organization (WHO) (Adu-Bonsaffoh et al., 2021). Besides, it is planned care that ensures the woman's dignity, privacy, confidentiality, consent are upheld without physical harm, neglect, detention and discrimination during pregnancy, labor and birth (Abebe & Mmusi-Phetoe, 2022). RMC is considered as a key aspect of quality maternity care for any positive birth experience as outlined by the WHO (Adinew, Hall, et al., 2021; Sudhinaraset et al., 2021).

RMC has become a top WHO priority in ensuring quality of care is availed to all women seeking maternity care services (Zeleke et al., 2022). Despite its known importance, there is global evidence of non-RMC of women during pregnancy, labor and birth (Sudhinaraset et al., 2021). The various forms of non-RMC as described by Bowser and Hill in 2010 are in seven classes which include; physical abuse, unconsented care, non-confidential care, non-dignified care, discrimination according to woman's attributes, abandonment and detention in facilities. These remains to be the main forms of non-RMC that women face when seeking maternity care and also

tend to affect negatively the clinical outcomes as they are partly responsible for maternal-neonatal deaths and morbidities globally (Bulto et al., 2020; Dzomeku et al., 2021; Mengistu et al., 2021).

Non-RMC of pregnant women in labor and childbirth is recognized as a significant and dominant issue around the world (Adu-Bonsaffoh et al., 2021; Berger et al., 2021; Sheferaw et al., 2021). Studies and anecdotal evidence from maternities in developed and developing countries around the globe show that despite the health status of any given nation non-RMC of pregnant women by health providers is alarming yet pregnancy and childbirth are supposed to be a positive season to the woman, community and the health providers (Leslie et al., 2021). Non-RMC of women seeking either direct or indirect maternity care is now recognized as an urgent problem as it runs deep into the healthcare system worldwide (Lavender et al., 2021; Stanton & Gogoi, 2022).

The worldwide push by authorities to have every pregnant woman receive facility delivery by a skilled health provider, has led to a positive impact in increasing facility deliveries although it has led to exposure of limitations within the health facilities and highlighted the problem of non-RMC of women receiving maternity care by the health providers (Dzomeku et al., 2021). There is robust evidence from several studies that women face non-RMC during delivery that includes verbal, sexual and physical abuse (Jolivet et al., 2021). This tends to happen in all forms of societies and settings both in developed and developing nations (Ansari & Yeravdekar, 2021; Smith et al., 2020).

Despite the high standards of care, people knowing their rights and presence of policies in developed countries the vulnerable women continue to suffer during childbirth in these nations (Jiru & Sendo, 2021; Lusambili, Naanyu, et al., 2020). Several studies also show that women seeking maternity care in various health facilities in different nations encountered non-RMC during delivery (Manu et al., 2021). In the United States for instance, studies show obstetric non-

RMC being a systemic problem that involves involuntary and coerced procedures which aren't consented by women like cesarean sections and episiotomies in great proportions (Kassa et al., 2020).

In sub Saharan Africa, 65% of pregnancy associated mortalities globally occur here yet it has been identified as one of the major areas where non-RMC of pregnant women continues to thrive (Adinew, Kelly, et al., 2021; Kiti et al., 2022; Lavender et al., 2021) with 44% of women having faced non-RMC during labor and birth (Amsalu et al., 2022b). Studies in this region show that women would choose to deliver in health facilities but don't due to prior experiences of poor quality and non-RMC by the health providers in the facilities (Bulto et al., 2020; Raval et al., 2021). The bad experiences women face usually lead to stress and fear that in turn project into poor delivery outcomes, poor lactation and delay or discourage facility maternity care in low and middle income countries (LMIC) as these women negatively influence others not to use the maternity services. These women therefore will choose to deliver without the help of skilled health provider and will only come to the facility when it is a case of ''too little too late'' to be done (Manu et al., 2021; Odiase et al., 2021; Smith et al., 2020), yet one of the main strategies to lower maternal mortalities is to increase skilled birth delivery but the bad relationship between health providers and pregnant women may lower the utilization of maternity services thus the burden of mortalities may remain the same or even go higher (Wassihun & Shegaw, 2018). Moreover, the strained relationships tends to lower their involvement in decision making thus lowering the woman's self-esteem (Ansari & Yeravdekar, 2021).

In East Africa, women coming to deliver in facilities are also still encountering non-RMC. Furthermore, women's prediction of how they will be treated in health facilities has an effect of where they will deliver (Jiru & Sendo, 2021). In a country like Ethiopia, prevalence of non-RMC

in maternity was about 49%, with 13.6% facing physical abuse and 16.4% being abandoned during care. Women were also denied a chance to have a companion during delivery (Bulto et al., 2020; Mengistu et al., 2021). In Tanzania and South Africa women experience all forms of non-RMC. In urban areas of Tanzania, at least 15% of non-RMC cases were reported but after follow up it was found to be at 70% (Hajizadeh et al., 2020a) while in Kenya, studies show that 20% of women have faced forms of non-RMC during labor and childbirth. On classes of non-RMC in Kenya, previous studies show that 1 out of 5 women were humiliated during delivery, 18% received non-dignified care, 8.5% received non-confidential care and 4.2% were physically abused (Kiti et al., 2022; Sudhinaraset et al., 2021). The most common forms of non-RMC in Kenya have been said to be; non-dignified care, physical abuse and non-consensual care (Hajizadeh et al., 2020a). Furthermore, studies in Ghana, India and Kenya have shown that health providers don't usually obtain consent from pregnant women when performing procedures. Women also reported verbal abuse (16%), lack of autonomy in decision making and physical abuse (3%) by the health providers. Women in Kenya have shown that they would easily utilize maternity services but due to non-RMC received from the health providers they are discouraged (Odiase et al., 2021).

Several women in Kenya don't benefit from skilled birth care as 96% of them attend at least one antenatal care clinic and only 62% give birth in hospitals (Adow et al., 2020; Ikamari, 2020). The rest receive unskilled births either by traditional birth attendants (TBAs) or by themselves. This large gap shows there is an issue with the quality of care being offered to pregnant women (Wubetu et al., 2021). This has a significant impact on increase of the maternal deaths and morbidities in the nation. It isn't clearly known what causes the backdrop in women delivering in health facilities but studies show that health providers behavior is becoming a key indicator of maternal healthcare (Moridi et al., 2020; Ngesa et al., 2021; Odiase et al., 2021). Studies do show that the drivers of

non-RMC in healthcare facilities are many and range from a singular provider to institutional and systemic factors (Ndwiga et al., 2017). Studies have shown that health providers do abuse and humiliate pregnant women who seek maternity care, pass sexual remarks at them and abandon care leaving women on their own, this contributes to most home deliveries (Ansari & Yeravdekar, 2021).

Finally, non-RMC, incompetent health providers and poor women-provider interaction have been listed as reasons why pregnant women may choose not to deliver in health facilities (Jiru & Sendo, 2021). Women who are the consumers of maternity services need to voice their concerns on the issues of RMC in our facilities in order to scale up quality of maternity care while health providers need to have the required skills in offering care. This study aimed at assessing RMC at Kitale county referral hospital in Trans Nzoia county.

1.3 Statement of the Problem

RMC ought to be provided to all pregnant women seeking maternity services in all health facilities. This care should encourage and support women without undermining their dignity. This care also needs to preserve the woman's privacy, confidentiality, freedom from harm and enhance their informed choice. Furthermore, women need to consent before procedures without force or coercion, they also need explanations of any procedures done on them and given feedback of the results (Maldie et al., 2021; Wubetu et al., 2021; Yosef et al., 2020). This will then lead to timely provision of care, enhancement in provider-patient interactions, improved treatment observance and maternal care service consumption hence improving maternal-neonatal outcomes (Maldie et al., 2021). Indeed evidence worldwide indicate that RMC encourages pregnant women seeking

behavior and clearly affects outcomes of the care given positively (Amare et al., 2022; Zeleke et al., 2022).

Despite the much effort made in maternal issues globally, non-RMC of pregnant women still finds room in the healthcare settings (Zeleke et al., 2022). Non-RMC though a universal violation of women rights is prevalent and serious issue that occurs globally at all levels of healthcare system (Haghdoost et al., 2021). Growing body of literature indicates that globally millions of women face non-RMC when they deliver by the health providers and aren't able to make choices or be in control during that time. This not only affects the labor, delivery and postpartum period but also the future interactions with the healthcare settings (Leslie et al., 2021; Smith et al., 2020; Wassihun & Shegaw, 2018). Studies have shown that health providers don't introduce themselves to women seeking maternity care, ask for permission to perform procedures and provide feedback, don't provide privacy when providing care, abuse women verbally and even physically (Chukwuemeka & Okoronkwo, 2021).

In LMIC of which Kenya is part, carries the largest burden of global maternal deaths of about 98%. The higher cases of maternal mortalities in the LMIC are associated with disrespectful care to women seeking maternity services (Patabendige et al., 2021). Non-RMC of women during labor and delivery leads to a reduced level of confidence in the maternity services (Haghdoost et al., 2021). Women who face non-RMC in the facilities may not want to extend their stay in these facilities even when they have complications while others choose not to use maternity care in the future thus increasing maternal deaths and morbidities in these areas (Ansari & Yeravdekar, 2021; Mdoe et al., 2021; Patabendige et al., 2021). Pregnant women in the LMIC do not usually receive the needed RMC by health providers in the health facilities (Afulani et al., 2019). In addition,

evidence shows that several pregnant women would utilize maternity services if the health providers displayed respect during labor and childbirth (Haghdoost et al., 2021).

In Kenya the maternal mortality ratio (MMR) remains high at 362 deaths per 100,000 live births compared to the UN (United nation) goal of less than 70 deaths per 100,000 live births (Sudhinaraset et al., 2021) yet the literature shows there is a big gap in provision of RMC in health institutions (Yosef et al., 2020) contributing immensely to low facility deliveries, maternal deaths and morbidities (Kiti et al., 2022; Smith et al., 2020). This goal will not be reached unless quality of care offered to pregnant women is enhanced (Wubetu et al., 2021). Furthermore, studies in Kenya have shown poor professional standards characterized by lack of privacy and informed consent (Adu-Bonsaffoh et al., 2021). Moreover, a significantly higher rate of non-RMC has been noted in Kenya with other studies reporting non-confidential care, non-dignified care, abuse, abandonment and detention in the facilities (Berger et al., 2021; Kiti et al., 2022). The health providers have reported verbal abuse, physical abuse, devoid of visual privacy, neglect and non-dignified care to pregnant women. Furthermore, they have indicated that the causes of non-RMC being; lack of equipment and supplies, negative view from women, high workload, exertion and power to control over them (Chukwuemeka & Okoronkwo, 2021).

Despite the free maternity care initiative in Kenya, access to emergency and obstetric care (EMOC) services and presence of skilled birth attendants, all hospital deliveries stand at 62% which is still low as a large population don't receive skilled care. Emerging evidence show that the reason why most women fail to use skilled facility delivery is due to neglect, abuse, poor quality of care and poor attitude from health providers (Adinew, Kelly, et al., 2021; Haghdoost et al., 2021; Lusambili, Naanyu, et al., 2020). In fact, the fear of disrespect and abuse in provision of maternity care is a

dominant obstacle to use of the services compared to financial and geographical barriers (Ige & Cele, 2022).

The efforts to improve the use of maternity care in any setting like Trans Nzoia county ought to be focused on improvement of quality of services and women's experiences of the care (Wassihun & Shegaw, 2018). The WHO recommends generation of data on RMC in order to help curb neglect and abuse in health facility skilled care deliveries and also emphasize on positive birth experience that help promote health seeking behavior by pregnant women (D-zomeku et al., 2020; Mgawadere & Shuaibu, 2021). A study on patient satisfaction at Kitale county referral hospital indicated that 4 in 10 patients wouldn't recommend anyone for a service in the facility (Mutunga et al., 2020). Moreover, anecdotal evidence shows that there is non-RMC of pregnant women though there is dearth literature on the subject in the region. Quality of maternity care remains compromised as long as respectful maternity care is not attained. This study sought to assess RMC at Kitale county referral hospital in Trans Nzoia county.

1.4 Justification

Despite the great efforts being made by several health authorities challenges deterring women seeking maternity care are many and aren't limited to non-RMC leading to high morbidities and mortalities and remains a burden in our society (Dahab & Sakellariou, 2020). Studies have shown that effective RMC interventions and practice greatly helps to lower the maternal and neonatal mortalities that remain high in several countries. Furthermore, it has been shown to reduce any chance of complications among pregnant women and newborns in the LMIC (D-zomeku et al., 2020; Mengistu et al., 2021). This then leads to deliveries being conducted by skilled birth attendants. 42% of women in Trans Nzoia county deliver in the hands of skilled birth attendants

and this is way below the national average of 62% (NCPD., 2017). Most women then are delivering in the hands of TBA's or by themselves. When women choose not to seek skilled deliveries in our facilities and deliver elsewhere then deaths and morbidities are imminent.

This study's aim was to assess RMC and associated factors at Kitale county referral hospital in Trans Nzoia county. It was intended to provide information to healthcare sector in Trans Nzoia county that will facilitate formulation of evidence based maternal health policies necessary for prevention of maternal mortalities and morbidities in the hospital and the county. Furthermore, the study adds to the body of knowledge especially in development and change of curriculum to ensure clinicians are well equipped on RMC.

1.5 Broad objective

To assess respectful maternity care and its associated factors at Kitale county referral hospital

1.6 Specific objectives

In this study the researcher intends to;

1. Explore perceptions on respectful maternity care among women who delivered at Kitale county referral hospital.
2. Determine women related factors that influence respectful maternity care at Kitale county referral hospital.
3. Assess institutional factors that influence respectful maternity care at Kitale county referral hospital.
4. Examine health provider factors that influence respectful maternity care at Kitale county referral hospital.

1.7 Research questions

1. What are the perceptions on respectful maternity care among women who delivered at Kitale county referral hospital?
2. Which women related factors that influence respectful maternity care at Kitale county referral hospital?
3. What institutional factors influence respectful maternity care at Kitale county referral hospital?
4. Which health provider factors influence respectful maternity care at Kitale county referral hospital?

1.8 Theoretical framework

Avedis Donabedian described characters of any given quality of medical care. They include; efficacy, effectiveness, efficiency, optimality, equity, legitimacy and acceptability. Effectiveness is the outcome of a given mediation, efficiency is the achievement of a goal with less waste, efficacy is the care given at best conditions, equity shows fairness in giving care to people, optimality is ensuring the benefits of healthcare are well balanced, legitimacy is the acceptability of an institution offering healthcare while acceptability is how healthcare is accessed by people (Ameh et al., 2017).

The model has three variables that is; structure, process and outcome. There is an association between the variables, a good structure promotes a good process which leads to a good outcome. These variables are usually pictorially shown by three boxes joined with arrows. He describes structure as the professionals and organizational resources that are associated with the provision of care e.g. equipment, medicine and staff training. Process are things which we do to the patient for example hospital referrals while outcome is usually the pertinent result of the care that was

given by a health provider like patient satisfaction (Lama et al., 2020). In this study the structure will consist of provider, women related factors and women perspectives on RMC, the process will include respectful maternity care while outcome will either be utilizing or not utilizing health facility care.



Figure 1.1: Donabedian model

1.9 Conceptual framework

A conceptual framework usually depicts a relationship between various variables. The independent variables in this study are divided into three; women perception on RMC, women related factors and provider factors which influence RMC. Institutional factors are intervening variables while RMC is a dependent variable. Pregnant women who seek care in health facilities and have positive perception after care may result in continuous use of services leading to reduced maternal morbidities and deaths. Lastly, health provider and women related factors on RMC are key as they inform us how RMC is associated with each of them.

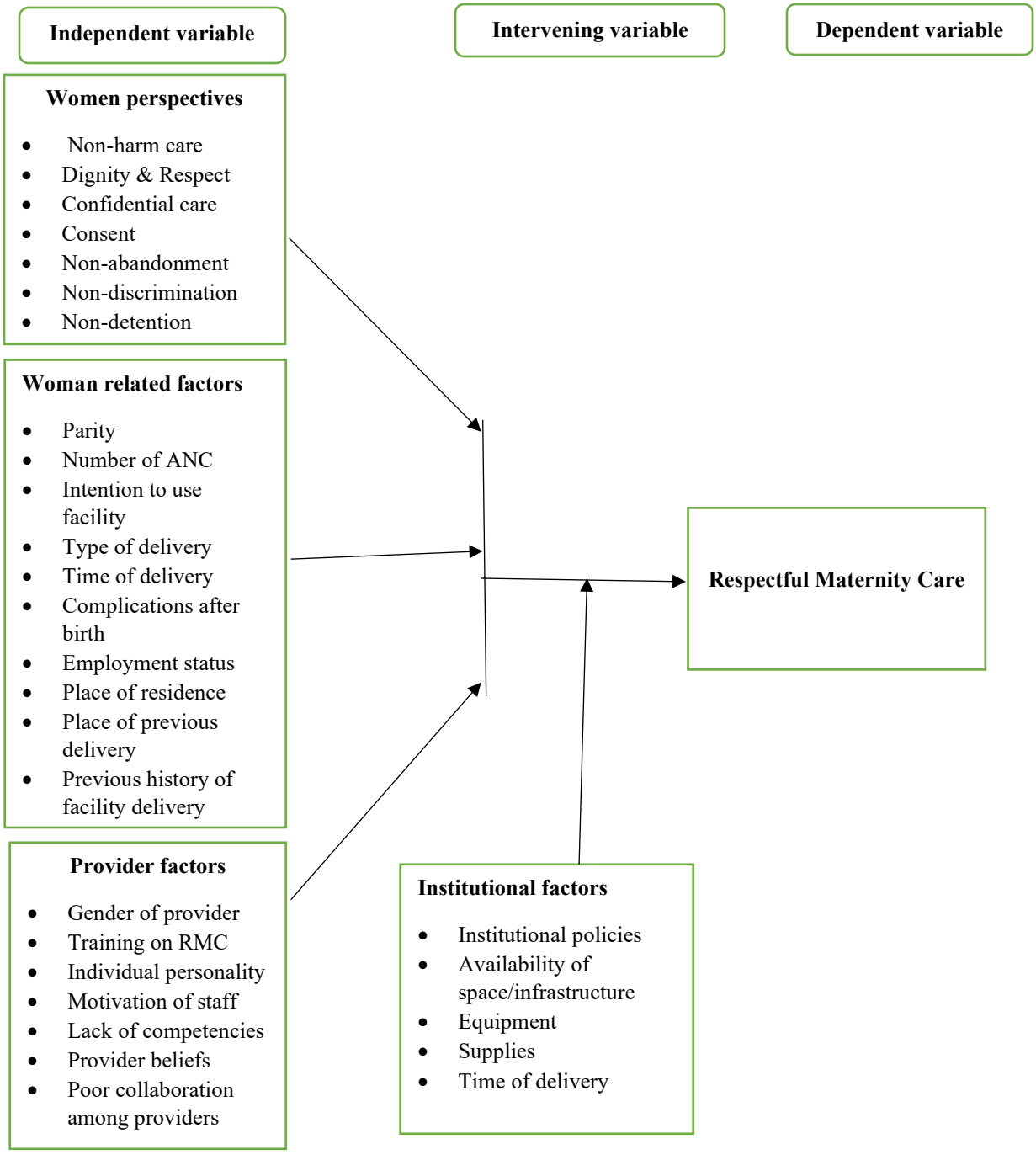


Figure 1.2: Conceptual framework

Source : Adopted and modified from Donabedian model (Lama et al., 2020)

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Overview

This chapter presents a detailed literature on respectful maternity care of pregnant women during labor, birth and postnatal period stated according to the study objectives; perspectives of women on RMC, women related factors, provider factors and institutional factors that influence RMC.

2.2 Prevalence of RMC

There has been a global reduction in the maternal deaths by 38% between the years 2000 and 2017. Despite this, there remains a great discrepancy between the developed and the LMIC. The LMIC have the largest burden compared to the developed nations probably because of many deterrent factors bringing under-utilization of health facility deliveries (Asefa, 2021; World Health organization, 2019). Health facility delivery has been identified as one of the major strategies by the WHO in lowering the maternal mortality burden globally especially when the birth is conducted by a skilled health provider. RMC is a key element of the WHO guidelines to ensure women receive care that respects their autonomy, dignity, preferences, choices and without neglect, detention and physical abuse in order to ensure facility deliveries aren't hampered (Ferede et al., 2022; Malatji & Madiba, 2020).

WHO carried out a multicounty study where it was found that 4 in 10 women suffered non-RMC that comprised of physical, verbal and neglect abuses during facility births (Bonsaffoh et al., 2022). In high and middle income countries, negative experiences during labor and delivery have been reported e.g. verbal abuse, forced interventions done on them and un-willful separation from their babies. In the high income nations, women who were immigrant, indigenous, having a poor socio-economic status, different ethnicity/race and those who depended on substances were usually at a risk of low level of RMC (Vedam et al., 2019).

Furthermore, in a survey conducted in the USA, 1 in every 6 women (17.3%) reported non-RMC from healthcare providers. The common forms of non-RMC were; being shouted at or scolded (8.5%), being ignored by health providers (7.8%), lack of physical privacy (5.5%) and being forced on treatment regimens (4.5%) (Vedam et al., 2019). In Slovakia, women couldn't make decisions about their care and consent weren't taken before procedures. Other forms of non-RMC like non-confidentiality, lack of privacy and non-dignified care were also reported (Vedam et al., 2019). Moreover, in Holland, it was observed that women of German ethnicity were discriminated and this was also the same picture in developed nations. Women in several studies have been physically abused, procedures done without consent and anesthesia like episiotomy, this was also the case in Nigeria (Mgawadere & Shuaibu, 2021).

Studies done in Iran show there has been poor communication between health providers and pregnant women seeking maternity services. Lack of emotional support was also observed. Furthermore, procedures like palpation, episiotomies and fundal pressure were done without the women's consent (Haghdoost et al., 2021). The prevalence of RMC in that nation was found to be 63% (Hajizadeh et al., 2020b).

