

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

FACULTY OF ALLIED HEALTH SCIENCE

DEPARTMENT OF NURSING

DIPLOMA PROGRAMMES



**KNOWLEDGE, ATTITUDE AND PRACTICES OF RESPECTFUL MATERNITY
CARE AMONG MIDWIVES IN HOLY FAMILY HOSPITAL, BEREKUM**

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DECLARATION

We hereby declare that this submission is our own work towards the Diploma in General Nursing and that, to the best of our knowledge, it contains no material previously published by another person nor material which has been accepted for the award of diploma of the University, except where due acknowledgement has been made in the text.

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ABSTRACT

The study aimed to assess the knowledge, attitude and practices of Respectful Maternity Care among midwives in Holy Family Hospital, Berekum. A cross-sectional design was used to collect in-depth information for the study. The sample population was obtained using a convenient sampling technique. A total of 40 respondents were sampled for the study. The data for the study was collected by administering the questionnaire to the participants.

The study found that almost all (97.5%) the respondents indicated they were aware of respectful maternity care. Majority (82.5%) of the respondents indicated they have ever taken a course covering respectful maternity care. Over half (52.5%) of the respondents correctly matched right to timely health care to abandonment, few (27.5%) of the respondents were able to correctly match freedom from harm and ill treatment to physical abuse. Almost all the respondents agreed that there is the need for service providers introduce themselves to women during labor (97.5%).

The study recommended the management of the hospital should organize frequent training of midwives on respectful maternity care. Education is one strategy to promote respectful maternity care among care providers in facility-based childbirth.

The study concluded that awareness of midwives on respectful maternity care was high. They demonstrated low knowledge on the various rights of RMC and their corresponding category of disrespect and abuse. Midwives demonstrated good attitudes towards respectful maternity care.

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ABBREVIATION

ANC	Antenatal Clinic
D&A	Disrespect and Abuse
ICM	International Confederation of Midwives
LMICs	Low-And-Middle-Income Countries
MHCPs	Maternal Health Care Providers
PNC	Postnatal Care
RMC	Respectful Maternity Care
WHO	World Health Organization

ACKNOWLEDGEMENT

We would like to extend our deepest gratitude and praise to the Almighty God for providing us with strength and knowledge for this study.

Our deepest appreciation also goes to our supervisor for her constructive criticisms, objective guidance, and direction for the study and the entire staff of the College for their support throughout the study.

We are grateful to all the respondents for their contributions and efforts. Without them, the study would not be possible.

Finally, our sincere appreciation goes to the authors and publishers of pieces of literature used in the study. Thank you all and God bless you.

CHAPTER ONE

INTRODUCTION

1.0 Background of the study

Maternal health is important for the women during pregnancy, childbirth, the postpartum period and maternal health care services includes antenatal care (ANC), delivery care and postnatal care (PNC) services (Browser & Hill, 2019). Maternal health is becoming a global concern because the lives of millions of women in reproductive age can be saved through maternal health care services (Miller, et al., 2019). Despite efforts that have been made to strengthen maternal health care services, maternal mortality is still high in most of the developing countries. Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth and 99% of all maternal deaths occur in developing countries (Vijayalakshmi, 2020).

Globally, an estimated five hundred thousand women die annually due to complications arising during pregnancy, labour and childbirth and the postpartum period, with approximately half of those deaths occurring in Sub-Saharan Africa (World Health Organization, 2018). For instance, the maternal mortality ratio (MMR) in sub-Saharan Africa is 500/100,000 live births (Mwoma, et al., 2021).

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability. The concept of “safe motherhood” is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family (White Ribbon Alliance, 2018). After the extensive research that indicates adequate proof on women mistreatment during pregnancy and childbirth, the World Health Organization (WHO) published a statement on stoppage and eradication of such disrespect

and abuse (D&A) occurring in health institutes (World Health Organization, 2018). The statement emphasizes the government and development partners for the initiation of support and sustains programs to deliver quality maternal and newborn health services. The statement also highlights the provision of respectful maternity care (RMC) as a significant element of the quality of care (World Health Organization, 2018). Respectful maternity care (RMC) has been prioritized by nursing associations and regulators, global health researchers, policy makers, and women’s advocacy groups (Miller, et al., 2019). High quality care during pregnancy, childbirth, and the postpartum period is crucial to improve maternal and neonatal outcomes (Graham, et al., 2019).

Humble and dutiful care during childbirth has been termed as “a universal human right that encompasses the principles of ethics and respect for women’s feelings, dignity, choices, and preferences (White Ribbon Alliance, 2018).” RMC is centered on increasing the interpersonal interactions between a woman and health care providers during various stages of childbirth such as labor, delivery, and postpartum. RMC predominantly focuses on the elimination of ill and abusive behavior by health care providers and associated staffs along with a sensitive and encouraging working environment to make a woman feel satisfied during her childbirth experience (White Ribbon Alliance, 2018).

Respective Maternity Care (RMC) refers to “care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth (World Health Organization, 2018). RMC is recognized as a universal human right, emphasizing respect for every woman’s humanity, feelings, and preferences. Increasing evidence of mistreatment during facility-based childbirth has raised RMC to the forefront of global discussions on quality of maternity care (World Health Organization, 2018). How women are treated during childbirth can empower and comfort them, or inflict lasting damage

and emotional trauma (White Ribbon Alliance, 2018). How they are treated also affects their future health seeking behavior and that of their communities (Bohren, et al., 2019). In addition, some aspects of RMC like timeliness of care, patient-provider communication, and labor support, can have direct impacts on pregnancy outcomes (Miller, et al., 2019).