Although, non-RMC is common, some women have experienced RMC globally and it differs depending on the nation, for instance, studies in Gujrat Pakistan, the prevalence was at 0.3% (Yosef et al., 2020), in Brazil 81.7% (Wubetu et al., 2021), teaching hospital in Nepal 84.7%, India 43% (Uttar Pradesh) (Ferede et al., 2022; Kedir et al., 2022) while in Iran 24.3% (Amare et al., 2022), Holland 99.84%, Sweden 99.3% and Norway 79% (Hajizadeh et al., 2020b). Furthermore, other studies in India has observed RMC to be at 78% while self-reporting at 90.9% yet in another study it was at 28.7%, Peru 2.6% and Mexico 62.3% (Kassa et al., 2020).

Sub Saharan Africa has a prevalence of RMC of about 56% (Kassa et al., 2020) while the prevalence of abuse of women lies between 15-98% (Maldie et al., 2021). The region poses different RMC prevalence that varies, for instance in Ethiopia, Benishangul hospitals 12.6%, West Shewa 35.8% (Mengistie et al., 2022), North Showa 48.6% (Amare et al., 2022), Adama medical college 42.4%, Ethiopian health facilities 66%, North-West Amhara 56%, Bale 62.5%, Yeka health centers in Addis Ababa 14%, public facilities in Addis Ababa 22%, Harar hospitals 38%, South Gondar region 39.4%, South-West Nigeria 6.8%, in Kenya at 80% (Ferede et al., 2022; Kedir et al., 2022), Malawi 6.3% (Maldie et al., 2021), Tanzania 36% (Yosef et al., 2020) and in another study in Tanzania 85% (Bante et al., 2020).

In Kenya, studies have shown that only 80% of women didn't report any form of non-RMC (Sudhinaraset et al., 2021). Women seeking maternity care services in Kenya have testified of ordeal experiences they have gone through in the hands of health providers like delivering on their own, being asked for bribes for services and detention in facilities (Kibuye, 2019). Health providers have cited demoralization, lack of supportive supervision and unavailability of resources for poor RMC (Bonsaffoh et al., 2022).

2.2.1 Respectful maternity care components

There are seven universal rights of all childbearing women globally with corresponding seven forms of non-RMC as developed by the White Ribbon Alliance. These are shown in table 2.1 below.

Table 2.1 Respectful maternity care components

Item	Type of abuse	**Corresponding right** (Right to)
1.	Physical abuse	Being free from harm
2.	Non-consented care	Information, informed consent and refusal, respect for her choices and preferences, including companionship during maternity care
3.	Non-confidential care	Privacy and confidentiality
4.	Non-dignified care (including verbal abuse)	Be treated with dignity and respect
5.	Discrimination based on personal attributes	Equality, freedom from discrimination, equitable care
6.	Abandonment or denial of care	Healthcare to the highest attainable level of health
7.	Detention in facilities	Liberty, autonomy, self-determination and freedom from coercion

Adopted from International Confederation of Midwives (ICM, 2020; Jolivet et al., 2021)

2.3 Women perspectives on RMC (based on components)

2.3.1 Being free from harm

This means to be free from acts like; violence, harmful practices, torture, physical and sexual abuse (Jolivet et al., 2021). Studies in Kenya, India and Ghana, showed that more than 95% of women didn't report any form of physical abuse (Afulani et al., 2019) while another study in Kenya showed women free from any form of maltreatment were 95.6% (Sudhinaraset et al., 2021). Furthermore, a study in Nigeria, Ghana, Guinea and Myanmar showed that 94% of women weren't aided in delivery by use of fundal pressure while 96% weren't slapped in labor and delivery (Leslie et al., 2021). In Malawi, 98% of women didn't report any form of physical abuse (Hughes et al., 2022). Moreover, in a study in North West Amhara Ethiopia, 96.6% of women didn't report any slapping (Yosef et al., 2020). However, in another study in Ethiopia reported that only 42.4% of pregnant women weren't ill-treated during labor and delivery (Wubetu et al., 2021). Studies in Kenya, Addis Ababa and facilities in Gondar town in Ethiopia showed that 64.3%, 97.7% and

7.9% of pregnant women were given care free from harm and maltreatment. 9.2% of women weren't slapped or beaten during labor and delivery (Tenaw et al., 2022). Furthermore, a study in Oromia showed that 76.5% (434) of women were given care devoid of abuse and of these only 87.8% weren't handled forcefully (Bulto et al., 2020). In India, about half of women didn't report any form of physical abuse like pinching, slapping, pushing or any sign of doing so (Sharma et al., 2022) while studies in Nepal and Addis Ababa showed that, 81.3% and 77% of women didn't report any form of abuse like slapping, hitting and pinching (Pathak & Ghimire, 2020). In another study in Addis Ababa, 88.6% and 57.4% of women were encouraged to take enough fluid and mobilize freely in labor. However only, 18.8% of women received pain medications in labor (Abebe & Mmusi-Phetoe, 2022). In Kenya and Ghana, 40% and 20% of women respectively didn't feel health providers did enough to care about their pain (Afulani et al., 2019) while in Ethiopia, 91.2% received information concerning pain relief (Ferede et al., 2022).

2.3.2 Consented care

This is a way in which a pregnant woman is explained to by the health provider, the benefits, risks and alternatives of a given procedure or intervention (Shah et al., 2022). In Kenya women weren't allowed to question their care from the health providers (Aridi et al., 2021). Studies in Nigeria, Ghana, Guinea and Myanmar indicated that 44% of women received consented care while the rest procedures were done without their consent (Leslie et al., 2021). In addition, in Tanzania, 16% of women received consented care (Das et al., 2021). In Kenya, 95.7% of pregnant women received consented care before procedures and interventions (Sudhinaraset et al., 2021). In India, 39 (26%) of women reported that consent was never taken before procedures while 81 (54%) reported that consent was taken sometimes by health providers who never introduced themselves to the women (Sharma et al., 2022). In Malawi, 38% of women were involved in decision making, 58% were given consented care and only 19% said health providers introduced themselves (Hughes et al.,

2022) while in south Gondar and Berhan town facilities in Ethiopia concluded that 75.5% and 47.8% of women received consented care (Ferede et al., 2022; Wubetu et al., 2021). In Nepal, less than half of women were asked for consent before care was given (Gurung et al., 2022). In Oromia, 39.3% of women gave consent before care was given (Bulto et al., 2020) while those who received consented care in Jimma, Addis Ababa and Gondar town were 48.2%, 10% and 64.1% respectfully (Zeleke et al., 2022). In North East region 1.4% and 65.2% of women received consented care and were greeted by health providers (Tenaw et al., 2022) while in central Ethiopia only 2.8% of women reported to have received consented care (Adinew, Hall, et al., 2021). In Addis Ababa, 61% of women reported that they were asked for consent before examinations and 69% were free to voice their concerns freely to health providers (Abebe & Mmusi-Phetoe, 2022). Two studies in Addis Ababa and one in North East Ethiopia showed that 46%, 71% and 59% of women were allowed to deliver at their preferred position (Abebe & Mmusi-Phetoe, 2022; Tenaw et al., 2022). In addition, in central Ethiopia, only 5.1% of women reported to have been allowed to deliver in their preferred position (Adinew, Hall, et al., 2021). In Kenya and Ghana, about 39% to 70% of women felt they couldn't be in position to choose their position of delivery while three quarter of them and above reported they weren't referred to by their names by health providers (Afulani et al., 2019). On the contrary, several studies in Nigeria, Ghana, Ethiopia and Kenya have showed that women weren't allowed to deliver in their preferred position (Bonsaffoh et al., 2022; Buback et al., 2022; Chukwuemeka & Okoronkwo, 2021; Ige & Cele, 2022). Studies in Iran, Nepal and India have indicated that health providers didn't often greet women (Hajizadeh et al., 2020b; Pathak & Ghimire, 2020; Raval et al., 2021).

2.3.3 Confidentiality and privacy

Confidentiality encompass whether the information concerning a particular patient is or isn't disclosed while privacy is in terms of patient's space, choices and their own relationships (Valizadeh et al., 2021). Studies conducted in Tanzania, Nigeria and Ethiopia showed that confidential care to women was at 81%, 70.6% and 50.1% respectfully (Zeleke et al., 2022). In Tanzania, 42% of women were accorded confidential care (Das et al., 2021) while in Malawi, 41.8% of women were accorded privacy during labor and birth. Moreover, in Ghana 70.5%, Ethiopia 85.4% and India 37.7% were accorded confidential care (Ferede et al., 2022). In Kenya, 91.5% of pregnant women were accorded confidential care in labor and delivery (Sudhinaraset et al., 2021). In Malawi, 59% of women felt their information was kept confidentially while 51% were always covered with a clothing during examinations to ensure privacy (Hughes et al., 2022). In observational studies, 42% and 77% of the women were draped during examination and direct observation (Shimoda et al., 2020). In India, 57.3% (86) of the women said they weren't accorded privacy during birth but none of the women were guaranteed of their data being kept confidential (Sharma et al., 2022). Moreover, in another Indian study, privacy wasn't maintained at all and women weren't greeted and not encouraged to ask questions by health providers (Raval et al., 2021) while in Addis Ababa, 79.8% and 57% of women reported to have been accorded privacy and their documents were kept confidentially (Abebe & Mmusi-Phetoe, 2022). In another study in North East region Ethiopia, only 3.4% of women were accorded confidential care. 49.6% of women were draped during procedures (Tenaw et al., 2022) while in central Ethiopia 33.8% of women reported to have received confidential care (Adinew, Hall, et al., 2021). In a study in Oromia region, 93.7% of women were given confidential care as their files were well kept while 85.9% of them were draped during procedures to ensure privacy (Bulto et al., 2020).

2.3.4 Dignity and respect

Dignity is one's feeling of value while respect is acknowledgment of worth (Mdoe et al., 2021). A study conducted in Ghana, Guinea, Myanmar and Nigeria showed that 80% and 90% of women weren't shouted and scolded by health providers (Leslie et al., 2021) while in Wollo region of Ethiopia, 8.4% of women weren't verbally insulted by health providers (Zeleke et al., 2022). Moreover, in India, 60% of the women were shouted at sometimes, 54% were contented with the condition of the toilets being clean with functional taps and about 99% of them said beds were cleaned before use (Sharma et al., 2022). In Nepal, Kenya and Ethiopia, 70%, 82% and 92% of women weren't shouted at by health providers during labor and delivery (Pathak & Ghimire, 2020; Sudhinaraset et al., 2021) while in Malawi 85% of women reported to have delivered in a clean environment, more than 95% reported the facilities to have running water and electricity and 96% didn't experience any form of verbal abuse (Hughes et al., 2022). 85.1% of pregnant women weren't shouted at by the health providers in a study in North West Amhara Ethiopia (Yosef et al., 2020). In North East Ethiopia, 1% and 15.4% of women reported to have received dignified and respectful care (Tenaw et al., 2022) while in central Ethiopia and Debre Berhan town facilities 71% and 49% of women were accorded dignified care (Adinew, Hall, et al., 2021; Wubetu et al., 2021). In Oromia region of Ethiopia, 78% of women weren't shouted during labor and delivery (Bulto et al., 2020). In India, 94 (63%) of the women reported to have been greeted sometimes by the health providers (Sharma et al., 2022) while 81.2% of women in south Gondar Ethiopia were called by their names by health providers (Ferede et al., 2022). In Addis Ababa 92.2% of women reported to delivered in a clean environment (Abebe & Mmusi-Phetoe, 2022). On the contrary, non-dignified care has been recognized as a major problem that bedevil the LMIC, Kenya being part (Aridi et al., 2021).

2.3.5 Non-discriminative care

This is where a woman is looked upon positively without selective attitude based on their socio-economic status, HIV/AIDS status, religion and disability (Sharma et al., 2022). In India, all women felt they weren't discriminated based on their various status (Sharma et al., 2022). Moreover, studies in Nepal and Nigeria showed that 87% and 80% of women weren't discriminated as per their attributes while 96% reported to have been spoken to in a language they could understand (Pathak & Ghimire, 2020). In a qualitative study in Kenya, women felt they were discriminated based on status as the wealthy were treated better than those deemed low class (Lusambili, Naanyu, et al., 2020). A study in central, south Gondar and North-West Amhara regions of Ethiopia showed that 77.2%, 86.1% and 84.1% of pregnant women weren't insulted because of their personal attributes while the rest were insulted (Adinew, Hall, et al., 2021; Ferede et al., 2022; Yosef et al., 2020) while in Oromia region 91.5% of women weren't discriminated as per their attributes (Bulto et al., 2020).

2.3.6 Non-abandonment care

This means a woman isn't left alone, the woman is continuously cared for maintaining the relationship with provider during labor and delivery (Maradiaga et al., 2022). In Kenya, 86% of women weren't abandoned during care (Sudhinaraset et al., 2021) while in Oromia region, 56.3% of women weren't left alone without a provider (Bulto et al., 2020). In addition, in India, 52% (78) of the women reported that health providers answered to their call of needs immediately and 68% were given intervallic updates concerning labor. Moreover, 97.3% of them were never left alone without care (Sharma et al., 2022). Studies in Nepal, Nigeria and Ethiopia showed that 83.7%, 70.9% and 76.9% of women weren't left without care of a provider at any point in time (Pathak & Ghimire, 2020). However, in a study in North East, Ethiopia, only 2.6% of women weren't abandoned during labor and delivery (Tenaw et al., 2022) while in South Wollo Ethiopia, 69.1%

and 70.2% weren't neglected and left alone as 95.4% of women didn't give birth on their own but were assisted by health providers (Maldie et al., 2021). Moreover, in central Ethiopia, 65.3% of women didn't feel abandoned during labor and delivery (Adinew, Hall, et al., 2021). However, studies in Kenya and other LMIC showed that abandonment of women in labor and delivery is common (Aridi et al., 2021).

2.3.7 Non detainment in facilities

In India, no woman reported detention in facilities though 65% of them said were asked for bribes by providers (Sharma et al., 2022). In certain studies, 2.9-25.9% of women in Ethiopia were detained against their will to do unwarranted payments (Mengesha et al., 2020) which was similar to studies in Kenya where women were asked for bribes in hospitals (Aridi et al., 2021). In North East Ethiopia, 95.5% of women weren't detained in facilities (Tenaw et al., 2022). Furthermore, studies in Addis Ababa showed that 82% of health providers didn't witness any form of detainment of women in facilities for lack of fees (Asefa et al., 2018).

2.4 Woman related factors influencing RMC

These factors are classified into individual, pregnancy, labor related factors and woman support structure

2.4.1 Individual woman factors

2.4.1.1 Age

Studies in Kenya, Ethiopia and Tanzania showed that young women (15-19) years were less probably to receive RMC compared to those who were older (Yismaw et al., 2022). This was also observed in studies in a multi-country study in Ghana, Guinea, Myanmar and Nigeria (Gurung et al., 2022). Furthermore, in Malawi, young women (15-19) years reported higher RMC scores than those who were (20-29) years (Hughes et al., 2022), although previous studies have showed low RMC with young age compared to older women (Hughes et al., 2022). On the contrary, in India

and Nepal, age wasn't statistically associated with RMC or maltreatment (Nawab et al., 2019; Pathak & Ghimire, 2020). In a study in two rural counties in Kenya, women who were young were less likely to receive RMC (Lusambili, Naanyu, et al., 2020) similar to study in Nepal where those who were less than 18 years were more likely to be abused compared to those who were older (Gurung et al., 2022).

2.4.1.2 Marital status

Women who were married were two fold probably to receive RMC than those who weren't in a study in Ethiopia (Mengistie et al., 2022). Furthermore, studies in Kenya showed that women who were married were more likely to receive RMC than those who weren't (Afulani et al., 2019; Kiti et al., 2022). In North Shewa, marital status was insignificantly associated with RMC (Yismaw et al., 2022).

2.4.1.3 Place of residence

Studies in Ethiopia showed that women from urban areas were more probable to receive RMC compared to their counterparts in rural areas (Amsalu et al., 2022b). Furthermore, most women in Kenya who had better RMC scores were from urban areas and were also wealthy and educated (Afulani et al., 2019). Moreover, in Burkina Faso and Ethiopia, women from poor backgrounds and from rural areas were more likely to be abused compared to their counterparts in urban areas (Jiru & Sendo, 2021). Forms of maltreatment were more likely to be reported by rural than urban women in a study in central Ethiopia (Adinew, Hall, et al., 2021).

2.4.1.4 Parity

Studies done in Kenya and Malawi showed that primi-parous and younger women were accorded RMC compared to others (Arsenault et al., 2020). However, in Nepal the women who had more

than one child were almost four-fold to receive RMC than those who didn't have children while in Kenya those with high parity received low RMC (Pathak & Ghimire, 2020). However, in India, parity wasn't significantly related to RMC (Raval et al., 2021).

2.4.1.5 Level of education

Women in Kenya who had better RMC scores were educated (Afulani et al., 2019; Kiti et al., 2022) while in Ghana, women who had poor RMC scores were uneducated (Afulani et al., 2019). Furthermore, in Ethiopia, women who had completed secondary education were more likely to receive RMC compared to those who couldn't write and read (Ferede et al., 2022). In Debre Berhan town Ethiopia, women who had secondary education and above were more likely to receive RMC compared to those who didn't have an education (Wubetu et al., 2021) while in Tigray and Jimma Ethiopia, women who had secondary education and more literate were less likely to receive RMC compared to those who were uneducated (Siraj et al., 2019; Wubetu et al., 2021). However, in India and Nepal education wasn't significantly associated with RMC (Nawab et al., 2019).

2.4.1.6 Occupation

Studies in Tanzania, Pakistan and Ethiopia showed that students who were pregnant were more probably to receive RMC when likened to those who were housewives (Yismaw et al., 2022). Moreover, women who were employed and on salary in Kenya were at a higher chance to receive RMC than those who weren't (Afulani et al., 2019; Kiti et al., 2022). However, in Nepal one's occupation wasn't significantly associated with RMC (Pathak & Ghimire, 2020).

2.4.1.7 Religion

In a study in India, women were discriminated as per their religion (Raval et al., 2021). However, in Nepal, one's religion wasn't significantly associated with RMC (Pathak & Ghimire, 2020).

Similar observations were made in Kenya, Ghana and India (Afulani et al., 2019). This observation was also made in Gumuz, Oromia, Hadiya, North Shewa and Amhara regions of Ethiopia (Amsalu et al., 2022b; Bulto et al., 2020; Mengistie et al., 2022; Yismaw et al., 2022; Yosef et al., 2020).

2.4.2 Pregnancy and labor related factors

2.4.2.1 Planned pregnancy

Women who planned their pregnancy were three times likely to receive RMC in eastern Ethiopia than those who didn't (Bante et al., 2020). A similar observation was also made in south west region in the same nation (Yismaw et al., 2022). Moreover, in South Gondar region, Ethiopia, the odds of receiving RMC were higher among women who had a planned pregnancy than those who didn't (Ferede et al., 2022). On the contrary, those who didn't plan or had unwanted pregnancy in Oromia and Bahir dar were at a higher chance to receive RMC than those who planned (Bulto et al., 2020; Wassihun & Shegaw, 2018).

2.4.2.2 Time one begins ANC and ANC follow-up

A study in Malawi indicated that women who began their ANC visits in the first trimester were more likely to receive RMC than those who started clinic in the third trimester (Hughes et al., 2022). In Eastern and North-East Ethiopia women who had ANC follow-up were at a higher likelihood of receiving RMC than those who didn't (Bante et al., 2020; Tenaw et al., 2022). A similar observation was made in central Ethiopia (Ferede et al., 2022) while studies in Debre Berhan town, North West Amhara and Bahir dar town in Ethiopia showed that women who had more than 4 ANC visits were more likely to receive RMC compared to those who had less than 4 visits (Bulto et al., 2020; Wubetu et al., 2021; Yosef et al., 2020).

2.4.2.3 Intention to use the facility

Women who planned to deliver in healthcare facilities were given RMC by health providers than those who just came accidentally to the facility. This was shown by studies in Ethiopia, Kenya and Tanzania (Bante et al., 2020; Bulto et al., 2020).

2.4.2.4 Type of delivery

Studies in Kenya, Ethiopia and Tanzania have shown that women who delivered via cesarean section were accorded RMC by the health providers compared to those who had normal deliveries (Bante et al., 2020). This observation was also made in Hadiya, Ethiopia where those who had CS delivery were three fold probably to receive RMC (Mengistie et al., 2022). Furthermore, women in India who had an SVD were less likely to receive RMC (Nawab et al., 2019). However, a study in central Ethiopia showed that those who delivered via SVD were at a higher chance of receiving RMC than those who had CS and instrumental delivery (Ferede et al., 2022). Moreover, women in south-west Ethiopia and Nigeria who had instrumental delivery were subjects of poor RMC as likened to those who delivered normally (Yismaw et al., 2022).

2.4.2.5 Complications in labor and delivery

Women who didn't have complications in Malawi were associated with higher RMC scores compared to their counterparts (Hughes et al., 2022). However, women who had complications in labor and birth in south Wollo, public hospitals in Hadiya and south west Ethiopia were more likely to be maltreated than those who didn't (Maldie et al., 2021; Mengistie et al., 2022; Yismaw et al., 2022).

2.4.2.6 Previous history of facility delivery and ANC planning

Studies in Gujrat Pakistan and north-west Amhara Ethiopia showed that women who had previously delivered in the hospital were at a higher chance to receive RMC than those who didn't (Yosef et al., 2020). Furthermore, women who had planned in ANC the place of delivery were more likely to receive RMC than those who didn't (Bulto et al., 2020).

2.4.2.7 Length of stay in facility

Women who stayed in the facility for less than 24 hours were more likely to experience RMC than those who stayed for more than 24 hours in Nepal (Pathak & Ghimire, 2020). A different observation was seen in Tanzania where those who stayed for less than 24 hours were likely to experience maltreatment (Kruk et al., 2018). Moreover, in Oromia those who stayed for more than 12 hours experienced RMC compared to those who stayed less than 12 hours (Bulto et al., 2020).

2.4.3 Support structure

2.4.3.1 Presence of birth companions

Robust evidence indicates that availability of birth companions within delivery units improves RMC services. They accompany the pregnant women to health facilities giving updates to the woman, reassuring and helping with coping mechanisms. Studies in Egypt, Syria and Lebanon have shown that presence of a birth companion is significantly associated with RMC (Kiti et al., 2022). This was also observed in Iran and Ethiopia where spouses accompanied their partners (Hajizadeh et al., 2020a; Wubetu et al., 2021). Moreover, in Kenya, Ethiopia and Malawi a similar observation was made (Maldie et al., 2021). Birth companions have been known to promote better maternal outcomes and even reduce rates of cesarean births (Bonsaffoh et al., 2022). On the contrary, studies in four regions of Ethiopia indicated that there was insignificant association

between having a birth companion and RMC (Wubetu et al., 2021). Despite its importance several studies in Myanmar, Kenya, South Africa and Tanzania showed that health providers didn't see their importance unless when they were alone or in case of a poor outcome and they needed a witness (Chukwuemeka & Okoronkwo, 2021) while in Kenya, Ghana and India they weren't allowed in the labor ward as they would compromise privacy since space was limited (Aridi et al., 2021; Bonsaffoh et al., 2022; Sharma et al., 2022). In Malawi, 51% and 40% of women were encouraged to have companions in labor and delivery (Hughes et al., 2022). On the contrary, women in Kenya didn't want to have companions during delivery (Aridi et al., 2021).

2.4.3.2 Family, relations and friends

Studies have shown that women who come to deliver in hospitals and have support from the family members like the mother-in-laws, spouse and others are more likely to receive RMC by the health providers. Furthermore, those who are supported by their friends, neighbors and relatives are also at an upper hand to be given RMC when they come to deliver (Akter et al., 2020; Dorairajan et al., 2021; Maheen et al., 2021; Pathak & Ghimire, 2020).

2.4.3.3 Socio-economic factors

In developed nations, women from low socio-economic class like refugees and immigrants were looked down upon and not accorded RMC (Fair et al., 2020). In Kenya, health providers didn't give RMC to women from poor backgrounds while those from well of status were accorded RMC (Lusambili, Wisofschi, et al., 2020). Moreover, women from poor backgrounds were less likely to receive RMC (Lusambili, Naanyu, et al., 2020). Other studies demonstrate that health providers choose to give RMC to women who are educated and well economically as they can voice their concerns (Maheen et al., 2021). Studies in Kenya, Tanzania, Ethiopia and other areas have shown that women from well off backgrounds were accorded RMC (Arsenault et al., 2020; Bante et al.,

2020). In addition, studies in Kenya and Ghana showed that women who were from wealthy backgrounds had better RMC scores compared to those from poor backgrounds (Afulani et al., 2019). However, women from poor backgrounds in Burkina Faso, Sri Lanka, South Africa, Pakistan and Ethiopia weren't accorded RMC (Adinew, Hall, et al., 2021; Jiru & Sendo, 2021; Maldie et al., 2021) as was also seen in India (Nawab et al., 2019). In Afghanistan, women wouldn't deliver in hospitals because of poverty as money will be needed by health providers as bribes for services to be offered (Arnold et al., 2019).

2.5 Institutional factors influencing RMC

2.5.1 Hospital/facility policies

Several studies have shown that having policies in facilities helps promote RMC. Studies done in Bangladesh, Tanzania and Ghana have revealed that there existed a 'whistle blower' and human rights policies in facilities where women would easily report any form of maltreatment to help improve RMC (Manu et al., 2021). Moreover, in a study in Tanzania and Malawi, health providers cited that availability of government policies helps standardize care in all facilities, help in decision making and increase cognizance on RMC (Mdoe et al., 2021). Government policies like ensuring the mother and baby are together have been shown to enhance RMC. In a study in Bhutan, 90% of health providers weren't aware of any policies on provision of RMC (Deki & Choden, 2018). Furthermore, studies in Kenya (Kisii and Kilifi), it was recommended the need for hospital policies which are instituted to report and deal with maltreatment cases (Lusambili, Naanyu, et al., 2020). In South Asia, it was recommended that policies need to be in place for RMC to be provided (Kaphle et al., 2022). Finally, a study in Ethiopia recommended that clear policies need to be in place on health providers roles for RMC to be delivered (Adinew, Kelly, et al., 2021).

Globally, there are limited policies on improvement of RMC practices in the health facilities (Mdoe et al., 2021). Poor hospital policies usually inhibit the practice of RMC e.g. not allowing companions within labor rooms (Ige & Cele, 2022; Orpin et al., 2019). Furthermore, studies in India, Nepal and Nigeria showed that unclear ethical standards was why there was maltreatment of women during labor and birth (Lusambili, Naanyu, et al., 2020). Hospital policies in Ghana couldn't promote other birth positions and women were assisted only in lithotomy position (Dzomeku et al., 2021). A study in Palestine showed that poor standards were the conventional customs in facilities. HCP who tried to improve standards were hindered by the system as was also observed in Afghanistan where those who complained were told to quit (Arnold et al., 2019). Policies in Ghana like 24 hour shift for doctors and lack of 24 hour pharmacy services led to poor RMC (Bonsaffoh et al., 2022) while in Bhutan health providers weren't aware of any government policies for RMC thus its components were poorly practiced (Deki & Choden, 2018)

2.5.2 Availability of equipment and supplies

Availability of resources in terms of enough health providers to serve many women, having the required equipment and supplies play a critical role in provision of RMC (Kaphle et al., 2022). Furthermore, WHO highlights that availability of resources is key for any care to be provided (Lavender et al., 2021). HCP in Tanzania and Malawi cited increased resources in the facility like supplies and improvement of maternity building (equipping them with enough space and screens) as a measure to improve RMC (Mdoe et al., 2021). More than half of HCP in Bhutan said they lacked equipment and supplies for provision of quality care (Deki & Choden, 2018).

2.5.3 Inadequate space/infrastructure

Lack of enough rooms, toilets, bathrooms and screens in the maternity areas has been shown to deprive women of privacy and confidentiality. Studies conducted in Ethiopia, Kenya, Uganda and

South West Nigeria have shown so (Amsalu et al., 2022b; Buback et al., 2022; Chukwuemeka & Okoronkwo, 2021; Ige & Cele, 2022). Furthermore, in a study in South Asia one of the reasons why private facilities did well was because they had better infrastructure compared to the former (Kaphle et al., 2022) while in Bhutan 53% of the health providers said inadequate infrastructure was the reason for poor RMC (Deki & Choden, 2018). This was also seen in Ethiopia and Tanzania where health providers cited limited space as a source of non-confidential and lack of privacy (Adinew, Kelly, et al., 2021; Das et al., 2021). Health providers in Malawi and Tanzania narrated the need for improvement and renovation of facility infrastructure in order to provide space for companions, lower overcrowding and improve privacy (Mdoe et al., 2021).

2.5.4 Shortage of supplies & equipment

Inadequate resources like equipment, supplies and commodities have been associated with maltreatment in several nations (Ige & Cele, 2022; Orpin et al., 2019). This has also been cited by health providers in similar studies (Chukwuemeka & Okoronkwo, 2021). Moreover, HCP in Ghana cited that among the reasons why RMC wasn't provided was due to lack of equipment and supplies (Bonsaffoh et al., 2022). Lack of screens was also cited as an impediment for ensuring privacy to pregnant women (Dzomeku et al., 2021) while in Bhutan the health providers cited inadequate equipment as a reason for poor quality of care to women (Deki & Choden, 2018). In addition, studies in Kenya, Nepal, India and Nigeria have shown that use of inferior and outdated equipment and resources was the reason for disrespectful maternity care (Lusambili, Naanyu, et al., 2020). In Kenya and Afghanistan, health providers cited lack of key supplies and drugs being behind poor RMC practices (Afulani et al., 2020b; Arnold et al., 2019). Shortage of supplies and equipment was the reason for poor care in Ethiopia (Adinew, Kelly, et al., 2021).

2.5.5 Daytime deliveries

A study in Nepal showed that women who gave birth during daytime were two times likely associated with RMC than at night (Pathak & Ghimire, 2020). Furthermore, studies in Kenya and Ethiopia have indicated a similar observations (AOR=2.59 (95% CI: 1.26, 5.33)) (Hajizadeh et al., 2020a). Deliveries occurring at night were linked to four times maltreatment manifested as verbal and physical abuse (Kedir et al., 2022). This was also observed in studies in south Gondar region (AOR=1.9 (95% CI: 1.33, 2.72) (Ferede et al., 2022), Amhara region (AOR=2.46 (95% CI: 1.349, 4.482)) (Yosef et al., 2020), Debre Berhan town Ethiopia (AOR=2.45 (95% CI: 1.47, 3.99)) (Wubetu et al., 2021) and Iran where delivering at night increased the possibility of disrespectful maternity care (Hajizadeh et al., 2020a). However, in Gujrat the time of delivery was insignificantly associated with RMC (Raval et al., 2021).

2.5.6 Timeliness

In a qualitative study in Kenya, women were much appreciative when care was given within the shortest time possible and were cognizant of fact that some health providers couldn't provide care on time (Aridi et al., 2021). Moreover, another study in Kenya showed that 69.1% of women were okay with the speed by which health providers would attend to them as 64% of them waited for less than half an hour (Atai et al., 2018). Women who were satisfied with waiting time in Oromia were more probably to receive RMC than those who didn't (Bulto et al., 2020).

2.6 Health provider factors influencing RMC

2.6.1 Training of health providers on RMC

HCP who have an ongoing training or partake regular in-service trainings have been shown to do well when it comes to provision of RMC. This has been shown by studies in Ghana, South Asia

and Tanzania (Bonsaffoh et al., 2022; Das et al., 2021; Kaphle et al., 2022; Shimoda et al., 2020) and this has also been noted in several studies where programs like training HCP on communicating effectively with pregnant women enhances RMC practices (Dzomeku et al., 2021). HCP in Ghana recommended training on RMC for all maternity staff in order to improve RMC practices (Dzomeku et al., 2021). Moreover, literature review showed that training of maternity in-charges on arrangement of maternity ward and staff on how to handle hostile clients greatly helps to provide RMC (Mgawadere & Shuaibu, 2021) while in Bhutan HCP stated they needed training on RMC in order to improve their practices (Deki & Choden, 2018). Studies in Kenya, Nigeria, India and Nepal have cited lack of training on RMC as a source of disrespectful care in health facilities (Lusambili, Naanyu, et al., 2020) while in a study in Kenya it was suggested that ongoing training is key for provision of RMC (Lusambili, Naanyu, et al., 2020). A study in Malawi and Tanzania indicated that education of a HCP is needed but more importantly continuous professional development is key in provision of RMC (Mdoe et al., 2021). Health providers in Iran who had training on RMC had better scores in knowledge although this wasn't significantly related to practice (Mirzania et al., 2022). Services that were being offered by trained RMC health providers were 4.5 times probably to yield RMC than those conducted by those not trained, this was observed in a study in Gumuz region in Ethiopia (Amsalu et al., 2022b). A similar observation was made in another study in the same country (Jiru & Sendo, 2021).

2.6.2 Motivated staff

Studies done in the SSA have shown that HCP who are motivated in terms of remuneration, payment on time, incentives and being praised for what good they have done by pregnant women or the community tend to provide RMC (Lavender et al., 2021; Mgawadere & Shuaibu, 2021). HCP who had job satisfaction too would do well in providing RMC (Das et al., 2021; Haghdoost

et al., 2021). Furthermore, studies in South East and South West Nigeria showed that the reason why HCP didn't provide RMC was due to poor motivation (Chukwuemeka & Okoronkwo, 2021; Ige & Cele, 2022). In addition, studies in Malawi and Tanzania showed that the enablers of RMC were motivated staffs (Mdoe et al., 2021). Moreover, studies in sub Saharan Africa, Mozambique and Uganda have shown that health providers don't provide RMC due to poor salaries (Asefa et al., 2020; Bradley et al., 2019; Munabi-Babigumira et al., 2019). All health facilities in Malawi and some facilities in Tanzania provided lunch meals to health providers on duty. Incentives and allowances were also given to HCP as a way to improve RMC practices (Mdoe et al., 2021) while in Ghana, HCP cited that any motivation for what they do tends to improve output (Bonsaffoh et al., 2022). However, in Kabul Afghanistan, health providers would take bribes from patients as salaries were low (Arnold et al., 2019).

2.6.3 Health provider beliefs

HCP have different beliefs on privacy, birthing position, birth companion and pain management which are without scientific base rendering poor RMC. Women would be taken to be exaggerating pain during labor thus not given pain medications, lithotomy positions are preferred by midwives and other abuses would be done for the sake of a 'good outcome' (Bonsaffoh et al., 2022; Buback et al., 2022; Chukwuemeka & Okoronkwo, 2021; Ige & Cele, 2022). HCP in Ethiopia would only assist women in lithotomy position without considering other positions. They also believed urban women lacked respect (Adinew, Kelly, et al., 2021) while in Iran HCP didn't think choice of birth position, walking in labor and frequent VEs as a form of maltreatment (Mirzania et al., 2022).

2.6.4 Lack of competencies

HCP who lack key knowledge and skills are less likely to provide RMC. They may want to project their lack of skills to frustrate the pregnant women (Chukwuemeka & Okoronkwo, 2021). Studies

also indicate that those who lack proper training don't provide RMC (Orpin et al., 2019). Moreover, rudeness and arrogance among HCP was associated with lack of training thus deficiency of knowledge and skills (Mdoe et al., 2021).

2.6.5 Individual personalities

Different temperaments influence how RMC is provided, though it's not a yardstick for all professionals (Chukwuemeka & Okoronkwo, 2021). Those with bad temperaments will negatively influence RMC provided (Ige & Cele, 2022). HCP who have poor attitudes like being authoritarian without considering the women needs tend to ill-treat pregnant women (Jolly et al., 2019; Orpin et al., 2019). HCP in Nigeria noted that having a positive attitude promoted quality of care while being rude and non-committal impeded RMC (Mdoe et al., 2021). HCP in Kenya cited that some health providers are just arrogant hence no RMC (Afulani et al., 2020b).

2.6.6 Poor collaboration among professionals

Studies have shown existence of poor relationships between doctors and midwives. Doctors presume the reports given to them on women by midwives and prescribe medications for midwives to administer being viewed as subordinates. Midwives would then exert power on women since they are superior to them (Chukwuemeka & Okoronkwo, 2021; Ige & Cele, 2022). Studies show that midwives don't provide RMC due to this poor relationships (Asefa et al., 2020). A study in Afghanistan indicated that senior midwives were an impediment to their juniors and resident doctors to use their skills. Several studies in the LMIC also show that doctors control the midwives limiting their scope of practice (Arnold et al., 2019). However, in Malawi there were senior staff who offered hands on clinical know-how and acted as models in care provision (Mdoe et al., 2021). Poor relationships too amongst midwives has been shown to lead to poor RMC (Shimoda et al.,

2020) while in Ethiopia, midwives felt their supervisors weren't in support of the profession as they treated physicians better than them (Adinew, Kelly, et al., 2021).

2.6.7 Inadequate number of health providers

Studies show that having enough number of HCP in any facility is key to provision of RMC thus a small number will translate into abusive care (Bradley et al., 2019; Pokharel et al., 2022). Furthermore, studies conducted in Kenya, three quarters of health providers reported always having shortage as a reason why they didn't provide RMC (Afulani et al., 2020a; Buback et al., 2022) while health providers in Tanzania reported staff shortage as a source of poor RMC (Das et al., 2021). This was also observed in studies conducted in Mozambique, South Africa, Uganda, Benin, Ghana, Kenya, Nepal, India and Nigeria (Asefa et al., 2020; Bonsaffoh et al., 2022; Chukwuemeka & Okoronkwo, 2021; Lusambili, Naanyu, et al., 2020) so was in Bhutan where 74% of health providers interviewed said low number of staff was why there was poor quality of care provided to women. Staff had to cover antenatal, labor and postnatal wards respectively (Deki & Choden, 2018). Lack of enough staff was the reason for lack of RMC practices as cited by health providers in Ethiopia and Kenya (Adinew, Kelly, et al., 2021; Afulani et al., 2020b). Studies conducted in Ethiopia showed that having a small number of health providers is more likely to lead to maltreatment of pregnant women (Amsalu et al., 2022b; Jiru & Sendo, 2021). This was also seen in South Asia and South West Nigeria (Ige & Cele, 2022; Kaphle et al., 2022). Moreover, the few number of staff in the maternity led to poor care in Afghanistan (Arnold et al., 2019). However, in Tanzania, the number of staff had no relationship with care provision (Shimoda et al., 2020).

2.6.8 High workload

In a study in South-West Nepal it was established that workload was negatively associated with RMC (Coef. -7.47; 95% CI -12.72 to -2.22) (Pokharel et al., 2022). This was similar to studies done in Ethiopia, Kenya, South East and South West Nigeria on RMC where workload was associated with less time spent with pregnant women (Amsalu et al., 2022b; Buback et al., 2022; Chukwuemeka & Okoronkwo, 2021; Ige & Cele, 2022). A similar opinion was brought up by health providers in Ghana where they complained of excessive workload hence poor quality of care rendered (Bonsaffoh et al., 2022) while in Tanzania providers cited increased working hours leading to poor RMC (Das et al., 2021). High workload among midwives led to poor interactions with women (Dynes et al., 2018). This observation was also brought up by providers in Ethiopia (Adinew, Kelly, et al., 2021). High level of workload would lead to stress among providers in Kenya (Afulani et al., 2020b). This observation was also made in Afghanistan where providers complained of high workload leading to poor care (Arnold et al., 2019). Long working hours in Tanzania were directly linked to poor RMC (Shimoda et al., 2020).

2.6.9 Female provider and number of providers assisting in delivery

A study in two rural counties in Kenya showed that female health providers were likely to ill-treat pregnant women than their male counterparts (Lusambili, Naanyu, et al., 2020). Male health providers in Ethiopia found it unethical to abuse pregnant women (Adinew, Kelly, et al., 2021) while in Malawi, high RMC scores were associated with women who were delivered by male health providers (Hughes et al., 2022). In addition, studies conducted in Mozambique and Ethiopia showed that women who were cared by female health providers were more likely to experience maltreatment (Adinew, Hall, et al., 2021). However, women may prefer male or female health providers in labor and delivery (Kassa et al., 2020) but others prefer purely female health providers

as a case of women in South Asia and Kenya (Kaphle et al., 2022; N'Gbichi et al., 2019). However, in Ethiopia, male health providers were associated with RMC (Bante et al., 2020). On number of providers, in Ethiopia those who were helped by two providers or less experienced RMC compared to those who were helped by three or more providers (Bulto et al., 2020).

2.7 Summary

Gaps in literature shows that several studies focused only on the study of women perception on RMC. In addition, the studies tended to use purposive sampling method in selecting women into studies. Moreover, some studies have used a 4 component tool with 15 items on studying the RMC. Other studies have used purely a qualitative approach on studying RMC using only interviews while other studies were conducted in the community after women were discharged from maternity wards. Studies in Kenya have mainly looked on disrespectful maternity care. This study looked at RMC at Kitale county referral hospital among women who were still be in the immediate postpartum (24 hours) period in the facility. This study unlike previous ones looked at all women who had delivered at the county referral hospital. This generated data on various groups of women perceptions during labor and delivery. Further, it provides baseline data on RMC within the facility which is dearth adding on to the evidence of RMC in the region. It is against this context that this study aimed at assessing RMC among women who delivered at Kitale county referral hospital in Trans Nzoia county.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This chapter presents the description of study design, study area, target population, sample size calculation, sampling procedure, research instruments, validity of instruments, reliability of instruments, data collection procedure, data management, data analysis and ethical considerations.

3.2 Study design

Institutional based cross sectional study design with mixed method approach was used to assess respectful maternity care and associated factors at Kitale county referral hospital in Trans Nzoia county. This is an appropriate design since it enables the investigator to collect data at one point in time (Wang & Cheng, 2020). This assisted the researcher to achieve all the study objectives.

3.3 Study area

The study was conducted at Kitale county referral hospital from May 2023 to July 2023. The facility is in Trans Nzoia County in the former Rift Valley province. Trans Nzoia County is found amid Mt. Elgon and river Nzoia. It borders other counties like Uasin Gishu and Kakamega to the south, Bungoma to the west and the country of Uganda to the north west. It has five sub counties which include; Kiminini, Saboti, Endebes, Cherang'any and Kwanza. The County has an area of 2469.9 km^2 and a population of 990,341 people. There are 223,808 households with an average household size of 4.4. The population density (number per square kilometer) is 397 (KNBS, 2019). Most residents here are Christians and practice mainly agriculture as their source of livelihood.

The fertility rate in the county stands at 5.2 children per woman. 64% of women use contraceptives while 42% of the births are conducted by skilled birth attendants. Most young people in the county are affected by teenage pregnancies, HIV/AIDS among others (NCPD., 2017). 69.8% of women use any method of family planning while 65.4% use the modern methods. Moreover, 98.8% of

pregnant women received ANC from skilled providers and only 68.1% of pregnant women had four or more ANC visits (KNBS and ICF., 2023).

Kitale county referral hospital is the main referral public facility of Trans Nzoia county. It is a 250 bed capacity facility that offers various services ranging from medical, surgical, obstetrics and others. It has various cadres of health providers who practice in it and also acts as an attachment center for various medical colleges.

3.4 Target population

The target population was 7754 women who delivered in the last 12 months in the year 2022 (DHIS, 2022). For each month averagely 646 women gave birth in the facility and this was the target for every month while 25 health providers working within the maternity unit (Antenatal, labor and postnatal wards) were also targeted.

3.4.1 Inclusion criteria

A woman who delivered in the facility within 24 hours and signed consent form

A health provider involved in the care of pregnant woman and had worked for more than six months in the maternity unit (studies have shown that health providers who work in a unit for six months are usually competent and informed about practice in that area) and consented to participate in the study.

3.4.2 Exclusion criteria

A woman who presented with obstetric emergencies.

3.5 Sample size calculation

The Fishers formula was used to arrive at the sample (Charan & Biswas, 2013).