Disrespect and abuse of women during childbirth continues to be a global phenomenon affecting the care women receive during pregnancy, child birth and the postpartum period, with its prevalence increasing over the years (Lusambili, et al. 2020). The current prevalence ranges from 20% in Kenya to 98% in Nigeria, and this has seen the WHO make a statement against to promote Respectful Maternity Care (RMC) and human rights during pregnancy and child birth (Hajizadeh, et al., 2020). Seven categories of disrespect and abuse have been identified: physical abuse (beating, slapping, or pinching), discrimination (based on culture, age or social status), non-consented clinical care, non-dignified care (yelling, chiding, undignified comments), non-confidential care, abandonment of care (leaving client unattended), and detention in health facilities (Hajizadeh, et al., 2020). Respectful maternity care (RMC) as one that accords women the freedom to make informed choices, protects them from any form of harm and harassment, accords them continuous support during labour and child birth and also upholds their privacy, confidentiality and dignity (WHO, 2018). This is echoed by D-zomeku, et al., (2020) where RMC entails providing quality care that is not disrespectful, discriminating, dehumanizing, humiliating, and abusive; physical, psychological, or verbal.

The range of disrespect and abuse encountered by women during childbirth in health institutions is well defined and classified. It consists of physical abuse (beating, slapping, and pinching), undignified care (yelling, chiding, and humiliating comments), abandonment (leaving alone during different phases of delivery), and discrimination based on the cultural

group, social status, age, or restriction of facilities for nonfulfillment of fees (Bohren, et al., 2019).

Studies have shown the effectiveness of RMC interventions in reducing D&AC and maternal and neonatal deaths in n low-and-middle-income countries (LMICs) (Afulani, et al., 2019).

Interventions providing mentorship and training that transformed negative provider attitudes and improved the interpersonal communication skills of caregivers, along with interventions equipping facilities with efficient monitoring systems, and interventions educating childbearing women on their rights have had the most positive effect (Bohren, et al., 2019).

To prevent and eliminate facility-based disrespect and abuse during childbirth, WHO recommended five key actions, one of which is to generate data related to respectful and disrespectful care practices (World Health Organization, 2015). In line with this, several studies have generated knowledge on the perspectives of childbearing women and skilled providers on disrespect and abuse (Yates, et al., 2017).

A study conducted in Meerut, India found that out of 30 Health Care Workers (10%) had inadequate knowledge, (50%) had moderate knowledge and (40%) had adequate knowledge regarding the Respectful Maternity Care (Mathew, 2021). Another study in Iran revealed that Iranian midwives had good awareness but fair performance of RMC. Work experience had positive significant effects on midwives' awareness along with performance on RMC.

Promoting respectful maternity care requires essential interpersonal and communication skills and supportive attitudes from midwives (Haghdoost, et al., 2021).

Currently, maternal mortality remains one of the leading global causes of death among women, especially in sub-Saharan Africa and is considered a pressing public health challenge (Patton, et al., 2020). Research shows that obstetric violence and abuse is common in many healthcare facilities in sub-Saharan Africa. These abuses have led many women's and children's health researchers, advocates, and policymakers to begin several initiatives to

promote respectful and non-abusive maternity care during pregnancy, childbirth, and in the time after birth. The truss of these respectful maternity care efforts is the deep recognition that childbearing women have inalienable rights to quality care and a zero-tolerance for violence and abuse (WHO, 2018).

In certain African settings, women attended ANC only to obtain an ANC card, which was necessary in order to book deliveries or out of fear of being abused by MHCPs for not attending ANC (Cham & Vangen, 2019). For example, five of 83 women (6%) surveyed in Mozambique stated that they only presented for ANC to obtain a prenatal evaluation form and vaccination record card as proof of attendance so that they would be admitted to the maternity clinic at the time of delivery. Otherwise, these women saw no benefit in attending ANC, largely due to the attitudes and behaviours of the personnel at the maternity clinic (Chapman, 2020). In a Ugandan study, rude staff was the most common reason cited for women feeling uneasy about delivering at a health centre (Cham & Vangen, 2019). Delivery at hospitals was viewed as a last resort, even in the case of high-risk deliveries or complications during labour (Kyomuhendo, 2018).

Ashenafi, et al (2019) conducted a study that aims to assess the status of disrespectful and abusive maternity care during childbirth and associated factors among postnatal women in public hospitals of Bale zone, Southeast Ethiopia. An institutional-based crosssectional study was done from March, 1 to July 25, 2018, among 580 postnatal women in three public hospitals of Bale zone using exit interview. Epi info for data entry and SPSS for analyzing were use and based on the results it was stated as the status of disrespectful and abusive maternity care is 37.5%. In the association result, the significantly associated factors with disrespectful and abusive maternity care are; marital status with married women are 82% less likely to get disrespectful and abusive maternity care than their counterpart. Secondly, women who do not

have antenatal care follow-up history are 8.62 times more likely to encounter disrespectful and abuse maternity care compared to those who had.

In Ethiopia, verbal and physical abuse (e.g hitting to encourage women to comply with position changes), and treatment without consent were experienced by women and acknowledged by midwives (Burrows, et al., 2019). Authors of a Kenyan study of 13 institutions found evidence of the following types of abuse towards women during childbirth: physical abuse (including use of force and restraint), verbal abuse, stigma and discrimination based on ethnicity and socio-economic status, failure to meet professional standards of care (including lack of informed consent for exams and procedures, lack of confidentiality and privacy, and neglect and abandonment), lack of rapport with health care providers (including lack of autonomy and detainment), and health system factors (Warren, et al., 2021).

A study conducted in Nigeria reported that poor provision of RMC was attributed to normalization of disrespectful care, inadequate supplies and commodities, midwives' personal beliefs, poor implementation of RMC and poor accountability (Ige & Cele, 2021).

The RMC was launched in 2011 by White Ribbon Alliance and from this time it rooted in the international human right. The RMC community built a document, the human right of childbearing women (RMC Charter), with a common goal to demonstrate the respectful maternity care application as a fundamental human right in maternal health context. It has been used globally as a tool to help healthcare providers how maternity can be performed in accordance to the human right respect. To the best of the authors' knowledge and after extensive literature search, no study in Ghana has explicitly focused on exploring the challenges that midwives face in attempting to provide RMC to women, neither has the existing studies explored the prospects and opportunities that exist to promote RMC in health facilities in Ghana. This paucity of literature informed the conceptualisation of our study.