$N = z^2p(1-p)/e^2$

Where

N = sample size

p = sample proportion

z = 1.96 z value set at 95% confidence interval (CI)

e = margin of error

$$\frac{1.96 \times 1.96\ (0.5\ (1\text{-}0.5)}{(0.05)^2} = \frac{3.8416 \times 0.25}{0.0025}$$

= 384

For a population less than 10,000 we use the modified Fishers formula

$$nf = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

Where

nf is the new adjusted sample size

n_0 is taken to be the Fishers sample size (in this case 384)

N is the population of women who deliver per month in this case 646

$$\frac{384}{1 + \frac{(384\text{-}1)}{646}} \qquad \frac{384}{1 + \frac{(383)}{646}}$$

$$= \frac{384}{1.593}$$

This gave 241 adding 10% non-response the total sample was 265 women

For health providers, all the 25 were sampled

3.6 Sampling procedure

The facility was purposively picked, that is the County referral hospital, since most pregnant women go to this facility thus capturing many women of different characteristics. About 10-20 women delivered on daily basis. Census method was used to arrive at the women as long as they did fit into the inclusion criteria. Moreover, census method was also applied on health providers in this study since they were few

3.7 Data collection

The study used an interview guide and two questionnaires (postnatal women tool and healthcare providers tool) to collect data from women who had delivered in the facility and health providers involved in the care of women in the maternity unit.

3.7.1 Interview guide

A structured interview guide was used to conduct discussions among women who had delivered and were in the postpartum period. The discussion covered the areas of birth experiences, consensual care, dignified care, birth position, pain relief, physical/sexual/verbal abuse, companionship and health system constraints. This was adopted and modified from protocol developed in Sri Lanka (Patabendige et al., 2021). The accountability section was omitted in this guide. This was used to enrich data on objective 1.

3.7.2 Postnatal women tool

It was a structured questionnaire with several sections. It was adopted and modified from (Wubetu et al., 2021) and other literatures as provider profession and stage of labor when the woman reached facility wasn't included in the questionnaire. It had four sections including; A: socio-demographic data, characteristics of women B: obstetric characteristics C: Social support D: health system factors E: perspectives of women on RMC. The tool contained closed ended questions. It had a

total of 50 questions; 9 on socio-demographic, characteristics of women, 9 on obstetric features, 4 on social support, 8 on health system factors that affect RMC and 20 questions on perception of women on RMC. The tool was used to address objective 1 and 2.

3.7.3 Healthcare provider tool

This was a structured questionnaire that dealt specifically with healthcare providers. It was adopted and modified from tools used by MCHIP used for training by USAID (USAID, n.d.). It had four sections with a total of 37 questions. Section A; sociodemographic characteristics 9, section B; Training on RMC and policies 5, section C; Factors affecting RMC 3 and section D; RMC components 20 parts. This was analyzed to answer objective 3 and 4.

3.8 Validity of instruments

This is the capability of a tool to measure what it is required to measure. The tools (postnatal women tool, health providers tool and interview guide) were reviewed by supervisors and co-opted experts before use. The Bartlett's test was evaluated through chi-square test for all the variables and they were all significant at $p < 0.05$. The findings of the study were also validated by reviewing other similar studies.

3.9 Reliability of the instruments

This is the accuracy of the tool, that is being consistent with the results. The tools to be used had been used in several studies, tested and found to be reliable. Although, because of some modifications they were pre-tested in a pilot study at Kapenguria county hospital which has a similar environment as Kitale county referral hospital before the actual data collection. 10% of the sample size was used. The three independent variables, one intervening and one dependent variable were subjected to reliability test using SPSS and results for all were more than 0.78 thereby achieving the recommended 0.7 value for internal consistence.

3.10 Data collection procedure

Two research assistants were recruited into this study, nurses who had experience in data collection. They were trained on study objectives, correct administration of the study tools, sampling methods, data collection and ethical considerations. The training was thorough to ensure good quality of data was collected. Any questions from the research assistants were addressed during the whole process. The researcher was supervising what the research assistants were doing to ensure the process was credible.

Data was collected from Kitale County referral hospital. This was done among health providers working in the maternity unit and women who had delivered in the facility within the first 24 hours while still in the postnatal wards respectively.

Structured questionnaires and interview guides were used to collect data from the women and health providers. The women in the postnatal wards were approached and informed about the study, those who agreed were given a consent form to sign and then answered questionnaires via exit interviews. Similarly, the health providers in the maternity unit were approached, informed on the purpose of the study, signed consent forms and filled the questionnaires.

3.11 Data management

Upon collection of data from women and health providers, data was stored in both computer devices and hard copies for the researcher to prepare for data analysis. Quality of the data collected was assessed by undertaking regular checks. This data was stored in a computer that was password protected and was only accessed by the researcher.

3.12 Data analysis

Data was checked for completeness, coded and entered into SPSS version 23.0 database by the researcher. Data was also edited, entered into analysis tool and cleaned. Quantitative data was analyzed by the use of descriptive statistics (like frequency and percentages) and inferential

statistics like chi square. Bivariate analysis was used to identify independent variables which were associated with RMC while multivariate analysis was done to control for confounders. Independent variables included; woman's age, marital status, number of ANC attended, educational status, time of delivery among others. A 0.05 value was taken as the p-value to determine statistical significance. For qualitative data, focused group discussions were audio-recorded, translated, transcribed and themes were formed.

3.13 Ethical considerations

Approval was sought from the Masinde Muliro University of Science and Technology directorate of postgraduate studies and then Institutional and Ethics Review Committee (IERC) to conduct the study. Furthermore, a permit was obtained from National commission for science, technology and innovation (NACOSTI) to carry out research. Moreover, permission from the county government of Trans Nzoia and Kitale county referral hospital administration was obtained.

The following ethical principles were applied in this study;

3.13.1 **Informed consent:** -In this study the women and health providers consent was sought. A written consent form was given to those who agreed to participate in the study to sign. This was preferred as it helped in keeping records. The health providers and postnatal women were explained to in detail the purpose of the study, expected duration of the study, methods used in the study and the possible outcomes from the study. In cases of any questions or concerns that could have arisen, a contact was given for purposes of clarity but in this study no concern was raised.

3.13.2 **Anonymity and confidentiality:** - In this study names of the women and health providers were not included in the questionnaires and interview guides, only codes were used to maintain anonymity. They were assured that the information they gave was to be treated

with confidentiality. This was ensured by properly storing the questionnaires and information from FGD under lock and key while data in software was kept in a computer that is password protected only known to the researcher. This was ensured during storage, analysis and publication. The questionnaires and information from FGD were destroyed after some time.

3.13.3 **Autonomy: -** In this study the women and health providers were not coerced into the study but were free to choose to volunteer to participate in the study. Their decision to or not to participate in the study was respected. They were also free to withdraw from the study at any point in time.

3.13.4 **Beneficence and non-maleficence**: -Research should be beneficial and ensure no harm is inflicted to the participants. In this study respondents were not in any way harmed as only questionnaires and interview guides were used. The study also provided benefits in terms of knowledge and updates on respectful maternity care to women and health providers.

3.13.5 **Justice**: -Research should be just; that is equal or fair treatment to all. In this study there was equal distribution of benefits emanating from it to the women and health providers and the outcomes of the study was to be disclosed to all respondents.

3.13.6 **Integrity**: -Research is meant to ensure that certain set standards of integrity are met and transparency is ensured. Practices like plagiarism were not done. In this study the researcher ensured that the information provided by the respondents was the one used and no falsification was allowed.

CHAPTER FOUR
RESULTS

4.1 Overview

This chapter presents the findings from the study conducted on **"**respectful maternity care and associated factors at Kitale county referral hospital.**"** It also presents analysis and interpretation of findings of the study. The demographic characteristics of the respondents are presented, thereafter; other findings are presented as per the objectives of the study.

4.2 Response Rate

In this study, out of a total of 265 questionnaires which were distributed to the sampled respondents (women), 260 of them were filled and returned. Therefore, 260 were correctly filled and these were the ones used for the analysis, which made up a response rate of 98.1%. For healthcare providers, out of the 25 questionnaires only 18 were filled correctly and returned representing 72% thus also used in analysis. Moreover, focused group discussions were conducted till saturation was reached. In total four FGDs were done among women who had delivered and were in the postnatal ward.

4.3 Demographic characteristics of the women

This section contains the analysis of information on respondent's age, marital status, residence, education level, occupation, religion and mode of delivery. The main purpose of this was to find out any trend from the respondents' profile that was directly linked to the variables of the study.

As indicated in table 4.1, the mean age of women was 27.18, majority 69.6% (181) of women were married, 70.4% were from rural setting, majority of them 95% (247) were Christians, 55% had studied to post primary level, 35% (91) had self-employment and 70% (182) belonged to the medium wealth quantile.

Table 4.1 Demographic characteristics of women

Characteristic		Frequency	Percent
Marital status	Single	78	30.0
	Married	181	69.6
	Divorced/separated	1	0.4
	Widowed	0	0.0
Residence	Urban	77	29.6
	Rural areas	183	70.4
Religion	Christian	247	95.0
	Muslim	13	5.0
	Traditionalist	0	0.0
	No religion	0	0.0
Educational status	No education	3	1.2
	Primary level	57	21.9
	Post primary (secondary or vocational)	144	55.4
	College and above	56	21.5
Employment status	Employed	50	19.2
	Self employed	91	35.0
	Farmer	7	2.7
	House wife	51	19.6
	Student	61	23.5
Wealth status of the family	Low	73	28.1
	Medium	182	70.0
	High	5	1.9
Do you suffer from any of the conditions below	HIV/AIDS	20	7.7
	Mutism & deafness	0	0.0
	Hypertensive condition	14	5.4
	Physical disability	0	0.0
	None	226	86.9

4.4 Demographic characteristics of health providers

In table 4.2, the mean age of the health providers was 32.94, 55.6% (10) of the health providers were male, 72.2% were nurses, 38.9% had studied up to degree level, 66.7% had experience of between 3-6 years in the maternity unit, 83.3% were permanently employed while 72.2% (13) didn't have job satisfaction.

Table 4.2 Demographic characteristics of health providers

Characteristic		Frequency	Percent
Gender	Male	10	55.6
	Female	8	44.4
Cadre	Medical doctor	3	16.7
	Midwife	0	0.0
	Nurse	13	72.2
	Clinical officer	2	11.1
Qualifications	Masters	0	0.0
	Degree	7	38.9
	Higher diploma	2	11.1
	Diploma	9	50.0
	Certificate	0	0.0
Experience in maternity practice	Less than a year	2	11.1
	1-3 years	2	11.1
	3-6 years	12	66.7
	Over 6 years	2	11.1
Employment type	Permanent	15	83.3
	Contractual	3	16.7
Job satisfaction	Yes	5	27.8
	No	13	72.2

4.5 Perceptions on RMC among women at Kitale County Referral Hospital

4.5.1 Quantitative analysis

Majority of women, 210 (80.8%) were protected from physical harm, with 78.9% of women being free from physical force like slapping and hitting. Those who were given comfort/pain relief in labor were 55.4% (144) while as many as 95.4% (248) of women reported to have been allowed to use food and fluids in labor. 80.4% of women reported to have received the aspect of consent and information and of this 94.5% (245) reported to have been allowed to freely move in labor, 58.1% (151) of women were asked for consent before procedures were done while 71.5% of them said their companions were encouraged to remain with them as much as possible.

Moreover, 67.7% (176) of women received privacy and confidentiality with the least number of women 63.5% (165) reported to have been covered with drapes during delivery while 71.5%, visual barriers were used in examinations.

Furthermore, 99.2% (258) of women were given care free from discrimination and of these, 98.5% were not disrespected based on their attributes like physical disability. Finally, 88.2% (230) of women were not left without care of which 100% reported to have been spoken to at the language level they understood well as shown in table 4.3.

Table 4.3 Quantitative analysis of women perspectives on RMC

	PERFORMANCE INDICATOR	YES accorded RMC n (%)	NO not accorded RMC n (%)
The Woman is Protected from physical harm	The woman wasn't denied food or fluid in labor unless medically necessitated	248(95.4)	12(4.6)
	The woman wasn't physically restrained	243(93.5)	17(6.5)
	The woman was given comfort/pain relief as necessary	144(55.4)	116(44.6)
	No physical force or abrasive behavior was used on the woman, including slapping or hitting	205(78.9)	55(21.1)
Right to information, informed consent and choice	Health provider introduced self to woman and companion	196(75.4)	64(24.6)
	The companion was encouraged to remain with woman as much as possible	186(71.5)	74(28.5)
	Woman and companion were encouraged to ask questions	161(61.9)	99(38.1)
	The woman was explained to what was being done and what to expect in labor & birth	235(90.4)	25(9.6)
	Woman was given periodic updates on progress & status of labor	245(94.2)	15(5.8)
	The woman was allowed to move about freely in labor	245(94.2)	15(5.8)
	The woman was allowed to assume position of choice during birth	259(99.6)	1(0.4)
	Consent was obtained prior to procedure	151(58.1)	109(41.9)
Confidentiality and privacy	Visual barriers were used in exams, procedures, birth	186(71.5)	74(28.5)
	Woman was covered with drapes in birth	165(63.5)	95(36.5)
Dignity and Respect	Woman and companion were spoken to politely	251(96.5)	9(3.5)
	Woman or companion were never intimidated, threatened or coerced	259(99.6)	1(0.4)
Equitable care, free of discrimination	Woman was spoken to at the language level she understands	260(100.0)	0(0.0)
	Woman wasn't disrespected based on an attribute	256(98.5)	4(1.5)
The woman is never left without care	Woman was encouraged to call if needed	202(77.7)	58(22.3)
	Woman wasn't left alone or unattended to	257(98.8)	3(1.2)

4.5.2 Qualitative perceptions on RMC among women who delivered at KCRH.

4.5.2.1 Abuse free care

Generally, women felt they had a good birth experience and were treated well by the health providers.

"*I had a good experience and I feel the HCP treated me well from the beginning till delivery.*" (FGD 1, 40-year-old, para 5+0)

"*Health provider referred to me as 'we', for 'you'...and I didn't feel okay at all.''* (FGD 2, 31-year-old, para 1+0).

"*HCP referred to me as 'mama' and I felt okay since I am a mother.''* (FGD 2, para 1+0, 26-year-old)

"*I was welcomed well in the facility and the HCP were friendly. I was treated well and didn't have a tear*" (FGD 3 para 2+0, 38 years)

4.5.2.2 Pain relief in labor

Women mentioned limited pain medication were offered or were not available in labor and weren't taught about it but rubbing of the back was done.

"*I wasn't given pain medication but rubbing of the back was done*" (FGD 2, para1+0)

"*My back was rubbed by a HCP*" (FGD 3, para 2+0, 22 years)

"*I didn't have strong pains and was given some medication to fasten the labor*" (FGD2, para 3+0, 26 years)

4.5.3 Privacy and confidentiality

There wasn't enough privacy provided to the women as they felt they were exposed during labor and delivery

"*I didn't feel comfortable as there were no curtains separating beds. One can easily be seen by others and it isn't okay. This could bring stress to those who haven't delivered.''* (FGD3, para 3+0, 38 years)

"*I wasn't comfortable as I could be seen easily by the person next bed. There was no privacy at all*" (FGD3, para 3+0, 22 years)

''*There was no privacy at all accorded to us.*'' (FGD 4, para 1+0, 22 years)

4.5.4 Dignified care

Women expressed their feelings that there weren't enough beds within the facility and cleanliness was generally poor.

"*Beds aren't enough and we are sharing one bed amongst two or three mothers. Additionally, bed sheets and toilets aren't clean*" (FGD 2, para 3+0, 37 years)

"*Beddings aren't changed, even when another mother has been there and cleanliness of toilets in the evening is wanting*." (FGD 1, para 1+0, 26 years)

4.5.5 Consensual care

Women noted that consent was taken before procedures could be carried out by the HCP

"*They would ask for permission explaining why before doing a procedure*." (FGD para 5+0, 40 years)

"*Before procedure they would explain*" (FGD3, para 3+0, 26 years)

"*Yes I was asked for permission before examination*" (FGD 4, para 1+0, 25 years)

"*I was given instruction before any examination was done on me*" (FGD 3, Para 3+0, 26 years)

4.5.5.1 Birthing positions

Most women mentioned not being aware of other delivery positions apart from lying on the back and felt what the HCPs directed them was okay since the health providers are skilled in that area.

"*I was showed the position by the HCP and I was okay with it.*'' (FGD 2, para 1+0, 31 years)

"*Squatting is the only method I have seen it being shown by the TBA's and not in the hospital*" (Para 3+0, FGD 2, 37 years)

"*I have delivered in other facilities but this facility treats people well. I knew of squatting position and I delivered in that position*'' (FGD 3, para 6+0, 38 years)

''*I had been taught in previous births to deliver on my back, of which I was comfortable. If taught another position, I won't be comfortable*" (FGD3, para 3+0, 26 years)

4.5.5.2 Companions in labor

Most women came with companions in the facility and were comfortable to have them as they would assist when need arose, were okay to have them in labor rooms but weren't comfortable to have them in the delivery room but few of them were willing to have them in the delivery room.

"*The doctors in the room are just enough to handle all that with me and not them*" (FGD 1, para 5+0, 40 years)

"*I was brought by others but I won't be comfortable to have them in labor and delivery rooms*" (FGD3, para 6+0, 38 years)

4.5.5.3 Health system factors

Women felt resources weren't adequate within the facility as they were to buy some items

"*We were told to buy cotton wool and gloves*" (FGD 2, para 2+0, 37 years)

"*Maternity space is small and water is cold, hence making women to fear bathing*" (FGD3, para 6+0, 38yrs)

4.6 Women related factors that influence respectful maternity care at KCRH.

4.6.1 Prevalence of RMC

Out of 260 women who gave birth at Kitale county referral hospital, 217 (83.5%) women received RMC, but the remaining 43 (16.5%) women were accorded non-RMC during labor and delivery.

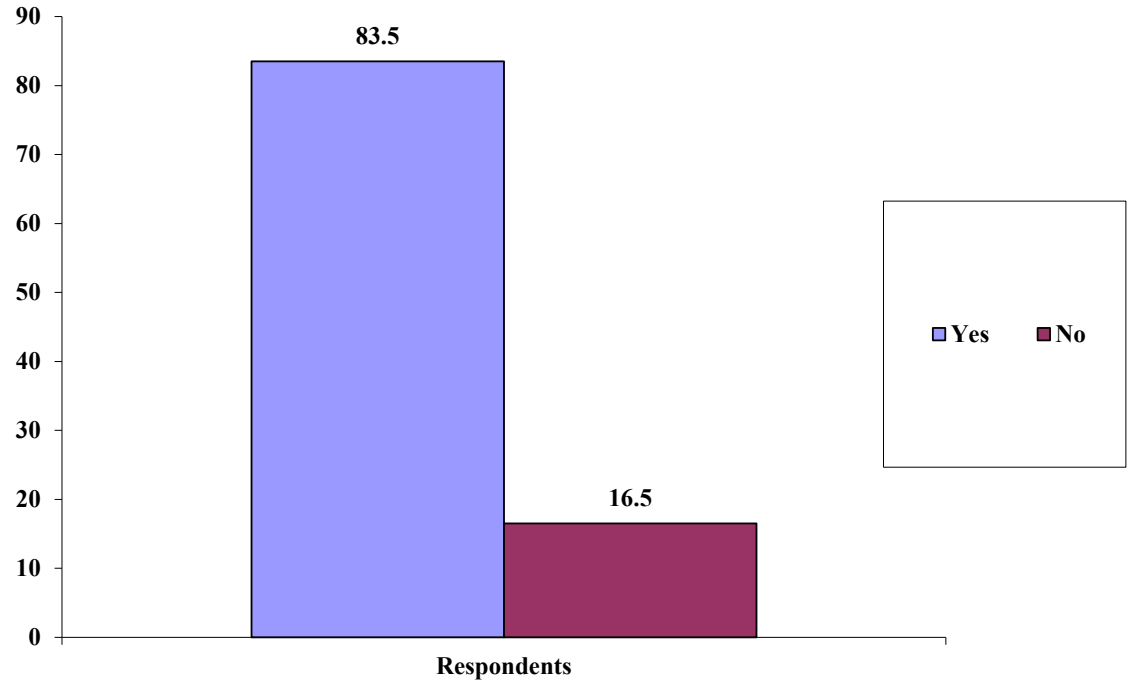


Figure 4.2: Responses on RMC prevalence

This showed that the overall prevalence of respectful maternity care was 83.5% at Kitale county referral hospital as shown in figure 4.2.

4.6.2 Obstetric characteristics

Of the total women, 42.3% (110) were first time mothers, 56.9% had previously delivered in the hospital and 96.5% had intended to use the hospital for delivery, 53.8% labored for less than 24 hours before delivery, 72.3% delivered via SVD and 59.6% had complications after delivery as shown in table 4.4.

Table 4.4 Obstetric characteristics

Characteristic		Frequency	Percent
Number of births/parity	One	110	42.3
	Two	65	25.0
	Three	54	20.8
	Four or more	31	11.9
Previous Birth place	Hospital	148	56.9
	Home	107	41.2
	NA if she is first time mother	5	1.9
Was the pregnancy planned	Yes	144	55.4
	No	116	44.6
When did you begin ANC?	First trimester	203	78.1
	Second trimester	29	11.2
	Third trimester	18	6.9
	Didn't attend	7	2.7
	Don't know	3	1.1
Number of ANC visits	None	9	3.4
	1 to 4	140	53.9
	More than 4	111	42.7
	Yes	251	96.5

Did you intend to use the facility for delivery	No	9	3.5
Length of time labored in the facility before delivery	< 24 hours	140	53.8
	≥ 24 hours	120	46.2
Mode of delivery	SVD	188	72.3
	AVD	0	0.0
	CS	72	27.7
Any complication after delivery	Yes	155	59.6
	No	105	40.4

4.6.3 Support structure

In table 4.5, majority of the women, 81.9% (213) and 65.4% (170) had a companion in labor ward and delivery room respectively, 50.8% of the women were accompanied by their spouses to the hospital and 53.5% were encouraged to have a companion in labor and delivery by the health providers.

Table 4.5 Support structure

Support in labor & delivery		Frequency	Percent
Had a companion in labor room	Yes	213	81.9
	No	47	18.1
Had a companion in delivery room	Yes	170	65.4
	No	90	34.6
Who accompanied you to the hospital	None	12	4.7
	Spouse	132	50.8
	Friend/neighbor	70	26.9
	Mother	54	20.8
	Mother in law	7	2.7
Encouraged to have a companion in labor & delivery	Yes	139	53.5
	No	121	46.5

The result of this study revealed that women who were from urban were 1.46 times more likely to receive respectful maternity care (RMC) than their counterparts from rural areas, [AOR = 1.46 (95% CI: 0.35-3.01)]. Married women were1.51 times more likely to receive RMC than those who were either single or divorced/separated [AOR = 1.51 (95% CI: 0.46-2.33)]. The odds of women who were housewives were almost two times more likely to receive RMC compared to those who were students [AOR = 1.83 (95% CI: 1.61-3.26)]. Moreover, women with three children were 1.74 times to be accorded RMC than those who had four or more children [AOR = 1.74 (95% CI: 0.27-3.28)]. Those who had delivered previously in the hospital were two times probably of receiving RMC compared to those who were first time mothers [AOR = 2.01 (95% CI: 1.51-2.45)]. Furthermore, those who delivered via SVD were 1.13 times to receive RMC than those who delivered via CS [AOR = 1.13 (95% CI: 0.24-3.28)]. Finally, the odds of women who had complications after delivery were two times more likely to be accorded RMC compared to those who didn't have any complication [AOR = 2.17 (95% CI: 0.25-1.26)]. These were significant attributes towards women who had delivered receiving RMC at Kitale county referral hospital as shown in table 4.6.

Table 4.6 Bivariate analysis of women characteristics

Variable	Category	RMC		AOR	95% CI	p value
		Yes	NO			
Marital status	Single	56	22	1.22	0.47-2.51	0.002
	Married	138	43	1.51	0.46-2.33	
	Divorced/separated	1	0			
Residence	Urban	57	20	1.46	0.35-3.01	0.025
	Rural areas	138	45			
Educational status	No education	2	1	2.65	0.81-1.90	0.073
	Primary level	47	10	2.58	1.06-4.32	

	Post primary (secondary or vocational)	110	34	1.40	0.38-4.12	
	College and above	36	20			
Employment Status	Employed	39	11	1.62	0.41-2.27	0.001
	Self employed	78	13	1.40	1.20-3.20	
	Farmer	5	2	1.42	0.43-2.39	
	House wife	41	10	1.83	1.61-3.26	
	Student	52	9			
Wealth status	Low	53	20	1.41	0.81-1.65	0.421
	Medium	137	45	1.23	0.75-1.02	
	High	4	1			
Number of births/parity	One	79	31	1.24	0.24-1.62	0.001
	Two	48	17	1.33	0.81-2.17	
	Three	43	11	1.74	0.27-3.28	
	Four or more	25	6			
Previous Birth place	Hospital	127	21	2.01	1.51-2.45	0.016
	Home	79	28	1.97	1.34-3.28	
	NA if she is first time mother	3	2			
Was the pregnancy planned	Yes	113	31	4.45	1.12-2.70	0.053
	No	82	34			
Number of ANC visits	None	5	4	1.34	0.36-2.13	0.584
	1 to 4	103	37	2.52	0.39-2.25	
	More than 4	87	24			
Did you intend to use the facility for delivery	Yes	190	61	1.13	0.27-3.23	0.281
	No	5	4			
Length of time labored in the facility before delivery	< 24 hours	108	32	1.41	0.25-1.3	0.072
	≥ 24 hours	87	33			
Mode of delivery	SVD	151	37	1.13	0.24-3.28	0.018
	CS	44	28			
Any complication after delivery	Yes	119	36	2.17	0.25-1.26	0.001
	No	76	29			

In table 4.7, 203 (78.1%) women reported to have waited to be served in the hospital for less than 30 minutes while 225 (86.5%) of them were comfortable with the waiting time. 56.5% of women delivered during the night time. Moreover, 245 (94.2%) women intended to deliver in the facility in future while 244 (93.9%) would recommend other pregnant women to deliver at Kitale county referral hospital.

Table 4.7 Health system factors

Other facility & health provider factors		Frequency	Percent
Length of time (waited) to be attended to once in the facility	Less than 30 min	203	78.1
	About one hour	30	11.5
	More than $1\frac{1}{2}$ hours	27	10.4
Was waiting time okay for you?	Yes	225	86.5
	No	35	13.5
Day delivered	Weekend	95	36.5
	Weekday	165	63.5
Time you delivered	Night	147	56.5
	Daytime	113	43.5
Sex of the provider who conducted the delivery	Male	143	55.0
	Female	117	45.0
Number of providers assisting in delivery care	One	49	18.9
	Two	143	55.0
	Three or more	68	26.1
Intending to deliver in the facility in future	Yes	245	94.2
	No	15	5.8
Recommending any pregnant woman to deliver here	Yes	244	93.9
	No	16	6.1

The study also revealed that the odds of RMC were two times more among those who waited for less than half an hour than those who waited for more than one and a half hours to be attended within the maternity unit [AOR = 2.1 (95% CI: 1.32-3.21)]. Moreover, the odds of RMC were

more among those whose waiting time was okay with them in contrast to those whose waiting time wasn't okay with them [AOR = 1.1 (95% CI: 1.46-3.68)]. Those who delivered during the night time were almost four times likely to receive RMC than those who delivered during the day [AOR = 3.46 (95% CI: 1.12-2.70)]. Furthermore, the odds of receiving RMC in a delivery being conducted by two providers were almost two times more than that done by three providers [(AOR = 1.56 (95% CI: O.45-1.31)]. In addition, women who had intention to deliver in the facility in future were also in a better position to receive RMC than those who didn't, this was also observed among women who would recommend others to deliver in the facility in future. This health factors were also significant on determining RMC as shown in table 4.8.

Table 4.8 Bivariate analyses on health system factors

Characteristic		RMC		AOR	95% CI	p-value
		Yes	No			
Length of time (waited) to be attended to once in the facility	Less than 30 min	187	203	2.1	1.32-3.21	0.003
	About one hour	21	9	1.04	0.61-1.75	
	More than $1\frac{1}{2}$ hours	20	7			
Was waiting time okay for you?	Yes	165	60	1.1	1.46-3.68	0.018
	No	30	5			
Day delivered	Weekend	65	30	1.13	0.27-3.23	0.261
	Weekday	130	35			
Time you delivered	Night	112	35	3.46	1.12-2.70	0.021
	Daytime	83	30			
Sex of the health provider who conducted the delivery	Male	115	28	1.2	1.21-3.26	0.183
	Female	80	37			
Number of providers assisting in delivery care	One	35	14	0.7	1.38-2.16	0.041
	Two	120	23	1.56	0.45-1.31	
	Three or more	40	28			

Intending to deliver in the facility in future	Yes	180	60	0.7	1.36-2.19	0.002
	No	10	5			
Recommending any pregnant woman to deliver here	Yes	184	60	0.71	0.21-1.34	0.039
	No	11	5			

Items with a p value of less than 0.05 level of significance were moved to multivariable model in order to control for confounders. The factors that were significant in the bivariate retained their significance in the multivariate model.

There was statistical significant difference on respectful maternity care based on marital status [F (3, 96) = 16.782, p =0.002]. Other factors that retained their significance were; place of residence [F (2, 86) = 15.726, p=0.025], employment status [F (5, 72) = 16.720, p=0.001], parity [F (4, 81) = 17.402, p=0.001], previous birth place [F (3, 87) = 19.707, p=0.016], mode of delivery [F (2, 79) = 18.472, p=0.018)] and having a complication after delivery [F (2, 70) = 18.372, p=0.001)] as shown in table 4.9

Table 4.9 Multivariate analysis on women characteristics

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.892	2351.031	5.000	15.000	0.517
	Wilks' Lambda	.0176	2351.031	5.000	15.000	
	Hotelling's Trace	63.812	2351.031	5.000	15.000	
	Roy's Largest Root	62.348	2351.031	5.000	15.000	
Marital status	Pillai's Trace	.982	13.509	3.000	92.00	0.002
	Wilks' Lambda	.881	14.784	3.000	97.00	
	Hotelling's Trace	.806	16.782	3.000	98.00	
	Roy's Largest Root	.752	14.731	3.000	96.00	
Residence	Pillai's Trace	.468	15.042	2.000	79.00	0.025
	Wilks' Lambda	.591	15.726	2.000	86.00	

	Hotelling's Trace	.752	14.283	2.000	82.00	
	Roy's Largest Root	.599	13.681	2.000	83.00	
Employment Status	Pillai's Trace	.583	20.562	5.000	82.00	0.001
	Wilks' Lambda	.536	16.720	5.000	72.00	
	Hotelling's Trace	.561	18.572	5.000	64.00	
	Roy's Largest Root	.527	19.381	5.000	67.00	
Number of births/parity	Pillai's Trace	.663	18.632	4.000	79.00	0.001
	Wilks' Lambda	.602	17.402	4.000	81.00	
	Hotelling's Trace	.682	16.364	4.000	83.00	
	Roy's Largest Root	.672	18.202	4.000	88.00	
Previous Birth place	Pillai's Trace	.618	18.472	3.000	86.00	0.016
	Wilks' Lambda	.459	19.707	3.000	87.00	
	Hotelling's Trace	.992	20.204	3.000	83.00	
	Roy's Largest Root	.561	22.816	3.000	82.00	
Mode of delivery	Pillai's Trace	.804	20.637	2.000	77.00	0.018
	Wilks' Lambda	.582	18.472	2.000	79.00	
	Hotelling's Trace	.892	15.356	2.000	73.00	
	Roy's Largest Root	.699	17.265	2.000	88.00	
Any complication after delivery	Pillai's Trace	.781	16.426	2.000	72.00	0.001
	Wilks' Lambda	.459	18.372	2.000	70.00	
	Hotelling's Trace	.992	17.348	2.000	71.00	
	Roy's Largest Root	.561	17.002	2.000	72.00	

4.7 Institutional factors that influence RMC at Kitale County Referral Hospital.

Table 4.10 Rankings on the institutional factors influencing RMC

Indicator	N	P.I	Rank
Inadequate equipment	15	0.85	1
Limited supplies	14	0.80	2
Limited space/infrastructure	8	0.48	3
Working environment	6	0.44	4
Facility management	4	0.32	5
Government policies	2	0.22	6

Source: Researcher, 2023

From the results in table 4.10, chi square test was performed as shown in table 4.11 to determine any associations of institutional factors with RMC.

Table 4.11 Chi-square analysis depicting the association between institutional factors and respectful maternity care

Indicator	χ^2	P (sig)
Inadequate equipment	5.1	<0.01
Limited supplies	5.4	0.01
Limited space/infrastructure	6.1	0.03
Working environment	7.2	0.04
Facility management	10.8	0.04
Government policies	17.3	0.78

From the study findings in Table 4.12, the value of R-square is 0.331. This implies that, 33.1% of variation of respectful maternity care was explained by institutional factors.

Table 4.12 Regression summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
	.417[a]	.331	.337	5.03502

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	432.774	1	432.774	15.431	.003[b]
	Residual	570.176	64	8.909		
	Total	1002.950	65			

a. Dependent Variable: Respectful maternity care (RMC)

b. Predictors: (Constant), Institutional factors

From the findings in Table 4.12, at 0.05 level of significance the test indicated that in this model the independent variable namely; institutional factor(s) is important in prediction of respectful maternity care as indicated by significance value=0.003 which is less than 0.05 level of significance (p=0.003 < 0.05).

4.8 Health provider factors that influence RMC at KCRH.

Table 4.13 indicates the rankings of health provider factors that influence respectful maternity care at KCRH.

Table 4.13 Rankings of the health providers' factors influencing RMC

Indicator	N	P.I	Rank
Inadequate number of healthcare providers	13	0.89	1
High work load	12	0.81	2
Being motivated	7	0.72	3
Trainings on RMC	5	0.57	4
Poor inter-health provider relationships	3	0.51	5
Inadequate health provider knowledge and skills	2	0.45	6
Poor health provider personality	1	0.39	7

Source: Researcher, 2023

Chi square test was performed from the above results to find the relationship between health provider factors with respectful maternity care as indicated in table 4.14.

Table 4.14 Chi-square analysis depicting the association between health provider factors and respectful maternity care

Indicator	χ^2	p (sig)
Inadequate number of healthcare providers	4.21	0.01
High work load	5.63	0.01
Being motivated	6.05	0.02
Trainings on RMC	6.94	0.04
Poor inter health relationships	7.82	0.06
Inadequate health provider knowledge and skills	13.82	0.09
Poor health provider personality	13.98	0.12

From the study findings in Table 4.15, the value of R-square is 0.428. This implies that, 42.8% of variation of respectful maternity care was explained by health provider factors.

Table 4.15 ANOVA test

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.442[a]	.428	.403	2.4161

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	199.221	1	199.221	23.812	.001[b]
	Residual	432.296	96	7.720		
	Total	631.517	97			

a. Dependent Variable: Respectful maternity care

b. Predictors: (Constant), health provider factors

From the findings in Table 4.15, at 0.05 level of significance the ANOVA test indicated that in this model the independent variable namely; health provider factor(s) is important in predicting respectful maternity care as indicated by significance value p=0.001 which is less than 0.05 level of significance (p=0.001 < 0.05).

Majority of health care providers (70%), demonstrated positive care for women by protecting them from harm, neither restraining nor mistreating them, while approximately 50% provided comfort and pain relief using pharmacological methods.

Furthermore, health providers performed poorly on allowing women to assume position of choice in delivery on always aspect at 33% and on never aspect at 16.7%. In addition, only 38.9% of health providers would always introduce themselves to women and their companions. On confidentiality and privacy, use of drapes by healthcare providers in maternity scored poorly on always aspect at 38.9%. Moreover, the equitable care without discrimination components scored above 70% on the always category as shown in table 4.16.

Table 4.16 Descriptive analysis of maternity care assessment of health providers

	Performance Indicator	Always	Often	Sometimes	Rarely	Never
The Woman is Protected from physical harm	I do not deny food or fluid to the woman in labor unless medically necessitated	14 (77.7)	2 (11.1)	0 (0.0)	1 (5.6)	1 (5.6)
	I never physically restrain woman	14 (77.7)	2 (11.1)	0 (0.0)	1 (5.6)	1 (5.6)
	I provide comfort/pain-relief as necessary	10 (55.5)	2 (11.1)	1 (5.6)	5 (27.8)	0 (0.0)
	I never use physical force or abrasive behavior with the woman, including slapping or hitting	13 (72.2)	3 (16.6)	0 (0.0)	1 (5.6)	1 (5.6)
Right to information, informed consent and choice	I do Introduce myself to woman and companion	7 (38.9)	6 (33.3)	1 (5.6)	4 (22.2)	0 (0.0)
	I do encourage the companion to remain with woman as much as possible	3 (16.6)	6 (33.3)	1 (5.6)	7 (38.9)	1 (5.6)
	I do encourage woman and companion to ask questions	9 (50.0)	5 (27.8)	0 (0.0)	3 (16.6)	1 (5.6)
	I do explain what is being done and what to expect in labor & birth	12 (66.6)	5 (27.8)	0 (0.0)	1 (5.6)	0 (0.0)
	I give periodic updates on progress & status of labor	9 (50.0)	6 (33.3)	1 (5.6)	2 (11.1)	0 (0.0)

	I allow the woman to move about freely in labor	13 (72.2)	2 (11.1)	1 (5.6)	2 (11.1)	0 (0.0)
	I allow the woman to assume position of her choice during birth	6 (33.3)	5 (27.8)	0 (0.0)	4 (22.2)	3 (16.7)
	I do obtain consent prior to procedure	14 (77.8)	2 (11.1)	0 (0.0)	2 (11.1)	0 (0.0)
Confidentiality and privacy	I ensure there are visual barriers during examination, procedures and during birth	9 (50.0)	3 (16.6)	0 (0.0)	5 (27.8)	1 (5.6)
	I ensure the woman is covered with drapes during birth	7 (38.9)	2 (11.1)	3 (16.6)	4 (22.2)	1 (5.6)
Dignity and Respect	I do speak politely to women and companion	13 (72.2)	5 (27.8)	0 (0.0)	0 (0.0)	0 (0.0)
	I never intimidate, threaten or coerce women or companion	14 (77.8)	4 (22.2)	0 (0.0)	0 (0.0)	0 (0.0)
Equitable care, free of discrimination	I do speak to women at the language level they understand	13 (72.2)	2 (11.1)	2 (11.1)	1 (5.6)	0 (0.0)
	I don't show disrespect based on an attribute to women	13 (72.2)	2 (11.1)	2 (11.1)	1 (5.6)	0 (0.0)
The woman is never left without care	I do encourage women to call if needed	12 (66.6)	5 (27.8)	1 (5.6)	0 (0.0)	0 (0.0)
	I never leave women alone or unattended	9 (50.0)	4 (22.2)	2 (11.1)	2 (11.1)	1 (5.6)

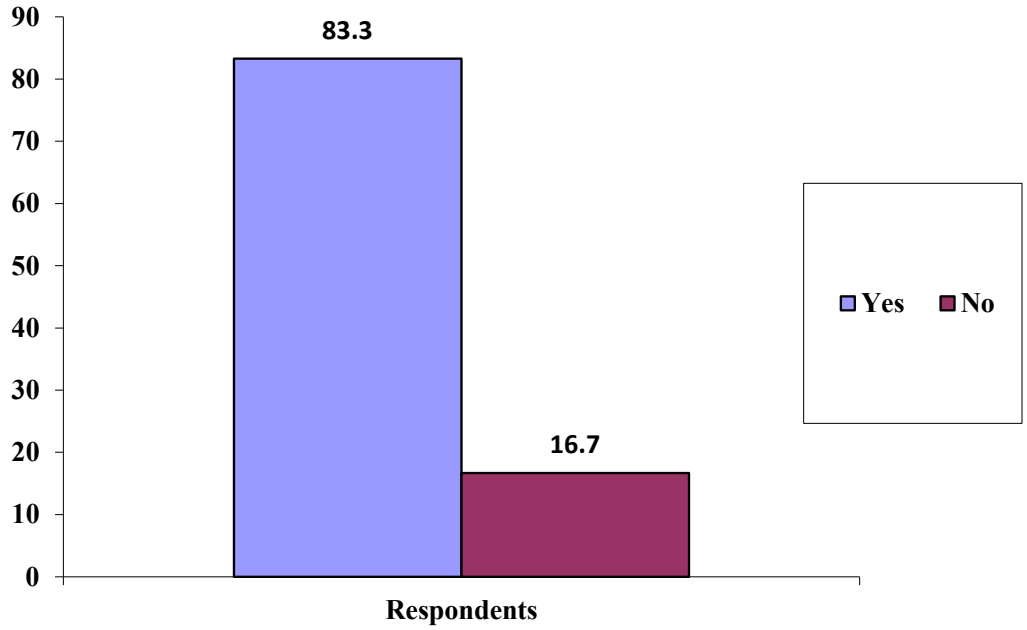


Figure 4.2: Responses on whether health providers apply RMC in their daily practice

83.3% (15) of the health providers reported to be providing respectful maternity care in the facility in their day today service delivery in the maternity as shown in Fig 4.2.

CHAPTER FIVE
DISCUSION

5.1 Overview

This chapter presents the discussion of findings on the study conducted at Kitale county referral hospital on respectful maternity care and associated factors. The discussion is presented as per the objectives of the study.

5.2 Women perceptions on respectful maternity care at KCRH

5.2.1 Abuse free care

From the study, 80.8% (210) of women were protected from physical harm. This finding is lower than previous studies done in India, Ghana and Kenya that have reported values above 95% (Afulani et al., 2019; Sudhinaraset et al., 2021). This could be credited to difference in settings where the first study was done in three different countries as earlier mentioned and the later study was done in urban counties in Kenya (Kiambu and Nairobi). Besides, the methodology used in the studies could have contributed as all the studies samples of over 1,000 women were involved using a different tool. Moreover, quantitative findings revealed that 55.4% of women were provided with comfort/pain relief. However, in FGDs limited pain relief was offered with some women reporting rubbing of the back. Low level of pain management in labor has been reported by women in several studies where in Ethiopia 18.8% of women reported to have received pain care while 40% and 20% of women in Kenya and Ghana reported little was done by health providers concerning their labor pain (Abebe & Mmusi-Phetoe, 2022; Afulani et al., 2019). This could be due to unavailability of pain medications, HCP competencies on labor pain medications and normalization of labor pain.

5.2.2 Privacy and confidentiality

Privacy was the most violated aspect of RMC in this study with 32.3% (84) of women reporting to haven't been accorded privacy in labor and birth. Findings in other regions have shown different values. In Addis Ababa those who were given privacy were 79.8% (Abebe & Mmusi-Phetoe, 2022) while in India at 0% (Raval et al., 2021). The differences in the findings could be because the first study was done on a higher scalar using 50 health centers which are smaller health facilities and may have fewer deliveries compared to the current study facility while the second study was mainly an observational study which was more objective compared to the current study that was subjective. Furthermore, 63.5% of women in this study reported to have been covered with drapes in delivery. This finding is higher than studies in Malawi (51%), Tanzania (42%) and Ethiopia (49.6%) (Hughes et al., 2022; Shimoda et al., 2020; Tenaw et al., 2022). This could be credited to study methodologies where in Malawi the study was done on a higher scale with a study population of over 660 women using a different tool, while study in Tanzania was done in a different population, that is among midwives and the study in Ethiopia was done using a sample of over 390 women using systematic sampling which mainly focused on non-RMC practices. During FGDs women reported that they were poorly accorded privacy during delivery in the facility as they were visible to many people. This could be due to inadequate resources within public facilities that serve large populations hence items like curtains, drapes and delivery rooms might be a challenge.

5.2.3 Dignified care

During FGDs women complained of the small number of beds in the maternity unit as two to three women were sharing. They also reported poor level of general cleanliness. This

contradicts findings of (Abebe & Mmusi-Phetoe, 2022) in Ethiopia where more than 90% of women reported to have delivered in a clean environment. The difference could be explained by the study settings, where the study in Ethiopia was done in health centers which are mainly level 3 facilities serving a smaller population hence may have fewer deliveries thus cleanliness and bedding may not be a challenge compared to the current study done in a higher facility that has a large catchment population. Non-dignified care has been identified as one of the major components of disrespectful care mostly prevalent in LMIC (Aridi et al., 2021). This could be due to high volume of pregnant women seeking care in the facility compared to the small space and the limited number of beds within the maternity unit.