It is in this purpose that it is used in this study to help researchers assessing the knowledge, attitude and practices of Respectful Maternity Care among midwives in Holy Family Hospital, Berekum.

1.1 Problem statement

Although maternal health care providers (MHCPs) attitudes and behaviours have a considerable influence on women's and their families' perceptions of quality of care and thereby decisions to seek care, and ability to access appropriate and adequate maternal health care, surprisingly few studies have comprehensively sought to understand these issues in low- and middle-income countries (LMICs) (Mannava, et al. 2020).

Respectful maternity care during childbirth is still a global concern especially in low-income countries (Uwamahoro, et al., 2019). Between 1990 and 2017, the global maternal mortality ratio declined by 44%, from 385 deaths to 216 deaths per 100,000 live births (United Nations, 2018). Progress has been made in reducing maternal mortality globally, with an estimated 44% reduction between 1990 and 2018 (UNICEF, 2019).

Abuya et al., (2019) conducted a mixed-methods study of 13 Kenyan facilities, sampling 641 mothers who received care from a multidisciplinary team that included midwives. The researchers noted a significantly greater amount of disrespect and abuse from providers was observed in multiparous, married, lower socioeconomic mothers and ranged from facial expressions to demands of bribes or physical abuse. The mothers identified their perceptions of satisfying birth as birth that was not humiliating.

Unhealthy relations and traumatic birthing experiences can have long lasting effects on the mental as well as psychological health of women. Women need psychological and emotional support at the time of pregnancy and delivery. Moreover, Women's experiences with caregivers in crucial time of labour have the impact to empower and comfort or to inflict lasting damage and emotional trauma, adding to or detracting from women's confidence and

self-esteem. This underscores the need to assess the knowledge, attitude and practices of Respectful Maternity Care among midwives in Holy Family Hospital, Berekum.

1.2 General objective

To assess the knowledge, attitude and practices of Respectful Maternity Care among midwives in Holy Family Hospital, Berekum.

1.3 Specific objective

1. To determine knowledge of midwives on Respectful Maternity Care
2. To assess the attitude of midwives towards Respectful Maternity Care
3. To investigate the self-reported practice of Respectful Maternity Care midwives

1.4 Operational definition of terms

Knowledge: defined as having a satisfactory understanding of Respectful Maternity Care

Attitude: refers to an established way of feeling about something

Practice: refers to the expected way of doing of something.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Review of literature is an ongoing process and it covers the entire planning stage. Good research is always supported by its evidences and review of literature serves as a mean of support. Review of literature is important to an investigator in order to know what has been established and documented as there are critical summaries of what is known about a particular topic. Therefore, a review of literature helps to relate the present study to the previous ones in the same field. Reviews for this study has been collected from primary and secondary sources of books, journals and net references.

2.1 Overview

The Respectful Maternity Care addresses the issue of disrespect and abuse toward women and newborns utilizing maternal and newborn care services and provides a platform for improvement by: Raising awareness of women during pregnancy and human right (Vijayalakshmi, 2020). Prior to 2015, the concept of respectful care was difficult to measure. It was often implied when researchers examined related issues of patient satisfaction, high-quality humanistic care, and freedom from abuse (Browser & Hill, 2019). Respect appeared to be a subjective and personal goal hoped for, noticeable when it was absent, an ethical gold standard that healthcare professionals aspired to, but difficult to measure when it was achieved. Fortunately, the World Health Organization (WHO) developed broad definitions of respectful care that provide objective, concrete parameters by which researchers, policy makers, and educators can observe and measure globally what might otherwise appear to be nebulous and subjective outcomes of quality maternity care (World Health Organization, 2019). The seven domains for measuring respectful care, comprising various components, were identified by

WHO and include: (a) freedom from physical harm and ill treatment; (b) informed consent and refusal and shared decision-making, including choice of a support person in labor; (c) privacy and confidentiality; (d) dignity and respect, including freedom to change positions for labour or birth; (e) equality, freedom from discrimination, and equitable care; (f) access to the highest quality health care available; (g) liberty, autonomy, self-determination, and freedom from detention or coercion.

Maltreatments have been documented in many countries across the globe. The World Health Organization (2014) estimated that 35% of women (one in every three women) worldwide have experienced physical or sexual intimate partner violence or non-partner sexual violence at some point of their lives. Existing research suggests that even in high resource setting, childbirth could be excruciating and terrifying experience (Carlo, et al., 2015).

In the context of maternal health however, Pakistan is one of the countries with the highest prevalence of maltreatment of women during childbirth in south Asia (Azhar, Oyebode, & Masud, 2018). It is estimated that 61% of women who use health facilities during their first birth in Pakistan, do not use it again in their subsequent birth. Azhar et al., (2018) reported the most common form of abuse as violation of women's right to be informed and make their own choice (97.5%), followed by abandonment of care (72.5%) , and non-confidential care (58.6%).

Findings from women and healthcare providers in two regional health facilities in Ethiopia revealed underutilization of facility based delivery, despite a national scale up in the numbers of train providers in health facilities (Burrowes et al., 2017). At 28% skill birth attendance, 82% of providers cited occurrences of disrespect and abuse in their facilities (Burrowes et al., 2017). Several, of the post-partum women surveyed reported maltreatment (21%), non-consented care (17.7%), and lack of privacy (15.2%) as barriers to use of health facilities (Burrowes, et al., 2017).

A systematic review by Bohren et al. (2017) on prevalence of maltreatment of women during childbirth also reported verbal abuse, such as shouting at women, physical abuse such as slapping, and detention for non-payment. In some extreme cases, women strive to reach a hospital, only to be unattended by healthcare providers and give birth on the floor. In rural northern Ghana, evidence by Moyer et al. (2014), suggest that women experience physical abuse such as being hit, slapped, kicked, or beaten in an attempt to get them to comply with instructions and to push.

2.2 Knowledge on Respectful Maternity Care

A quantitative study was conducted to evaluate the effect of awareness programme on knowledge regarding respectful maternity care (RMC) among antenatal women in a selected hospital of West Bengal. Quasi experimental research approach along with non-randomized control group design was adopted for the study. Non-probability purposive sampling technique was used to select 60 antenatal women (30 each in experimental and control group) were selected. Results revealed that the mean post-test knowledge score (32.53) of experimental group was significantly higher than mean pretest knowledge score (18.50).

There was significant difference between the mean post-test knowledge scores of experimental and control groups, indicating the effectiveness of awareness programme. The study also found that there is also significant association between knowledge score of women with educational qualification and socio-economic status (Das Debyani , et al., 2018).

A descriptive cross sectional study was conducted to assess the level of knowledge among postnatal mothers about RMC. Non probability purposive sampling technique was used to select the postnatal mothers. Fifty seven postnatal mothers were interviewed face to face using structured interview schedule. The findings were, among 57 postnatal mother half of the postnatal mothers, 30 (52.63%) had average level of knowledge regarding RMC. Highest knowledge was in the area of confidentiality and lowest in the areas of physical abuse. There

is still lack of knowledge among mothers regarding RMC. There were statistically significant association between religion and knowledge of postnatal mothers (Maharjan, et al., 2019).

A descriptive study was conducted to assess the knowledge regarding RMC. 20 samples were selected by convenient sampling method. Structured interview questionnaire was used as evaluation tool. The samples were free to express their knowledge and ideas. The data was analyzed and conclusion was drawn. The present study concluded that knowledge assessment regarding RMC, 85% of mothers had moderately adequate and 15% had adequate knowledge. The mean and standard deviation as follows 16.75 and 1.57 (Kavitha, et al., 2020).

A qualitative cross sectional study aimed to investigate the knowledge of midwives in the provision of RMC during childbirth was conducted in three district hospitals from Kigali city: Masaka district hospital of Kicukiro District, Kacyiru district hospital of Gasabo district and Muhima district hospital of Nyarugenge district. A purposive sampling method was used. The study reported that midwives working in maternity services from Masaka district hospital, Kacyiru district hospital and Muhima district hospital were knowledgeable on the RMC, they confirmed that they have had a course covering RMC during their curriculum, they have internal regulation and an orientation form guiding them about what information they need to share with their clients including their right to information, privacy and confidentiality. The majority of participants understood well seven rights which are the right to be free from harm and ill treatment, the right to information, informed consent and refusal, and respect for a woman's choices and preferences, including companionship during maternity care, the right to privacy and confidentiality, the right to be treated with dignity and respect, the right to equality, freedom from discrimination, and equitable care, the right to healthcare and to the highest attainable level of health, and the right to liberty, autonomy, self-determination, and freedom from coercion; stated in RMC (Uwamahoro, et al., 2019).

A study was conducted to assess the knowledge and perception of midwives on Respectful Maternity Care and to associate the level of knowledge with the selected demographic and obstetric variables using Non – experimental descriptive design, 60 postnatal mothers were selected by using purposive sampling technique. Data was collected by interview method by using modified Pattern 25 Matrix RMC Scale. The majority of 51(85%) midwives had poor knowledge, 9(15%) midwives had moderately adequate knowledge and none of them had adequate knowledge on Respectful Maternity Care (Alageswari, et al., 2019).

Phenomenological qualitative research was conducted on exploring midwives understanding of respectful and non-abusive maternal care in Kumasi, Ghana. Data were generated through individual in-depth interviews, which were audio-recorded and transcribed. The results were, understanding of respectful maternity care was comprised of the following components: non-abusive care, consented care, confidential care, non-violation childbearing women’s basic human rights, and nondiscriminatory care. Based on the results it was concluded as Midwives reported an understanding of most components of respectful maternity care, but their gap in knowledge on evidenced-based care requires policy attention and in-service training. To understand the extent to which this gap in knowledge can be generalized for midwives across Ghana to warrant a redesign of the national midwifery curriculum, the authors recommend a nationwide cross-sectional quantitative study (D-zomeku, et al., 2020).

A previous qualitative study conducted on exploring midwives’ understanding of respectful and non-abusive maternal care in Ghana demonstrated information on how midwives provide information to mothers which include their right to healthcare, to information, to privacy, to consent, to best healthcare, to choice to treatment and the possible consequence to the chosen treatment (Asefa, et al., 2018).

2.3 Attitude of midwives towards Respectful Maternity Care

The attitudes and behaviours of maternal health care providers (MHCPs) are an important element of quality as they influence both positively and negatively how women, and their partners and families perceive and experience maternal health care. Lack of respectful care from providers, such as doctors and midwives, may lead to dissatisfaction with the health system, diminishing the likelihood of seeking antenatal (ANC), delivery and postnatal services (WHO, 2019). In addition, MHCP attitudes and behaviours might directly affect the well-being of patients and clients, and the relationship between patients and providers (WHO, 2018). Moreover, negative attitudes and behaviours could undermine the quality of care and the effectiveness of maternal and infant health promotion efforts, in addition to compromising women's essential right to dignified and respectful maternal health care. Taken together, the attitudes and behaviours of MHCPs are an important determinant of maternal and infant health outcomes, and women being able to enjoy their basic rights of freedom from violence and discrimination and achievement of the highest attainable standard of physical and mental health (United Nations, 2018). A recent statement by the World Health Organization (WHO) and the Human Reproduction Programme calls for greater attention, research and advocacy around the maltreatment of women at the time of childbirth in facilities (WHO, 2018).

Maternal health care providers (MHCPs) working in public and private facilities in a few countries in Africa, as well as in the Dominican Republic, were more likely to show positive attitudes and behaviours when the patient was from the same catchment area as the health facility or when the patient was known to them (Asquo & Etuk, 2019).