5.2.4 Consented care

The study further showed that 80.4% of women were given right to information and informed consent. 75.4% of women reported that health providers introduced themselves. This contradicts findings in LMIC where over 80% of women reported that health providers didn't introduce themselves to them in the maternity (Afulani et al., 2019; Hughes et al., 2022). This differences could be due to study settings and methodologies where the first study was done in three nations (Ghana, India and Kenya) on a higher scale with over 3,000 women being involved and the later was done in Malawi with a sample size of 660 women using different tools. Health providers may fail to introduce themselves to women and take consent due to high workload.

Furthermore, only 58.1% of women reported that consent was taken before procedures were done. This finding is higher than study in Tanzania (16%), Guinea, Nigeria and Ghana (44%) (Das et al., 2021; Leslie et al., 2021), while lower than a study in Ethiopia

(75.5%) (Ferede et al., 2022). The differences could be attributable to study settings and methodologies where the first study was done in Tanzania and it was mainly an observational study which is more objective while the second was done in four nations as community surveys among postnatal women who had been discharged from health facilities. The later was a multicenter study done in Ethiopia. During FGDs, women reported that health providers would explain to them before performing procedures.

Moreover, 81.9% and 65.4% of women had companions in labor and delivery rooms respectively and this mirrors studies in India which showed that 85.3% of women's companions were allowed in labor wards (Sharma et al., 2022). Moreover, 53.5% of women were encouraged to have companions in labor and delivery. This findings are similar to those of (Hughes et al., 2022) in Malawi where 51% and 40% of women were encouraged to have companions in labor and delivery rooms respectively. Finally, most women in FGDs were not comfortable to have companions in delivery room and this is consistent with previous studies in Kenya (Aridi et al., 2021). This could be because women may feel exposed at such time when it comes to delivery and would want their privacy preserved hence are only contented to have health providers and not companions in delivery room.

5.3 Women related factors influencing respectful maternity care at KCRH

5.3.1 Prevalence of respectful maternity care

Majority of women, that is 83.7% (217) experienced RMC at KCRH while 16.5% of them received non-RMC. This finding is higher than studies conducted in South-West Nigeria 6.8% (Kedir et al., 2022), Benishangul Ethiopia 12.6% (Amsalu et al., 2022b), Iran 63% (Hajizadeh et al., 2020b) and India 43% (Kedir et al., 2022). The differences may be due to methods used in the studies where the first study was done among women attending

antenatal clinic for a period of six months, the second study was done among both laboring and postpartum women using direct observations, the next was done in both public and private facilities and the later was done outside health facility using community surveys. Additionally, these studies were done on a higher scale using a sample size of over 330 women. This finding was also similar to studies conducted in Tanzania 85%, Kenya 80% (Bante et al., 2020; Kedir et al., 2022) and Brazil 81.7% (Wubetu et al., 2021).

5.3.2 Women related factors

The present study showed that marital status, place of residence, employment status, parity, previous hospital delivery, type of delivery and complications after delivery were women related factors that were significantly associated with RMC.

Marital status was significantly associated with RMC ($p=0.002, < 0.05$) where married women were 1.51 times more likely to be accorded RMC compared to those who were not. This finding concurs with other findings in Kenya and Ethiopia (Kiti et al., 2022; Mengistie et al., 2022). These women have spouses who support them in different ways like emotionally, financially among other aspects thus they are well prepared during the whole pregnancy period. The spouses also act as birth companions serving as advocates for the women when they come to deliver in contrast to those who aren't married since they lack the luxury of the support given by a spouse.

Furthermore, place of residence was significantly associated with RMC ($p=0.025, < 0.05$) where women who were from urban areas were 1.46 times more likely to be accorded RMC compared to those who were from rural areas. Similar findings have also been noted in studies in Ethiopia as women from rural areas were more likely to be abused (Amsalu et al., 2022b; Jiru & Sendo, 2021). Women from urban areas are usually enlightened and

have easy access to information on maternal health through various media platforms like television and social media. These women may also be employed as there are many employment opportunities within urban areas and thus are well economically endowed. Moreover, in urban areas, there is a well-built infrastructure thus easy access to hospitals to consult on any health matters arising thus have an upper hand when it comes to communicating with HCP. They easily voice their concerns since they are confident and easily adapt to the hospital environment as compared to those from rural areas who may be timid and lack information due to poor infrastructure, network, media and finances.

In addition, there was a statistical difference on RMC based on employment status of a woman ($p=0.001$, <0.05) where those who were housewives were more likely to receive RMC in comparison to those who were students. This contradicts the findings of (Yismaw et al., 2022) in Ethiopia. This could be attributable to difference in study settings and study methodology used as the later was done using a different tool with four components and on a high scale in 17 facilities. Besides, women who are housewives are considered mature and may be accompanied by their spouses who act as birth companions and provide support in all aspects. In contrast, students who are pregnant may be looked down upon as being young, having made a mistake by jeopardizing their education and may not be accompanied by spouses as they aren't married at the time which may lead to non-RMC.

Furthermore, place of previous delivery was significantly associated with RMC ($p=0.016$, <0.05) where women who had previously delivered in a health facility were two times more likely to receive RMC than those who were not. This finding marries previous studies done in Pakistan and Ethiopia (Yosef et al., 2020). Women who have had hospital delivery are well acquainted with the environment, requirements, processes within the

hospital, language and instructions given by the HCP thus are subject to receiving RMC. On the contrary, those who haven't delivered in hospital before aren't aware of the processes, language and the requirements in maternity and thus may be perceived as proud by the HCP as they may face difficulty in adapting to the new environment hence may face non-RMC.

In addition, type of delivery was significantly associated with RMC. The odds of those who delivered via SVD to receive RMC were higher compared to those who delivered through CS. This finding was similar to a study conducted in central Ethiopia (Ferede et al., 2022) and is dissimilar to a study in the same nation in Hadiya region (Mengistie et al., 2022). The differences could be due to methodologies and study period used in the studies where the later was done on a higher scale in several public hospitals over a period of one month. Women who deliver via SVD spent less time within the hospital before discharge and thus may have limited contact time with HCP thus may not notice events of non-RMC compared to those who deliver via CS who need close contact with the HCP and may spent more time in the facility hence may be able to notice occasions when non-RMC is done.

Additionally, having any complication after delivery was significantly associated with RMC where women who had complications were two times more likely to receive RMC than those who didn't. This controverts the findings of (Hughes et al., 2022) in Malawi. The dissimilarity could be attributable to study setting and methodologies used in the two studies where the later was conducted on a higher scale in 25 facilities with a sample of over 600 women using a different tool. Complications are usually emergencies and thus these women may be accorded planned and careful care by the health providers since

mistakes may exacerbate complications into death, these women are therefore given quality care compared to those without complications who may be assumed to be well and thus candidates of non-RMC even when they would have needed care.

Moreover, there was statistical significant difference grounded on time of delivery where women who delivered at night time were 3.46 times more likely to receive RMC than those who delivered during the day. This finding is dissimilar to several studies conducted in Iran, Kenya and Ethiopia (Amsalu et al., 2022a; Hajizadeh et al., 2020a). The variance in findings could be due to different study methodology, where studies in Iran and Kenya were done in both public and private facilities with a study population of over 330 women. The study in Iran was also a longitudinal study carried between 6-18 hours of birth then 30-45 days' post discharge while in Ethiopia, the study had a population of over 400 women who were still in labor using direct observations. Besides, this could also be attributable to RMC trainings among the health providers, competencies and period when the studies were conducted. Furthermore, other key findings from the study that significantly touch on the health system leading to RMC were; waiting time less than half an hour, delivery attended by two health providers, women who intended to deliver in the facility in future and those who would recommend others to deliver

5.4 Institutional factors influencing respectful maternity care at KCRH

Respectful maternity care remains a key component of any healthcare system in order to achieve hospital deliveries and lowering of MMR in any healthcare set up.

This study showed that inadequate equipment, limited supplies, limited space/infrastructure, working environment among others had a significant influence on RMC. Inadequate equipment and supplies were key challenges in the provision of RMC

as enlisted by the HCP. This was analogous to various studies in several regions that listed inadequacy of supplies and equipment as an aspect that limits RMC (Bonsaffoh et al., 2022; Ige & Cele, 2022). HCP need supplies like gloves and cotton wool in order to attend to pregnant women as they are basic requirements in care provision. Furthermore, they also need adequate and functional equipment to conduct deliveries and offer competent care within the maternity unit. When equipment are inadequate or missing then HCP may be limited to attend to women so that they don't risk their life's leading to neglect of care (Adinew, Kelly, et al., 2021; Afulani et al., 2020b).

Moreover, limited space/infrastructure was also listed as a factor that influence how RMC is provided at Kitale county referral hospital. Limited space/infrastructure has been shown to lead to non-RMC in studies in Ethiopia and Nigeria (Amsalu et al., 2022b; Chukwuemeka & Okoronkwo, 2021). Space/infrastructure within the maternity units ensure that there are enough toilets, showers, rooms for HCP, rooms for antenatal, delivery, postnatal wards and washing areas are all under one roof. When all these are availed then rooms may be demarcated within the maternity unit to ensure privacy. Rooms for HCP within the maternity units will also ensure confidentiality to the women when taking history and examining them. Enough space will ensure companions are also accommodated along with the women within the maternity unit and can act as advocates for their care and help them whenever need arises.

In addition, about 72% of HCP mentioned being unaware of any policy within the facility that guide RMC. This was synonymous to several studies globally where there were no flawless policies that help promote RMC (Mdoe et al., 2021). Availability of RMC policies provides a framework on how pregnant women are to be treated and absence of

them may promote non-RMC since health providers may lack a standard on how to manage a particular condition hence confusion on managing women when it comes to different health providers.

5.5 Health provider factors influencing respectful maternity care at KCRH

This study found that health provider factors that influence RMC at KCRH include; number of health providers, high workload, motivation, training on RMC among others. 77.8% of the HCP reported to have been dissatisfied with their work due to inadequate number of HCP within the unit that in turn lead to high workload and burnouts which may translate to non-RMC as indicated by several studies (Afulani et al., 2020a; Pokharel et al., 2022; Raval et al., 2021). Having the required number of HCP within any given unit in a hospital ensures there is adherence to the HCP to patient ratio standard that is critical to service provision within any health unit. On the contrary, inadequate number of HCP will limit the HCP who are within the unit from attending to all pregnant women since few health providers are allocated within a given shift. Studies previously conducted in Kenya and Tanzania have indicated that HCP listed having insufficient number of HCP and high workload as a source of non-RMC (Buback et al., 2022; Das et al., 2021).

Staff motivation was also listed by the HCP as a factor that has an impact on promoting RMC. Studies in the Sub Saharan Africa have shown that HCP who were motivated were found to offer RMC (Lavender et al., 2021). HCP who are motivated in various aspects like improvement of terms of service, being appraised, being parted on the back amongst others are usually inspired to offer quality care to pregnant women in contrast to those who are demoralized as they tend to vent their frustrations to pregnant women in form of verbal and even physical abuse.

In addition, training on RMC was also found to be a key component influencing RMC. Studies in Ethiopia and Tanzania indicated that HCP who were trained on RMC were in a better position to offer RMC (Amsalu et al., 2022b; Das et al., 2021). In this study, more than 70% of HCP had been trained on RMC between this year and last year. Besides, 83.5% of health providers were found to be offering RMC and mentioned training to play a critical role. Training usually helps the HCP in value clarification and attitude transformation thus aiding the HCP to offer quality care where they weren't doing so previously.

Moreover, HCP are enlightened on the rights of the pregnant women and in the process knowledge and skills are passed unto them (Afulani et al., 2020b). These health providers are well equipped and in position to offer RMC as compared to their counterparts who aren't trained on RMC. Studies in Kenya, Nepal, Nigeria and India all concur that lack of RMC training for HCP is a source of non-RMC (Lusambili, Naanyu, et al., 2020).

CHAPTER SIX
RECOMMENDATIONS AND CONCLUSIONS

6.1 Overview

This chapter presents conclusions and recommendations of the study presented as per the objectives.

6.2 Conclusions

6.2.1 Women perspectives on respectful maternity care at KCRH

Women faced challenges like lack of privacy, sharing of beds, poor level of cleanliness in the maternity unit amongst others although they felt consent was always taken by the HCP before procedures. These challenges need to be addressed for better future care to women who come to deliver in the facility.

6.2.2 Women related factors influencing respectful maternity care at KCRH

Several factors play a role when it comes to RMC thus women need to be enlightened on RMC so that when they come to the hospital to deliver they will be offered respectful maternity care regardless of their marital status, place of residence, type of delivery, having complications after delivery and time of delivery.

6.2.3 Institutional factors that influence respectful maternity care at KCRH

Limited equipment, inadequate supplies, limited space/infrastructure, policies amongst other factors were found to significantly influence RMC at KCRH. The facility thus needs to put measures in place in mitigating these challenges in order to improve on RMC within the maternity unit.

6.2.4 Health provider factors that influence respectful maternity care at KCRH

The study found that inadequate number of health providers, high workload, motivation, training on RMC amongst other factors play a critical role when it comes to RMC. Health

providers are affected by their small number translating into high workload. They need to be motivated, trainings on RMC regularized and the challenge of inadequate number of health providers addressed. Finally, RMC needs a multi-system approach where the HCP, women and the health facility at large are involved in order to be achieved.

6.3 Recommendations

6.3.1 Women perspectives on respectful maternity care at KCRH

Women in this study expressed a poor knowhow of various birthing positions and pain relief/comfort. Therefore, there is need for health providers within the maternity unit to enlighten pregnant women on birthing positions and provide pain relief/comfort during labor. Furthermore, pregnant women need to embrace presence of companions in labor and delivery rooms respectively. Lastly, there is need for the unit in-charge to ensure increase in the number of beds in postnatal and improvement of privacy within labor and delivery rooms respectively.

6.3.2 Women related factors that influence respectful maternity care at KCRH

The study showed that marital status, residence, parity, place of previous delivery, type of delivery and any complication after delivery were significantly associated RMC. Pregnant women thus need to be aware of the universal rights of childbearing women (RMC) before coming to deliver in health facilities. This will help them to voice their concerns when it comes to their care thus there will be no discrimination when it comes to RMC based on particular factors.

6.3.3 Institutional factors that influence respectful maternity care at KCRH

The KCRH management team needs to ensure that there are adequate and functional equipment within the maternity unit. In addition, they should also see to it that there are adequate and consistent flow of supplies like cotton wool, gloves and other requirements within the maternity unit to ensure continuous provision of services. RMC policies need to be clearly documented, outlined and charted in the maternity and HCP made aware of them. Besides, the maternity space needs to be increased in order to create enough room for companions and privacy to the pregnant women. Moreover, HCP will need space to take history, do examination and store maternity files in order to maintain confidentiality and privacy.

6.3.4 Health provider factors that influence respectful maternity care at KCRH

Despite the myriad challenges the health providers face within the maternity unit for instance inadequate number, high workload and poor motivation among other factors they need to find self-motivation and continue providing RMC until such a time when the county government will employ and deploy more staff to the unit. The training on RMC where more than 70% have trained recently should encourage them to continue offering RMC to pregnant women who seek services in the maternity unit.

REFERENCES

Abebe, A. H., & Mmusi-Phetoe, R. (2022). Respectful maternity care in health centers of Addis Ababa city: a mixed method study. *BMC Pregnancy and Childbirth*, *22*(1), 1–9. https://doi.org/10.1186/s12884-022-05129-5

Adinew, Y. M., Hall, H., Marshall, A., & Kelly, J. (2021). Disrespect and abuse during facility-based childbirth in central Ethiopia. *Global Health Action*, *14*(1). https://doi.org/10.1080/16549716.2021.1923327

Adinew, Y. M., Kelly, J., Marshall, A., & Smith, M. (2021). *Care Providers ' Perspectives on Disrespect and Abuse of Women During Facility-Based Childbirth in Ethiopia : A Qualitative Study*. 1181–1195.

Adow, I., Mwanzo, I., Agina, O., Wanzala, P., & Kariuki, J. (2020). Uptake of antenatal care services among women of reproductive age in Mandera County, Kenya. *African Journal of Health Sciences*, *33*(1), 56–69. https://indexmedicus.afro.who.int/AIM/opac_css/doc_num.php?explnum_id=73592

Adu-Bonsaffoh, K., Mehrtash, H., Guure, C., Maya, E., Vogel, J. P., Irinyenikan, T. A., Aderoba, A. K., Balde, M. D., Adanu, R., Bohren, M. A., & Tuncalp, Ö. (2021). Vaginal examinations and mistreatment of women during facility-based childbirth in health facilities: Secondary analysis of labour observations in Ghana, Guinea and Nigeria. *BMJ Global Health*, *5*. https://doi.org/10.1136/bmjgh-2021-006640

Afulani, P. A., Kelly, A. M., Buback, L., Asunka, J., Kirumbi, L., & Lyndon, A. (2020a). Providers' perceptions of disrespect and abuse during childbirth: A mixed-methods study in Kenya. *Health Policy and Planning*, *35*(5), 577–586. https://doi.org/10.1093/heapol/czaa009

Afulani, P. A., Kelly, A. M., Buback, L., Asunka, J., Kirumbi, L., & Lyndon, A. (2020b). *Providers ' perceptions of disrespect and abuse during childbirth : a mixed-methods study in Kenya*. *March*, 577–586. https://doi.org/10.1093/heapol/czaa009

Afulani, P. A., Phillips, B., Aborigo, R. A., & Moyer, C. A. (2019). Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. *The Lancet Global Health*, *7*(1), e96–e109. https://doi.org/10.1016/S2214-109X(18)30403-0

Akter, S., Davies, K., Rich, J. L., & Inder, K. J. (2020). Barriers to accessing maternal health care services in the Chittagong Hill Tracts, Bangladesh: A qualitative descriptive study of Indigenous women's experiences. *PloS One*, *15*(8), e0237002. https://doi.org/10.1371/journal.pone.0237002

Amare, N. S., Mekuriyaw, A. M., Getaye, W. T., & Yeshinat, L. A. (2022). *Proportion and associated factors of respectful maternity care during childbirth in North Showa zone public health institutions , North Showa , Ethiopia : An institutional-based cross-sectional study*.

Ameh, S., Gómez-Olivé, F. X., Kahn, K., Tollman, S. M., & Klipstein-Grobusch, K. (2017). Relationships between structure, process and outcome to assess quality of integrated chronic disease management in a rural South African setting: applying a structural equation model. *BMC Health Services Research*, *17*(1), 1–15. https://doi.org/10.1186/s12913-017-2177-4

Amsalu, B., Aragaw, A., Sintayehu, Y., Sema, A., Belay, Y., Tadese, G., Kassie, N., Guta, A., Tibebu, A., & Tiruye, G. (2022a). Respectful maternity care among laboring women in public hospitals of Benishangul Gumuz Region, Ethiopia: A

mixed cross-sectional study with direct observations. *SAGE Open Medicine*, *10*. https://doi.org/10.1177/20503121221076995

Amsalu, B., Aragaw, A., Sintayehu, Y., Sema, A., Belay, Y., Tadese, G., Kassie, N., Guta, A., Tibebu, A., & Tiruye, G. (2022b). *Respectful maternity care among laboring women in public hospitals of Benishangul Gumuz Region , Ethiopia : A mixed cross- sectional study with direct observations*. https://doi.org/10.1177/20503121221076995

Ansari, H., & Yeravdekar, R. (2021). *Respectful maternity care in the achievement of universal health coverage*. 174–176.

Aridi, J. O., Afulani, P. A., Guzman, D. B., Makanga, C., & Graff, L. M. (2021). Exploring women ' s childbirth experiences and perceptions of delivery care in peri - urban settings in Nairobi , Kenya. *Reproductive Health*, 1–14. https://doi.org/10.1186/s12978-021-01129-4

Arnold, R., Teijlingen, E. Van, Ryan, K., & Holloway, I. (2019). *Villains or victims ? An ethnography of Afghan maternity staff and the challenge of high quality respectful care*. *6*, 1–12.