Evidence synthesized from public and private health facilities in 42 low- and middle-income countries (LMICs) across four regions (Africa, Asia, Latin America, Middle East) showed frequent reporting of negative attitudes and behaviours, most commonly verbal abuse, rude

behaviours and neglect. These were ascribed to a range of trained professionals, including doctors, nurses, midwives and paramedics, but reported predominantly in public rather than privately owned health facilities. The types of attitudes and behaviours did not vary significantly based on the stage of maternity care, with the exception of impatience and a lack of willingness to accommodate traditional practices which were reported only during delivery. Overall, negative attitudes and behaviours undermined health care seeking and affected patient well-being (Mannava, et al., 2020).

Shakibazadeh, et al. (2020) conducted a qualitative study aimed to explore the perceptions of Iranian midwives regarding respectful maternity care during labour and childbirth. Twenty-four semi-structured interviews were conducted with midwives, who had more than one year work experience in labor and childbirth units. Through a purposive sampling method. The result was stated as three themes were extracted including showing empathy, women centered care and protecting rights. Showing empathy reflects that establishing a friendly relationship and being with women. Women-centered care indicated keeping women safe and participating in decision making. Protecting rights reflected a need for safe guarding dignity as well as giving equal care and preparing appropriate environment. Based on the findings the study was concluded as Iranian midwives considered respectful maternity care a broader concept rather than preventing mistreatment. Promoting respectful care also should be through performing safe care by implementing evidence- based care and women's involvement in their care as well as appropriate environment for women, families and caregivers.

A cross-sectional study was conducted in Bangladesh reported that the understanding and caring nature of providers in private facilities was attributed, by the study researchers, to the providers familiarity with patients' cultural practices and communities (Afsana & Rashid, 2019).

A qualitative cross-sectional study was conducted in three district hospitals in Kigali city. A purposive sampling method was used. The study found that majority of midwives reported positive attitude towards RMC. They provide respectful maternity care services by respecting its underlying rights. Participants agreed that midwives support mothers during childbirth by not blaming them when they cry during contractions, but they try to educate them on how they can cope with contractions. The study reported that midwives had different views on existing kinds of women's mistreatment during childbirth period. They supported that the mothers should be free from any harm during childbirth. The majority agreed that mothers need to be respected and they considered mistreatment as unprofessional practice. In other hand, some participants report having observed some negative attitude among midwives while providing respectful maternity healthcare services and the most reported is shouting on mothers. Mothers are sometimes health cared in uncomfortable condition which is considered like unprofessional practice (Uwamahoro, et al., 2019).

A study in Mozambique described how one participant had been refused delivery care whilst in labour “and gave birth to a son on the roadside as she attempted to go back home. With her placenta still inside her and bleeding heavily, she had returned to the MC [maternity clinic]” (Chapman, 2020).

2.4 Practice of Respectful Maternity Care among midwives

Deki and Teka (2018), conducted a cross-sectional descriptive study intended to assess Knowledge, Attitude and Practices of Respectful Maternity Care among nurse midwives in Referral Hospitals of Bhutan. The sample consisted of 83 nurse midwives who were working in birthing and ma- tertiary unit. Analysis was mainly descriptive, simple percentages were used to calculate frequency distribution of aspects and determinants of respectful maternity care. The results are four in five of the respondents knew and practiced woman's right to

information and communication during childbirth process. However, providers were found lacking on some aspects of the knowledge and practices related to respecting choices and rights of the women during childbirth and recounted their experiences of observing events which are described as abusive in maternal health literatures. Inadequate facilities, overworked staffs and limited trainings were found as detrimental factors. Based on the findings it was concluded as aspects of RMC were not duly practiced. Providers must be made aware of the woman's right to respectful care which is crucial to improve maternal health services. Individual Health Facility must provide conducive environment to practice RMC. Future studies on RMC from receiver end are recommended.

A recent study by Thompson, et al., (2020) performed a rapid assessment of 83 maternity health workers in eight Latin American and Caribbean countries (including Guyana) which included 23 midwives using the WHO childbirth rights and respectful care framework. Mixed methods were used, including expert observations of clinical care throughout the perinatal period using reliable study instruments, chart reviews, interviews of staff and patients after discharge, and perinatal outcome records. Although midwives in the study tended to have higher quality care and competency ratings, they remained below expected WHO and International Confederation of Midwives (ICM) goals for promoting privacy, encouraging a supportive companion, providing information on progress of labor, and supporting maternal–newborn bonding and breastfeeding.

A cross-sectional study was conducted in East and Southern Africa. A total of 2164 labor and delivery observations were conducted at hospitals and health centers. The study revealed that encouragingly, women overall were treated with dignity and in a supportive manner by providers, but many women experienced poor interactions with providers and were not well-informed about their care. Both physical and verbal abuse of women were observed during

the study. The most frequently mentioned form of disrespect and abuse in the open-ended comments was abandonment and neglect (Rosen, et al., 2020).

A cross sectional study design was used to conduct a study in Tanzania. The study found that the most frequently practiced RMC element was ensuring that women take light food, occurring in (83%) observations followed by explaining what will happen during labour (81%), receiving and greeting pregnant women (77%), responding to a women/companion question politely (72%). The least practiced item was asking women's preference of birth position, observed in only (29%) of the observations. Health centers performed better than hospitals in all nine practices and the differences were statistically significant in the following five practices: receiving and greeting women, encouraging women to ask questions, encouraging walking and changing positions, ensuring women have taken light food and allowing women to give birth in the position she prefers (Kavitha, et al., 2020).

An exploratory descriptive research design was used to conduct a study in Lagos State, Nigeria. The study aimed at exploring provision of respectful maternity care by midwives during childbirth. The collection of data was through semi-structured individual interviews. Purposive selection of 20 midwives was from two health facilities. The study showed the adequate provision of confidentiality, availability of showers and water, availability of meals and drinks to women, and pain relief in labour and delivery. Findings further revealed other aspects of respectful maternity care poorly provided by midwives, included physical abuse, privacy, use of dignified tone/language/threat/neglect, obtaining consent for procedures during labour and delivery, discrimination, allowing birth companion, detention, mobility, positioning and availability of commodities. All the midwives claimed to be providing respectful maternity care and showed willingness to support provision of respectful maternity care. The study concluded that to foster provision, RMC requires an enabling environment where staff are highly motivated, there is adequate staff strength, reduced workload,

continuous in-service training on evidence-based practices, training and support of midwives on RMC, adequate provision of supplies, commodities and modern equipment, and restructuring the ward to private delivery suites to accommodate birth companions and provide privacy (Ige & Cele, 2021).