Arsenault, C., English, M., Gathara, D., Malata, A., Mandala, W., & Margaret, E. (2020). *Variation in competent and respectful delivery care in Kenya and Malawi : a retrospective analysis of national facility surveys*. *25*(4), 442–453. https://doi.org/10.1111/tmi.13361

Asefa, A. (2021). Unveiling respectful maternity care as a way to address global inequities in maternal health. *BMJ Global Health*, *6*(1), 1–4. https://doi.org/10.1136/bmjgh-2020-003559

Asefa, A., Delayehu, B., Alison, M., & Michelle, K. (2018). *Service providers ' experiences of disrespectful and abusive behavior towards women during facility based childbirth in*. 1–8. https://doi.org/10.1186/s12978-017-0449-4

Asefa, A., McPake, B., Langer, A., Bohren, M. A., & Morgan, A. (2020). Imagining maternity care as a complex adaptive system: understanding health system constraints to the promotion of respectful maternity care. *Sexual and Reproductive Health Matters*, *28*(1), e1854153. https://doi.org/10.1080/26410397.2020.1854153

Atai, O. P., Inyama, H., Wakasiaka, S., Jebet, J., & Oyieke, J. (2018). Prevalence of Disrespectful Maternity Care and Abuse among Women Seeking Maternity Care Services at the Kenyatta National Hospital, Nairobi: A Cross-Sectional Descriptive Study. *Open Journal of Obstetrics and Gynecology*, *08*(06), 610–629. https://doi.org/10.4236/ojog.2018.86067

Bante, A., Teji, K., Seyoum, B., & Mersha, A. (2020). Respectful maternity care and associated factors among women who delivered at Harar hospitals, eastern Ethiopia: A cross-sectional study. *BMC Pregnancy and Childbirth*, *20*(1), 1–9. https://doi.org/10.1186/s12884-020-2757-x

Berger, B. O., Strobino, D. M., Mehrtash, H., Bohren, M. A., Adu-Bonsaffoh, K., Leslie, H. H., Irinyenikan, T. A., Maung, T. M., Balde, M. D., & Tunçalp, Ö. (2021). Development of measures for assessing mistreatment of women during facility-based childbirth based on labour observations. *BMJ Global Health*, *5*, 1–15. https://doi.org/10.1136/bmjgh-2020-004080

Bonsaffoh, K. A., Tamma, E., Maya, E., Vogel, J. P., Tunçalp, Ö., & Bohren, M. A. (2022). Health workers ' and hospital administrators ' perspectives on mistreatment of women during facility - based childbirth : a multicenter qualitative study in

Ghana. *Reproductive Health*, 1–11. https://doi.org/10.1186/s12978-022-01372-3
Bradley, S., Mccourt, C., & Rayment, J. (2019). *Midwives ' perspectives on (dis) respectful intrapartum care during facility-based delivery in sub-Saharan Africa : a qualitative systematic review and meta-synthesis*. 1–16.
Buback, L., Kinyua, J., Akinyi, B., Walker, D., & Afulani, P. A. (2022). Provider perceptions of lack of supportive care during childbirth: A mixed methods study in Kenya. *Health Care for Women International*, *43*(9), 1062–1083. https://doi.org/10.1080/07399332.2021.1961776
Bulto, G. A., Demissie, D. B., & Tulu, A. S. (2020). *Respectful maternity care during labor and childbirth and associated factors among women who gave birth at health institutions in the West Shewa zone , Oromia region , Central Ethiopia*. 1–12.
Charan, J., & Biswas, T. (2013). How to calculate sample size for different study designs in medical research? *Indian Journal of Psychological Medicine*, *35*(2), 121–126. https://doi.org/10.4103/0253-7176.116232
Chukwuemeka, D. Io., & Okoronkwo, I. L. (2021). *Midwives ' perspectives on person-centred maternity care in public hospitals in South- east Nigeria : A mixed-method study*. 1–19. https://doi.org/10.1371/journal.pone.0261147
D-zomeku, V. M., Adwoa, B., Mensah, B., Nakua, K., Id, P. A., Lori, J. R., & Donkor, P. (2020). *Exploring midwives ' understanding of respectful maternal care in Kumasi , Ghana : Qualitative inquiry*. 1–13. https://doi.org/10.1371/journal.pone.0220538
Dahab, R., & Sakellariou, D. (2020). Barriers to Accessing Maternal Care in Low Income Countries in Africa: A Systematic Review. *International Journal of Environmental Research and Public Health*, *17*(12). https://doi.org/10.3390/ijerph17124292
Das, G., Masoi, T. J., Kibusi, S. M., Chaudhary, A., & Greenwald, M. (2021). *Patient and Provider Perspectives of Disrespect and Abuse during Childbirth in Tanzania : A Literature Review*. 1248–1272. https://doi.org/10.4236/ojog.2021.119118
Deki, S., & Choden, J. (2018). Assess Knowledge, Attitude and Practices of Respectful Maternity Care among nurse midwives in Referral Hospitals of Bhutan. *Bhutan Health Journal*, *4*(1), 1–7. https://doi.org/10.47811/bhj.50
Dorairajan, G., Gopalakrishnan, V., Chinnakali, P., & Balaguru, S. (2021). Experiences and Felt Needs of Women During Childbirth in a Tertiary Care Center: a Hospital-Based Cross-Sectional Descriptive Study. *Journal of Obstetrics and Gynaecology of India*, *71*(1), 21–26. https://doi.org/10.1007/s13224-020-01359-9
Dynes, M. M., Twentyman, E., Kelly, L., Maro, G., Msuya, A. A., Dominico, S., Chaote, P., Rusibamayila, R., & Serbanescu, F. (2018). Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016. *Reproductive Health*, *15*(1), 41. https://doi.org/10.1186/s12978-018-0486-7
Dzomeku, V. M., Boamah Mensah, A. B., Nakua, E. K., Agbadi, P., Lori, J. R., & Donkor, P. (2021). Midwives' experiences of implementing respectful maternity care knowledge in daily maternity care practices after participating in a four-day RMC training. *BMC Nursing*, *20*(1), 1–9. https://doi.org/10.1186/s12912-021-00559-6
Fair, F., Raben, L., Watson, H., Vivilaki, V., van den Muijsenbergh, M., & Soltani, H. (2020). Migrant women's experiences of pregnancy, childbirth and maternity care

in European countries: A systematic review. *PloS One*, *15*(2), e0228378. https://doi.org/10.1371/journal.pone.0228378

Ferede, W. Y., Gudayu, T. W., Gessesse, D. N., & Erega, B. B. (2022). *Respectful maternity care and associated factors among mothers who gave birth at public health institutions in South Gondar Zone , Northwest Ethiopia 2021*. https://doi.org/10.1177/17455057221116505

Gurung, R., Sunny, A. K., Bhandari, A., & Axelin, A. (2022). Mistreatment during childbirth and postnatal period reported by women in Nepal — a multicentric prevalence study. *BMC Pregnancy and Childbirth*, *6*, 1–10. https://doi.org/10.1186/s12884-022-04639-6

Haghdoost, S., Abdi, F., & Amirian, A. (2021). *Iranian midwives ' awareness and performance of respectful maternity care during labor and childbirth*. 1–9.

Hajizadeh, K., Vaezi, M., Meedya, S., Mohammad, S., & Charandabi, A. (2020a). *Prevalence and predictors of perceived disrespectful maternity care in postpartum Iranian women : a cross-sectional study*. *2*, 1–10.

Hajizadeh, K., Vaezi, M., Meedya, S., Mohammad, S., & Charandabi, A. (2020b). *Respectful maternity care and its relationship with childbirth experience in Iranian women : a prospective cohort study*. *0*, 1–8.

Hughes, C. S., Kamanga, M., Jenny, A., Zieman, B., Warren, C., Walker, D., & Kazembe, A. (2022). Perceptions and predictors of respectful maternity care in Malawi: A quantitative cross-sectional analysis. *Midwifery*, *112*, 103403. https://doi.org/10.1016/j.midw.2022.103403

ICM. (2020). *RESPECT WORKSHOPS*.

Ige, W. B., & Cele, W. B. (2022). International Journal of Africa Nursing Sciences Barriers to the provision of respectful maternity care during childbirth by midwives in South-West , Nigeria : Findings from semi-structured interviews with midwives. *International Journal of Africa Nursing Sciences*, *17*(September 2021), 100449. https://doi.org/10.1016/j.ijans.2022.100449

Ikamari, L. (2020). Uptake of maternal services and associated factors in the western region of Kenya. *The Pan African Medical Journal*, *37*, 192. https://doi.org/10.11604/pamj.2020.37.192.22406

Jiru, H. D., & Sendo, E. G. (2021). *Promoting compassionate and respectful based maternity care during facility- - delivery in Ethiopia : perspectives of clients and midwives*. 1–11. https://doi.org/10.1136/bmjopen-2021-051220

Jolivet, R. R., Gausman, J., Kapoor, N., Langer, A., Sharma, J., & Semrau, K. E. A. (2021). Operationalizing respectful maternity care at the healthcare provider level : a systematic scoping review. *Reproductive Health*, 1–15. https://doi.org/10.1186/s12978-021-01241-5

Jolly, Y., Aminu, M., Mgawadere, F., & Van Den Broek, N. (2019). we are the ones who should make the decision - Knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. *BMC Pregnancy and Childbirth*, *19*(1), 1–8. https://doi.org/10.1186/s12884-019-2189-7

Kaphle, S., Vaughan, G., & Madhusudan, S. (2022). *Respectful Maternity Care in South Asia : What Does the Evidence Say ? Experiences of Care and Neglect , Associated Vulnerabilities and Social Complexities*. *July*.

Kassa, Z. Y., Tsegaye, B., & Abeje, A. (2020). *Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa : a systematic*

review and. 1–9.
Kedir, F. K., Gurara, A. M., Yami, D. B., & Beyen, T. K. (2022). *Factors associated with compassionate and respectful maternity care among laboring mothers during childbirth in Ethiopia*. https://doi.org/10.4103/jnms.jnms
Kibuye, A. J. (2019). *Disrespect And Abuse Of Women During Pregnancy And The Effects On The Utilization Of Ante Natal Care Services: A Case Of Jaramogi Oginga Odinga Teaching And Referral Hospital In*.
Kiti, G., Prata, N., & Afulani, P. A. (2022). Continuous Labor Support and Person - Centered Maternity Care : A Cross - Sectional Study with Women in Rural Kenya. *Maternal and Child Health Journal*, *26*(1), 205–216. https://doi.org/10.1007/s10995-021-03259-4
KNBS. (2019). *2019 KENYA POPULATION AND HOUSING CENSUS VOLUME I : POPULATION BY COUNTY AND SUB-COUNTY: Vol. I* (Issue November).
KNBS and ICF., 2023. (2023). *Kenya Demographic and Health Survey 2022. Key Indicators Report. Nairobi, Kenya, and Rockville, Maryland, USA: KNBS and ICF*.
Kruk, M. E., Kujawski, S., Mbaruku, G., Ramsey, K., Moyo, W., & Freedman, L. P. (2018). Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy and Planning*, *33*(1), e26–e33. https://doi.org/10.1093/heapol/czu079
Lama, T. P., Munos, M. K., Katz, J., Khatry, S. K., LeClerq, S. C., & Mullany, L. C. (2020). Assessment of facility and health worker readiness to provide quality antenatal, intrapartum and postpartum care in rural Southern Nepal. *BMC Health Services Research*, *20*(1), 16. https://doi.org/10.1186/s12913-019-4871-x
Lavender, T., Bedwell, C., Kasengele, C. T., Kimaro, D., Kuzenza, F., Lyangenda, K., Mills, T. A., Nsemwa, L., Shayo, H., Tuwele, K., Wakasiaka, S., & Laisser, R. (2021). Respectful care an added extra: A grounded theory study exploring intrapartum experiences in Zambia and Tanzania. *BMJ Global Health*, *6*(4), 1–10. https://doi.org/10.1136/bmjgh-2020-004725
Leslie, H. H., Sharma, J., Mehrtash, H., Berger, B. O., Irinyenikan, T. A., Balde, M. D., Mon, N. O., Maya, E., Soumah, A. M., Adu-Bonsaffoh, K., Maung, T. M., Bohren, M. A., & Tunçalp, Ö. (2021). Women's report of mistreatment during facility-based childbirth: Validity and reliability of community survey measures. *BMJ Global Health*, *5*. https://doi.org/10.1136/bmjgh-2020-004822
Lusambili, A., Naanyu, V., Wade, T. J., Id, L. M., Mantel, M., Pell, R., Ngetich, A., Mulama, K., Nyaga, L., Obure, J., & Temmerman, M. (2020). *Deliver on Your Own : Disrespectful Maternity Care in rural Kenya*. 1–16.
Lusambili, A., Wisofschi, S., Shumba, C., Obure, J., Mulama, K., Nyaga, L., Wade, T. J., & Temmerman, M. (2020). Health care workers' perspectives of the influences of disrespectful maternity care in rural Kenya. *International Journal of Environmental Research and Public Health*, *17*(21), 1–18. https://doi.org/10.3390/ijerph17218218
Maheen, H., Hoban, E., & Bennett, C. (2021). Factors affecting rural women's utilisation of continuum of care services in remote or isolated villages or Pakistan - A mixed-methods study. *Women and Birth : Journal of the Australian College of Midwives*, *34*(3), 257–265. https://doi.org/10.1016/j.wombi.2020.04.001
Malatji, R., & Madiba, S. (2020). *Disrespect and Abuse Experienced by Women during Childbirth in Midwife-Led Obstetric Units in Tshwane District , South Africa : A*

Qualitative Study. 12–14.
Maldie, M., Egata, G., Genetu, M. C., Amare, M., Reta, D., Nigusu, W., Dereje, M., Id, A., Ewunetie, G. E., Birhane, T., Addisu, E., Ayele, W. M., & Id, M. A. (2021). *PLOS ONE Magnitude and associated factors of disrespect and abusive care among laboring mothers at public health facilities in Borena*. 1–18. https://doi.org/10.1371/journal.pone.0256951
Manu, A., Zaka, N., Bianchessi, C., Maswanya, E., Williams, J., & Arifeen, S. E. (2021). *Respectful maternity care delivered within health facilities in Bangladesh , Ghana and Tanzania : a cross- - sectional assessment preceding a quality improvement intervention*. https://doi.org/10.1136/bmjopen-2020-039616
Maradiaga, G. R., Hendley, N., & Moskop, J. C. (2022). Patient Abandonment in the Emergency Department? *The American Journal of Bioethics : AJOB*, *22*(7), 90–92. https://doi.org/10.1080/15265161.2022.2075963
Mdoe, P., Mills, T. A., Chasweka, R., Nsemwa, L., Petross, C., Laisser, R., Chimwaza, A., & Lavender, T. (2021). Lay and healthcare providers' experiences to inform future of respectful maternal and newborn care in Tanzania and Malawi: An Appreciative Inquiry. *BMJ Open*, *11*(9), 1–10. https://doi.org/10.1136/bmjopen-2020-046248
Mengesha, M. B., Desta, A. G., Maeruf, H., & Hidru, H. D. (2020). Disrespect and abuse during childbirth in Ethiopia: A systematic review. *BioMed Research International*, *2020*, 4–10. https://doi.org/10.1155/2020/8186070
Mengistie, T., Mulatu, T., Alemayehu, A., Yadeta, T. A., & Dheresa, M. (2022). Respectful maternity care among women who gave birth at public hospitals in Hadiya Zone, Southern Ethiopia. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.949943
Mengistu, B., Alemu, H., Kassa, M., Zelalem, M., Abate, M., Bitewulign, B., Mathewos, K., Njoku, K., Prose, N. S., & Magge, H. (2021). *An innovative intervention to improve respectful maternity care in three Districts in Ethiopia*. 1–10.
Mgawadere, F., & Shuaibu, U. (2021). Enablers and Barriers to Respectful Maternity Care in Low and Middle-Income Countries: A Literature Review of Qualitative Research. *International Journal of Clinical Medicine*, *12*(05), 224–249. https://doi.org/10.4236/ijcm.2021.125021
Mirzania, M., Elham, S., Meghan, A. B., Farah, B., Sedigheh, H., Abdoljavad, K., & Abbas, R. F. (2022). *Knowledge , attitude and practice of healthcare providers on mistreatment during labour and childbirth : a cross-sectional study in Tehran , Iran ,*.
Moridi, M., Id, F. P., Hajian, S., & Potrata, B. (2020). *Midwives ' perspectives of respectful maternity care during childbirth : A qualitative study*. 1–12. https://doi.org/10.1371/journal.pone.0229941
Munabi-Babigumira, S., Glenton, C., Willcox, M., & Nabudere, H. (2019). Ugandan health workers' and mothers' views and experiences of the quality of maternity care and the use of informal solutions: A qualitative study. *PLoS ONE*, *14*(3), 1–20. https://doi.org/10.1371/journal.pone.0213511
Mutunga, G. M., Lawrence, K., & Betsy, R. (2020). *Journal of Public Health 2 (1) January , 2020 Patient ' s Satisfaction with the Quality of Clinical and nursing care services offered in Trans Nzoia County Referral Hospital in Trans Nzoia County , Getrude Mwende Mutunga Dr . Lawrence Karanja (PhD) Mr*. *2*(1), 209–215.

N'Gbichi, C., Ziraba, A. K., Wambui, D. W., Bakibinga, P., Kisiangani, I., Njoroge, P., Noor, R., Njoroge, N., Salah, R. A., & Mohamed, E. (2019). "If there are no female nurses to attend to me, I will just go and deliver at home": a qualitative study in Garissa, Kenya. *BMC Pregnancy and Childbirth*, *19*(1), 332. https://doi.org/10.1186/s12884-019-2477-2

Nawab, T., Erum, U., Amir, A., Khalique, N., Ansari, M. A., & Chauhan, A. (2019). *Disrespect and abuse during facility - based childbirth and its sociodemographic determinants – A barrier to healthcare utilization in rural population*. 239–245. https://doi.org/10.4103/jfmpc.jfmpc

NCPD., N. C. for P. andDevelopment. (2017). *National adolescent and youth survey*. *January*. http://www.ncpd.go.ke/wp-content/uploads/2016/11/2015-National-Adolescents-and-Youth-Survey-Preliminary-Report.pdf

Ndwiga, C., Warren, C. E., Ritter, J., Sripad, P., & Abuya, T. (2017). *Exploring provider perspectives on respectful maternity care in Kenya : " Work with what you have ."* 1–13. https://doi.org/10.1186/s12978-017-0364-8

Ngesa, A. M., Kirui, J., Matheka, I., Otieno, G., & Yoos, A. (2021). Utilization of free maternity services among women of child bearing age in Machakos County, Kenya. *The Pan African Medical Journal*, *39*, 25. https://doi.org/10.11604/pamj.2021.39.25.26499

Odiase, O., Akinyi, B., Kinyua, J., & Afulani, P. (2021). *Community Perceptions of Person-Centered Maternity Care in*. *2*(October), 1–10. https://doi.org/10.3389/fgwh.2021.668405

Orpin, J., Puthussery, S., & Burden, B. (2019). Healthcare providers' perspectives of disrespect and abuse in maternity care facilities in Nigeria: a qualitative study. *International Journal of Public Health*, *64*(9), 1291–1299. https://doi.org/10.1007/s00038-019-01306-0

Patabendige, M., Agampodi, S. B., Jayawardane, A., Wickramasooriya, D. J., & Agampodi, T. C. (2021). Perceptions on respectful maternity care in Sri Lanka: Study protocol for a mixed-methods study of patients and providers. *PLoS ONE*, *16*(5 May), 1–12. https://doi.org/10.1371/journal.pone.0250920

Pathak, P., & Ghimire, B. (2020). Perception of Women regarding Respectful Maternity Care during Facility-Based Childbirth. *Obstetrics and Gynecology International*, *2020*. https://doi.org/10.1155/2020/5142398

Pokharel, A., Kiriya, J., Shibanuma, A., Silwal, R., & Health, G. (2022). *Association of Workload and Practice of Respectful Maternity Care Pandemic in South Western Nepal : A Cross-Sectional Study*. 1–33.

Raval, H., Puwar, T., Vaghela, P., Mankiwala, M., Pandya, A. K., & Kotwani, P. (2021). *Respectful maternity care in public health care facilities in Gujarat : A direct observation study*. https://doi.org/10.4103/jfmpc.jfmpc

Shah, P., Thornton, I., Turrin, D., & Hipskind, J. E. (2022). *Informed Consent.*

Sharma, S. K., Rathod, P. G., Tembhurne, K. B., Ukey, U. U., & Narlawar, U. W. (2022). Status of Respectful Maternity Care Among Women Availing Delivery Services at a Tertiary Care Center in Central India: A Cross-Sectional Study. *Cureus*, *14*(7). https://doi.org/10.7759/cureus.27115

Sheferaw, E. D., Bakker, R., Taddele, T., Geta, A., Kim, Y., Akker, T. Van Den, & Stekelenburg, J. (2021). *Status of institutional-level respectful maternity care : Results from the national Ethiopia EmONC assessment*. *May 2020*, 260–267.

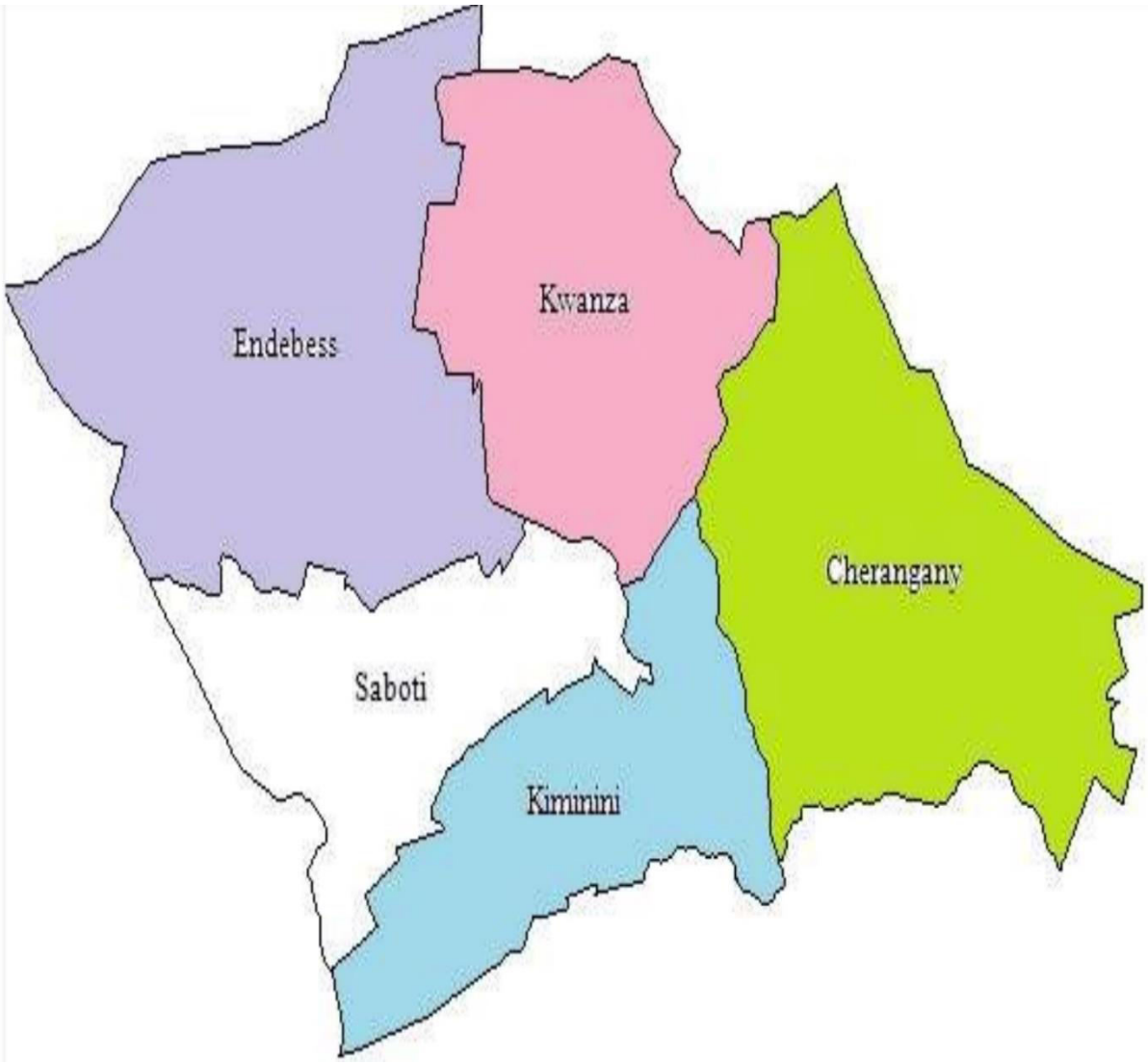
https://doi.org/10.1002/ijgo.13452
Shimoda, K., Leshabari, S., & Horiuchi, S. (2020). Self-reported disrespect and abuse by nurses and midwives during childbirth in Tanzania: A cross-sectional study. *BMC Pregnancy and Childbirth*, *20*(1), 1–10. https://doi.org/10.1186/s12884-020-03256-5
Siraj, A., Teka, W., & Hebo, H. (2019). Prevalence of disrespect and abuse during facility based child birth and associated factors, Jimma University Medical Center, Southwest Ethiopia. *BMC Pregnancy and Childbirth*, *19*(1), 1–9. https://doi.org/10.1186/s12884-019-2332-5
Smith, J., Banay, R., Zimmerman, E., Caetano, V., Musheke, M., & Kamanga, A. (2020). *Barriers to provision of respectful maternity care in Zambia : results from a qualitative study through the lens of behavioral science*. 1–11.
Stanton, M. E., & Gogoi, A. (2022). Dignity and respect in maternity care. *BMJ Global Health*, *5*, 8–11. https://doi.org/10.1136/bmjgh-2022-009023
Sudhinaraset, M., Landrian, A., Golub, G. M., Cotter, S. Y., & Afulani, P. A. (2021). Person-centered maternity care and postnatal health : associations with maternal and newborn health outcomes. *AJOG Global Reports*, *1*(1), 100005. https://doi.org/10.1016/j.xagr.2021.100005
Tenaw, L. A., Onoh, V., & Endalifer, M. L. (2022). *Abusive maternal care and associated factors during childbirth in Northeast Ethiopia*. *26*(February), 118–125. https://doi.org/10.29063/ajrh2022/v26i2.11
USAID. (n.d.). *Respectful Maternity Care Toolkit*. 1–7.
Valizadeh, F., Heshmat, F., Mohammadi, S., & Motaghi, Z. (2021). Affecting Factors of Parturient Women's Privacy Preservation in The Maternity Ward: A Qualitative Study. *Journal of Family & Reproductive Health*, *15*(3). https://doi.org/10.18502/jfrh.v15i3.7137
Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., Mclemore, M., Cadena, M., Nethery, E., Rushton, E., & Schummers, L. (2019). *The Giving Voice to Mothers study : inequity and mistreatment during pregnancy and childbirth in the United States*. 1–18.
Wang, X., & Cheng, Z. (2020). Cross-Sectional Studies: Strengths, Weaknesses, and Recommendations. *Chest*, *158*(1), S65–S71. https://doi.org/10.1016/j.chest.2020.03.012
Wassihun, B., & Shegaw, Z. (2018). *Compassionate and respectful maternity care during facility based child birth and women ' s intent to use maternity service in*. 1–10.
World Health organization. (2019). Maternal mortality Evidance brief. *Maternal Mortality*, *1*, 1–4. https://apps.who.int/iris/bitstream/handle/10665/329886/WHO-RHR-19.20-eng.pdf?ua=1
Wubetu, Y. A., Nigussie, T. S., & Mohammed, O. Y. (2021). *Respectful Delivery Care and Associated Factors in Public Health Facilities in Debre Berhan Town , Ethiopia*. 1–14.
Yismaw, W. S., Teklu, T. S., & Panduragman, H. (2022). Respectful maternity care during facility - based child birth and associated factors in public health facilities of Ilu AbaBor zone , Southwest Ethiopia. *Reproductive Health*, 1–7. https://doi.org/10.1186/s12978-022-01368-z
Yosef, A., Kebede, A., & Worku, N. (2020). *Respectful Maternity Care and Associated*

Factors Among Women Who Attended Delivery Services in Referral Hospitals in Northwest Amhara , Ethiopia : A Cross-Sectional Study. 1965–1973.

Zeleke, A. M., Melkie, G., & Mph, B. (2022). *Maternal Disrespect and Abuse among Mothers who gave childbirth at Public Health Facilities and Associated Factors in Gondar town , Northwest , Ethiopia*. https://doi.org/10.22038/jmrh.2022.62507.1767

APPENDICES

APPENDIX 1: TRANS NZOIA COUNTY MAP



Source: Kerosi blog

APPENDIX 2: WORK PLAN

TIME	ACTIVITY	DURATION
NOVEMBER 2022-JAN 2023	Proposal writing	3 months
FEBRUARY 2023	Proposal defense	One day
MARCH 2023	Corrections	One month
APRIL 2023	Application to conduct research from MMUST ethics review board	One month
MAY-JULY 2023	Data collection and preparation of report	Three months
AUGUST 2023	Submission of draft report to supervisors	One month
SEPTEMBER 2023	Defense	One day

APPENDIX 3: BUDGET

NO.	ITEM	COST (Ksh)	COMMENT
1.	Logistics	70,000	Training of the research assistants, cost of data collection and analysis
2.	Stationery	10,000	Purchase of stationery
3.	Equipment	80,000	Electronics e.g. printers
4.	Airtime	10,000	Zoom/google meetings, calling the supervisors, research assistants in the field
5.	Travelling	10,000	Travelling to stations where study is conducted
6.	Total cost	180,000	

APPENDIX 4: CONSENT FORM

MASINDE MULIRO UNIVERSITY OF SCIENCE & TECHNOLOGY

SCHOOL OF NURSING, MIDWIFERY & PARAMEDICS

My name is Georgeadez Sabwami, a second year MSc. Nursing student at Masinde Muliro University. I am carrying out a research on "Respectful maternity care and associated factors at Kitale county referral hospital in Trans Nzoia county."

The aim of the study is to assess respectful maternity care at Kitale county referral hospital.

The results obtained from the study will be used to assess the various factors from institutional, provider, women and their perceptions and recommendations from the study will be used by the providers, women and the stakeholders within the county.

Confidentiality and privacy of your information is assured. In case of any inquiries kindly contact me on cell phone 0722207958 or Masinde Muliro University postgraduate school at directordps@mmust.ac.ke

I kindly ask you to participate.

I agree/refuse to participate…… (Sign)

……(Date)

APPENDIX 5: INTERVIEW GUIDE

START TAPE RECORDER

My name is……and am facilitating the FGD on Respectful maternity care at Kitale County referral hospital.

We would like to know and share the experiences you went through during your time in this facility that's from labor, to delivery and after that.

Component	Main questions	Probing questions	Notes
Birth experience	How did you feel about your birth experience? How did you decide to deliver in this hospital?	Describe your feelings about labor and childbirth? • Did it happened as you expected? • Were you happy or tired? • Do you have positive/negative memories? • Is it painful to be reminded of the experience? • Were you called by your name? How did you feel about that?	
Birthing position	How did you feel about your birthing position	• Were you satisfied with the position you delivered in? • How do you feel about freely moving in labor and being restrained in bed during labor?	
Pain relief	How did you feel about pain relief in labor	• Were you satisfied with the pain relief given during labor? • How was education concerning pain relief in labor to you?	
Abuse/sexual/verbal abuse	How did you feel about language used in labor and delivery? How did you feel about privacy in labor	• How did you feel about vaginal examinations done? • How did you feel about the treatment in	

	and delivery, do you think you were exposed?	delivery, did you in any way feel abused? Describe	
Consent	How did you feel about being asked for permission before procedures? Did you have the power to choose what is to be done	• Were all procedures done after permission had been asked e.g. examinations, medications and procedures • How did you feel about being respected during labor and delivery? • How did you feel about care, were you at any point left without care? • Were there others according to your opinion who were given good care than others in labor? why • Were you allowed to drink or take food freely in labor?	
Companionship	How did you feel about having a companion in labor?	• Did you have a companion in labor & delivery? • Were you allowed to have a companion? • Were you comfortable having a companion?	
Health system constraints	How did you feel about resources in the facility? How was the quality of care provided to you?	• Were the resources adequate in the facility (gloves, drugs, beds, space, infrastructure) • How did the providers give care to you, did you feel they had the needed skills? • Were the providers adequate in your opinion to give care?	

Anything else you would like to say. Thank you

APPENDIX 6: POSTNATAL WOMEN TOOL

Section A: Socio-demographic

1. What is your age in years……?
2. Where do you reside?
   a) Urban
   b) Rural area
3. What is your marital status?
   a) Married
   b) Single
   c) Widowed
   d) Divorced
4. What is your religion?
   a) Christian
   b) Muslim
   c) Traditionalist
   d) No religion
5. What is your educational status?
   a) No education
   b) Primary level
   c) Post primary (Secondary or vocational level)
   d) College and above
6. What is your employment status?
   a) Employed
   b) Self employed
   c) Farmer
   d) House wife
   e) Student
7. What is the employment status of your spouse? (refer to 3 above)
   a) Employed
   b) Self employed
   c) Farmer
   d) Others……
8. What is the wealth status of the family?
   a) Low
   b) Medium
   c) High
9. Do you suffer from any of the conditions below? Tick as appropriate
   a) HIV/AIDS
   b) Mutism & deafness
   c) Hypertensive condition
   d) Physical disability
   e) Other, specify……
   f) NA

Section B: Obstetric characteristics

1. What is your number of births/parity?
   a) 1
   b) 2
   c) 3
   d) 4 or more

2. What is the previous birth place?
   a) Hospital
   b) TBAs place
   c) Home
3. Was the pregnancy planned?
   a) Yes
   b) No
4. When did you begin ANC?
   a) First trimester
   b) Second trimester
   c) Third trimester
5. What was the number of ANC visits?
   a) None
   b) 1 to 4
   c) More than 4
6. Did you intend to use the facility for delivery?
   a) Yes
   b) No
7. How long did you labor in facility before delivery?
   a) < 24 hours
   b) ≥ 24 hours
8. What was your mode of delivery?
   a) SVD
   b) AVD
   c) CS
9. Any complications after delivery
   a) Yes
   b) No

Section C: Support structure

1. Did you have a companion in labor room?
   a) Yes
   b) No
2. Did you have a companion in delivery room?
   a) Yes
   b) No

3. Who accompanied you to the hospital?
    a) None
    b) Spouse
    c) Friend/neighbor
    d) Mother
    e) Mother-in-law
4. Were you encouraged to have a companion in labor & delivery?
    a) Yes
    b) No

Section D: Health system

1. How long did you wait to be attended to once in facility?
    a) Less than 30 min
    b) About one hour
    c) More than $1\frac{1}{2}$ hours
2. Was the waiting time okay for you?
    a) Yes
    b) No
3. Which day did you deliver?
    a) Weekend
    b) Weekday
4. What time did you deliver?
    a) Night
    b) Daytime
5. What was the sex of the provider who conducted the delivery?
    a) Male
    b) Female
6. How many providers assisted in delivery care?
    a) 1
    b) 2
    c) 3 and more
7. Do you intend to deliver in this facility in future?
    a) Yes
    b) No
8. Do you recommend any person to deliver here?
    a) Yes
    b) No

Section E: Perspectives on RMC

ITEMS	PERFORMANCE INDICATOR	YES DONE TO STANDARD	NO NOT DONE TO STANDARD
A.	**The Woman is Protected from physical harm**		
1.	Does not deny food or fluid to the woman in labor unless medically necessitated		
2.	Never physically restrains woman		
3.	Provides comfort/pain-relief as necessary		
4.	Never uses physical force or abrasive behavior with the woman, including slapping or hitting		
B.	**Right to information, informed consent and choice**		
1.	Introduces self to woman and companion		
2.	Encourage the companion to remain with woman as much as possible		
3.	Encourage woman and companion to ask questions		
4.	Explains what is being done and what to expect in labor & birth		
5.	Give periodic updates on progress & status of labor		
6.	Allow the woman to move about freely in labor		
7.	Allow the woman to assume position of choice during birth		
8.	Obtain consent prior to procedure		
	Confidentiality and privacy		
1.	Visual barriers used in exams, procedures, birth		
2.	Woman was covered with drapes in birth		
	Dignity and Respect		
1.	Speaks politely to woman and companion		
2.	Never intimidates, threats or coerces woman or companion		
	Equitable care, free of discrimination		
1.	Speaks to the woman at the language level she understands		
2.	Doesn't show disrespect based on an attribute		
	The woman is never left without care		
1.	Encourage woman to call if needed		
2.	Never leaves a woman alone or unattended		

APPENDIX 7: HEALTHCARE PROVIDER TOOL

Section A: Socio-demographic characteristics

1. What is your age in years? ……

2. What is your gender? (a) Male (b) Female

3. What is your cadre?
   a. Medical doctor
   b. Midwife
   c. Nurse
   d. Clinical officer

4. What is your highest qualifications?
   a. Masters
   b. Degree
   c. Higher diploma
   d. Diploma
   e. Certificate

5. What is your number of years in experience working in the health sector? ……...

6. What is the number of years working in maternity unit (antenatal ward, labor and postnatal ward)? .....
7. What is your type of engagement with employer?
   a. Permanent
   b. Contractual
   c. Casual
8. Do you have job satisfaction while working?
   a. Yes
   b. No
9. If no above, why?
   a. Lack of clinical updates
   b. Long working hours
   c. Inadequate supplies
   d. Poor or untimely wages
   e. High workloads
   f. Few staff

Section B: Training on Respectful maternity care & policies

10. Have you had in service training on respectful maternity care (RMC)
    a. Yes
    b. No
11. If in 10 above is Yes, when was it……...……. (Year)

12. Do you apply respectful maternity care in your daily practice?
    a. Yes
    b. No

13. If no above, why?
    a. I have no training on respectful maternity care
    b. I lack skills on respectful maternity care
    c. High workload
    d. Inadequate equipment
    e. Uncooperative clients
    f. Lack of enough space in the maternity
    g. Others, specify

14. Are there any policies in your facility on respectful maternity care?
    a. Yes
    b. No

Section C: Factors affecting RMC

15. What challenges do you face in ensuring you are giving Respectful maternity care? Write Yes or no
    a) Inadequate number of midwives & other providers
    b) Limited supplies/equipment
    c) Poor inter-midwives' / nurse / doctor / clinician relationships
    d) High workload
    e) Inadequate health provider knowledge and skills
    f) Limited space/infrastructure
    g) Poor health provider personality
    h) Other, specify……

16. What are some of the things you could mention that promote respectful maternity care (RMC) in your working area? Write yes or no
    b) Being motivated
    c) Good government/facility policies
    d) Availability of resources
    e) Trainings on RMC
    f) Good working environment
    g) Other, specify……

Part D: Respectful maternity care components

In the table below choose one that applies to you

ITEMS	PERFORMANCE INDICATOR	ALWAYS	MOST TIMES	SOMETIMES	RARELY	NEVER
A	**The Woman is Protected from physical harm**					
	I do not deny food or fluid to the woman in labor unless medically necessitated					
	I never physically restrains women who come to deliver					
	I provide comfort/pain-relief as necessary in labor					
	I never uses physical force or abrasive behavior with the woman, including slapping or hitting					
B	**Right to information, informed consent and choice**					
	I do Introduce myself to women and companion					
	I do encourage the companion to remain with woman as much as possible in labor					
	I do encourage woman and companion to ask questions					
	I do explains what is being done and what to expect in labor & birth					
	I give periodic updates on progress & status of labor					
	I allow the woman to move about freely in labor					
	I allow women to assume position of choice during birth					

	I do obtain consent prior to any procedure					
C	**Confidentiality and privacy**					
	I ensure there are visual barriers during examination, procedures and during birth					
	I ensure the woman is covered with drapes during birth					
D	**Dignity and Respect**					
	I do speaks politely to women and companion					
	I never intimidate, threaten or coerce women or companion					
E	**Equitable care, free of discrimination**					
	I do speaks to women at the language level they understand					
	I don't show disrespect based on an attribute to women					
F	**The woman is never left without care**					
	I do encourage women to call if needed					
	I never leave a women alone or unattended					

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY
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Fax: 056-30153 50100.
E-mail: ierc@mmust.ac.ke Kakamega,
Website: www.mmust.ac.ke KENYA
Institutional Scientific and Ethics Review Committee (ISERC)

REF: MMU/COR: 403012 Vol 6 (01) Date: April 14th 2023

To: Mr. Georgeadez K. Sabwami

Dear Mr.,

RE: RESPECTFUL MATERNITY CARE AND ITS ASSOCIATED FACTORS AT KITALE COUNTY REFERRAL HOSPITAL, TRANS NZOIA COUNTY, KENYA.

This is to inform you that the Masinde Muliro University of Science and Technology Institutional Scientific and Ethics Review Committee (MMUST-ISERC) has reviewed and approved your above research proposal. Your application approval number is MMUST/IERC/147/2023. The approval covers for the period March 14th, 2023 to March 14th, 2024.
This approval is subject to compliance with the following requirements;

i. Only approved documents including informed consents, study instruments, MTA will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by MMUST-ISERC.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to MMUST-ISERC within 72 hours of notification iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to MMUST-ISERC within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period.
Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to MMUSTISERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://research-portal.nacosti.go.ke and also obtain other clearances needed

Yours Sincerely,

Prof. Gordon Nguka (PhD)
Chairperson, Institutional Scientific and Ethics Review Committee

Copy to:
- The Secretary, National Bio-Ethics Committee
- Vice Chancellor
- DVC (PR&I)

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY (MMUST)

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P.O Box 190
Kakamega
50100
Kenya

E-mail: directordps@mmust.ac.ke
Website: www.mmust.ac.ke

Directorate of Postgraduate Studies

Ref: MMU/COR: 509099

4th April 2023

Georgeadez K. Sabwami,
HNR/G/0l-
53588/2019,
P.O Box 190-
50100,
KAKAMEGA.

Dear Mr. Sabwami,

RE: APPROVAL OF PROPOSAL

I am pleased to inform you that the Directorate of Postgraduate Studies has considered and approved your Masters Proposal entitled: "Respectful Maternity Care and Its Associated Factors at Kitale County Referral Hospital, Trans Nzoia County, Kenya " and appointed the following as supervisors:

l. Prof. Mary Kipmerewo - MMUST

2. Dr. Tecla Sum - MMUST

You are required to submit through your supervisor(s) progress reports every three months to the Director of Postgraduate Studies. Such reports should be copied to the following: Chairman, School of Nursing & Midwifery Graduate Studies Committee and Chairman, Department of Reproductive Health, Midwifery and Child Health, Education and Management and Graduate Studies Committee.

Kindly adhere to research ethics consideration in conducting research.

It is the policy and regulations of the University that you observe a deadline of two years from the date of registration to complete your Master's thesis. Do not hesitate to consult this office in case of any problem encountered in the course of your work.

We wish you the best in your research and hope the study will make original contribution to knowledge.

Yours Sincerely,

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY DIRECTORATE OF POSTGRADUATE STUDIES P.O. Box 190 - 50100, KAKAMEGA (K) Date..... Sign.....

Prof. Stephen O. Odebero, PhD, FIEEP

DIRECTOR, DIRECTORATE OF POSTGRADUATE STUDIES

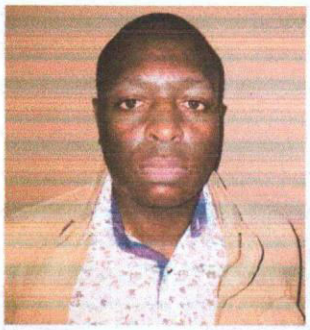
REPUBLIC OF KENYA

NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **919577**

Date of Issue: **01/May/2023**

RESEARCH LICENSE



This is to Certify that Mr.. Georgeadez Khisa Sabwami of Masinde Muliro University of Science and Technology, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Transnzoia on the topic: Respectful Maternity Care and its associated factors at Kitale County Referral Hospital, Trans Nzoia county, Kenya for the period ending : 01/May/2024.

License No: **NACOSTI/P/23/25636**

919577

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY &
INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

REPUBLIC OF KENYA
COUNTY GOVERNMENT OF TRANS NZOIA

TEL., 054 – 30301
054 30302p.o. BOX 4211 - 30200,
KITALE.
Email:
cohealthkitale@gmail.com

Offices of the Chief Officer,

DEPARTMENT OF HEALTH SERVICES

Our Ref; CGTN/HSÌHR)026 vol.5/2023 **Date:** Tuesday, May 2023

Georgeadez Khisa
Adm No HNR/G/01-53588/2019

RE: RESEARCH APPROVAL

Reference is made to your letter dated 9th May 2023 on the above subject and wish to inform you that your request has been accepted.

You are hereby granted one (1) month to conduct a study on respectful maternity care and its associated factors at Kitale County Referral hospital Trans Nzoia County in the Department of Nursing with effect from 9th May 2023 to 9th June 2023.

Please note that you will be required to strictly adhere to the Human Resource Regulations as stated in the Human Resource Manual for the County Civil Servants.

Best of wishes as you undertake your study.

N/B: You will always be expected to observe the official dress code while at work place.

Thank you.

09 MAY 2023

Mr. Philip M Kitio
FOR: CHIEF OFFICER HE

FOR CHIEF OFFICER HEALTH SERVICES AND SANITATION

cc

- Medical Superintendent —Kitale County Hospital

REPUBLIC OF KENYA
COUNTY GOVERNMENT OF TRANS NZOIA

TEL: 054 - 30301From the director 's office
054 - 30302P.O. BOX 4211 - 30200
KITALE

Email:
researchunit@transnzoia.go.ke

DEPARTMENT OF HEALTH SERVICES

Our Ref: Date:Sundav, Mqy 7. 2023

Georgeadez K. Sabwani HNR/G/01-53588/2019

Dear sir,

RE: RESEARCH APPROVAL

Following your request to conduct a study in Trans Nzoia County Department of Health on "respectful maternity care and its associated factors at Kitale County Referral hospital Trans Nzoia Countý', permission is hereby granted.

You will be required to work hand in hand with the department's research unit in every step of your data collection process.

Any queries in the due course should be directed to the Health Research Training and Development Coordinator Ms Selpha Amuko on +254714153616.

Thank you.

Dr Anthony Wamalwa
Chairperson Health Research, Tr
TRANS NZOIA COUNTY.

HEALTH RESEARCH UNIT

MAY g and Development Unit
TRANS • NZOIA COUNTY
P. O. Box 4211 - 30200, KITALE