CHAPTER THREE

MATERIALS AND METHODS

3.0 Introduction

This chapter details, the study area and study population, study design, sampling techniques, data collection method and instrument, data analysis techniques, ethical consideration, and the limitations of the study.

3.1 Study area

The Holy Family Hospital Berekum is situated in the Bono Region of Ghana. The hospital is a Catholic Diocesan Hospital which serves as a Municipal Hospital. Holy Family Hospital Berekum was established in 1948 by the Medical Mission Sisters and became a Diocesan Hospital in 1978. The major catchment area of the facility is Berekum Municipality. The Hospital provides a 24hour specialist and general services on both out-patient and in-patient basis. The hospital has a total of eleven units/wards. They are; Accidents and Emergency Unit, Females Ward, Males Ward, Surgical Ward, Paediatric Ward, Maternity Ward, Labour Ward, Neonatal Intensive Care Unit, PHC, ANC Unit, And Fevers Unit.

3.2 The study population

The study population was composed of midwives in Holy Family Hospital, Berekum. The inclusion criteria for the study were midwives who have had at least one year of professional practice.

3.3 Study design

A cross-sectional design was adopted for the study. A cross-sectional study design is a type of observational design that deals with the study of the characteristics of research participants

at a point in time. A cross-sectional study design was used because it is not costly to perform, does not require a lot of time, captures a specific point in time and the data can be used for various types of research.

3.4 Sampling technique and Size

Convenient sampling technique was used to select 40 respondents for the study.

3.5 Data collection methods and instruments

Each selected respondent was contacted and given an information sheet detailing what our study was about. Respondents who agreed to participate were given the data collection instrument. For this study, the questionnaire was used to collect data from respondents. The questionnaire contained closed-ended questions that required respondents to choose from already listed possible answers. Participants used approximately 20 minutes in answering the questionnaire.

3.6 Data analysis techniques

The completed questionnaires were hand-coded and entered into Microsoft Excel. Descriptive statistical analysis (frequency) was performed to describe important characteristics of respondents.

3.7 Ethical consideration

An introductory letter was obtained from the administration of Holy Family NMTC, Berekum. Ethical approval was then sought from Holy Family Hospital, Berekum. Participants were briefed on the study and their rights to voluntary participation and withdrawal from the study with no consequences. Only participants who consented were involved in the study. The participants gave their consent to the publication of findings.

Participants' confidentiality was ensured. Information that could reveal the identities of the participants were excluded from the transcripts to ensure participants' anonymity.

3.8 Limitation of the study

This study may be limited as it used only a quantitative method to assess the knowledge, Attitude and Practices of Respectful Maternity Care that cannot be generalized to the entire population. Another limitation may be social desirability bias, as participants will be careful in their responses not to implicate self, other colleagues or health facilities.

CHAPTER FOUR

DATA ANALYSIS AND RESULTS

4.0 Introduction

This chapter deals with analysis of data collected from the field of study and the results obtained from the analysis. The study findings are presented in tables and figures based on the demographic characteristics and specific objectives.

4.1 Socio-Demographic Data

Table 4. 1: Age of respondents

Variable	Frequency	Percentage
21-30 years	19	47.5
31-40 years	14	35
Above 40 years	7	17.5

Table 4.1 depicts that nearly half (47.5%) of the respondents were aged 21-30 years followed by 31-40 years (35%) and above 40 years (17.5%).

Table 4. 2: Marital status of respondents

Variable	Frequency	Percentage
Married	21	52.5
Single	15	37.5
Divorced	1	2.5
Widowed	3	7.5

As shown in table 4.2, over half (52.5%) of the respondents were married followed by those who were single (37.5%), widows (7.5%) and divorced (2.5%).

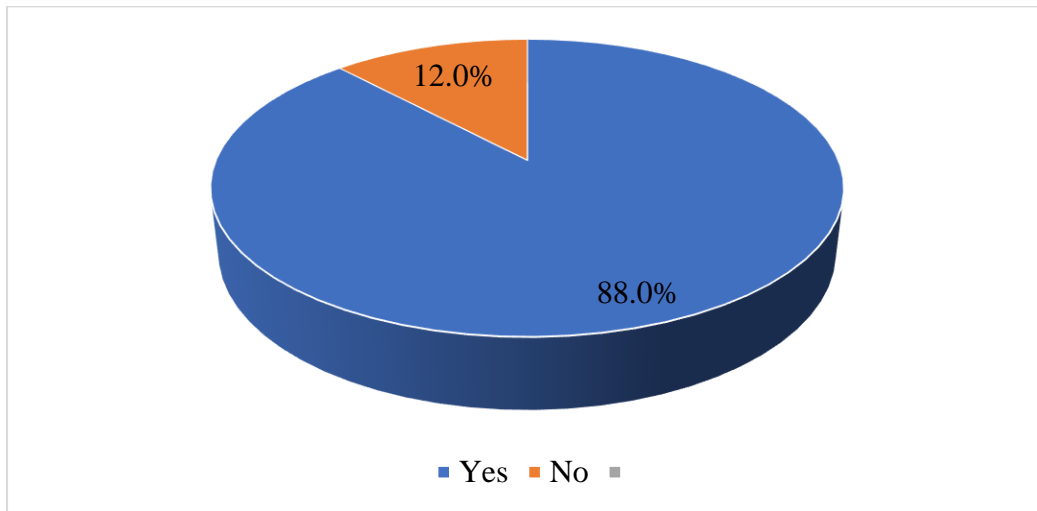


Figure 4. 1: Respondents educational level

Figure 4.1 illustrates that over half (55%) of the respondents were diploma holders followed by degree (40%) and certificate (5%).

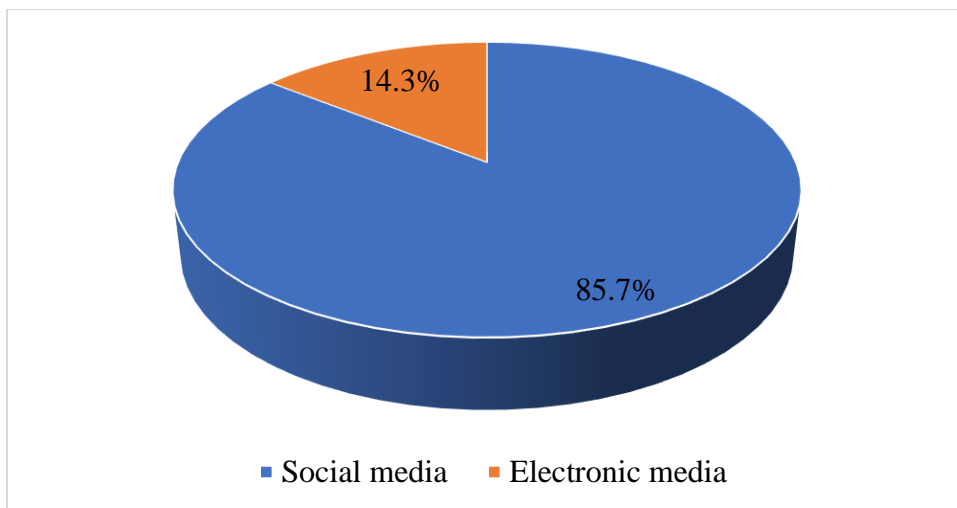


Figure 4. 2: Respondents religion

As shown in figure 4.2, most (60%) of the respondents were Christians.

Table 4. 3: Current workplace of respondent

Variable	Frequency	Percentage
Labour	7	17.5
Maternity	33	82.5
Other	0	0

As shows in table 4.3, majority (82.5%) were stationed at the maternity ward whiles only (17.5%) were at the labour ward.

Table 4. 4: Years of practice of respondent

Variable	Frequency	Percentage
One-five years	19	47.5
Six-ten years	17	42.5
>10 years	4	10

Table 4.4 shows that close to half of the respondents had practice for either one to five years (47.5%) or six to ten years (42.5%). Few (10%) of the respondents had practice for more than a year.

4.2 Knowledge of Midwives on Respectful Maternity Care

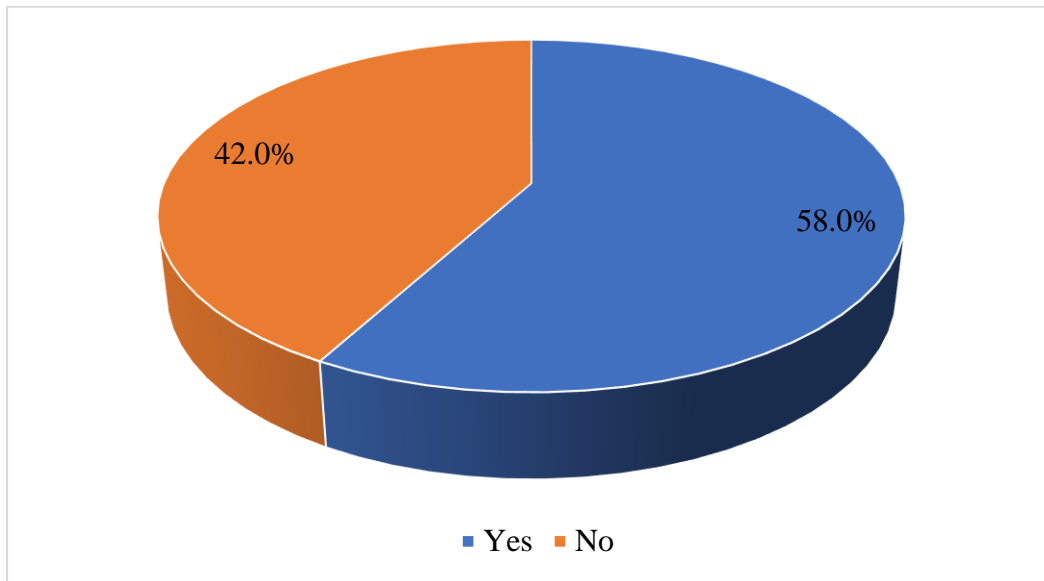


Figure 4. 3: Respondents awareness of respectful maternity care

From figure 4.3, almost all (97.5%) the respondents indicated they were aware of respectful maternity care.

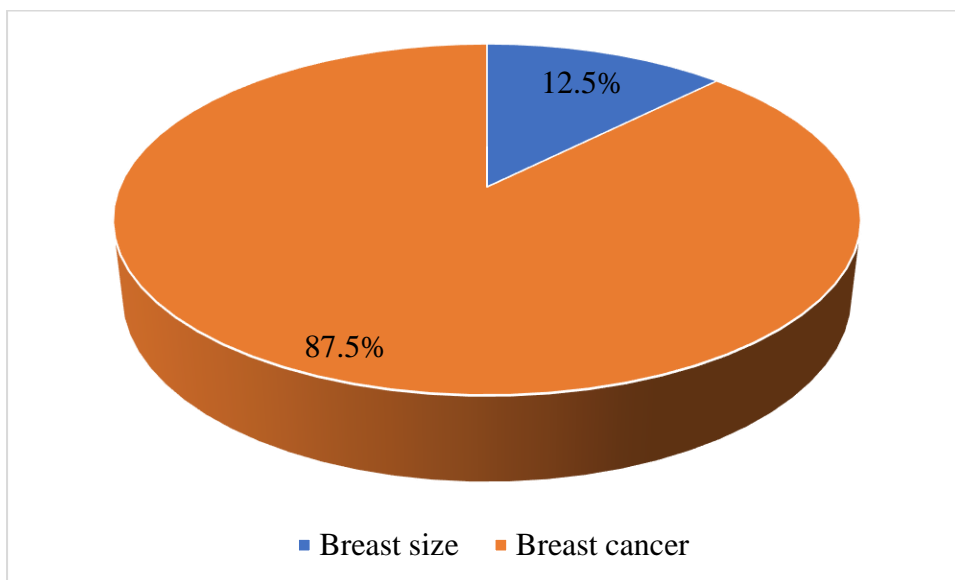


Figure 4. 4: Respondents on whether they have ever taken a course on RMC

As shown in figure 4.4, majority (82.5%) of the respondents indicated they have ever taken a course covering respectful maternity care.

Table 4. 5: Respondents on domains used for disrespect and abuse

Variable	Frequency	Percentage
Nine	4	10
Seven	16	40
Six	7	17.5
Five	9	22.5
Don't know	4	10

From table 4.5, most (40%) indicated that according to WHO there exist seven domains used for disrespect and abuse relating to RMC followed by nine (22.5%), six (17.5%), nine (10%). 10% of the respondents indicated they didn't know.

Table 4. 6: Respondents matching rights to corresponding category of disrespect and abuse

Variable	Category	Frequency	Percentage
Right to timely health care	Physical abuse	19	47.5
	Abandonment	21	52.5
	Non-confidential care	0	0
Freedom from harm and ill treatment	Non-confidential care	13	32.5
	Abandonment	16	40
	Physical abuse	11	27.5
Variable	Category	Frequency	Percentage
Confidentiality and privacy	Physical abuse	14	35
	Abandonment	14	35
	Non-confidential care	12	30
Liberty, autonomy, self-determination, and freedom from coercion	Denial of care	20	50
	Detention in facility	19	47.5
	Non-confidential care	1	2.5
Informed consent and refusal, and respect for choices	Non-dignified care	16	40
	Non-consented care	24	60
	Non-confidential care	0	0
Dignity and respect	Non-dignified care	17	42.5
	Non-consented care	21	52.5
	Non-confidential care	2	5
Right to information	Physical abuse	6	15
	Abandonment	19	47.5
	Non-consented care	15	37.5

Table 4.6 is an illustration of respondents matching the various right to their corresponding category of disrespect and abuse, over half (52.5%) of the respondents correctly matched right to timely health care to abandonment, few (27.5%) of the respondents were able to correctly match freedom from harm and ill treatment to physical abuse, only (30%) of the respondents were able to correctly match confidentiality and privacy to non-confidential care, less than half (47.5%) of the respondents correctly matched liberty, autonomy, self-determination, and freedom from coercion to detention in facility, less than half (42.5%) of the respondents correctly matched dignity and respect to non-dignified care and few (37.5%) of the respondents were able to correctly match right to information to non-consented care.

4.3 Attitude of Midwives Towards Respectful Maternity Care

Table 4. 7: Attitude of midwives towards respectful maternity care

Variable		Agree	Disagree	Don't know
There is the need for service providers introduce themselves to women during labor	n	39	1	0
	%	97.5	2.5	0
No need to blame mothers during child birth when they cry during contractions	n	39	1	0
	%	97.5	2.5	0
It is important to address client in labour with their name	n	36	4	0
	%	90	10	0
Clients should be allowed to choose their type of delivery	n	24	16	0
	%	60	40	0
Clients should not be discriminated because of ethnicity, race or economic situation	n	40	0	0
	%	100	0	0
Permission needs to be sought before any action and practice is taken on client	n	39	1	0
	%	97.5	2.5	0
It is important to provide privacy for client during labor	n	39	1	0
	%	97.5	2.5	0

Table 4.7 illustrates the attitudes of midwives towards respectful maternity care, all (100%)

the respondents agreed that clients should not be discriminated because of ethnicity, race or economic situation. Almost all the respondents agreed that there is the need for service providers introduce themselves to women during labor (97.5%), no need to blame mothers during child birth when they cry during contractions (97.5%), permission needs to be sought before any action and practice is taken on client (97.5%) and it is important to provide privacy for client during labor (97.5%). Majority (90%) of the respondents agreed that it is

important to address client in labour with their name. Most (60%) of the respondents agreed that clients should be allowed to choose their type of delivery.

4.4 Self-Reported Practice of Respectful Maternity Care by Midwives

Table 4. 8: Self-reported practice of emotional support by midwives

Variable		Unlikely	Neutral	Likely
I welcome laboring woman warmly	n	2	8	30
	%	5	20	75
I introduce myself to the laboring woman	n	0	12	28
	%	0	30	70
I use the name preferred by a laboring woman	n	6	13	19
	%	15	32.5	47.5
I support laboring woman to be in her desired birthing position	n	14	10	16
	%	35	25	40

Table 4.8 illustrates self-reported practice of emotional support by midwives, most of the respondents indicated that it is likely for them to warmly welcome a woman in labor (75%) and introduce themselves to the laboring woman (70%). Nearly half (47.5%) of the respondents cited that it is likely for them to use the name preferred by a laboring woman. Less than half (40%) of the respondents mentioned that it is likely for them to support laboring woman to be in her desired birthing position.

Table 4. 9: Self-reported practice of providing safe care by midwives

Variable		Unlikely	Neutral	Likely
I keep medical records and the results of examinations and consultations confidential	n	0	13	27
	%	0	32.5	67.5
I drape the laboring woman’s body during examinations, using sheets	n	4	13	23
	%	10	32.5	57.5
I perform all interventions with laboring woman’s informed consent	n	1	14	25
	%	2.5	35	62.5
I provide clear information about progress of labor	n	1	9	30
	%	2.5	22.5	75

Table 4.9 shows the self-reported practice of providing safe care by midwives, majority (75%) of the respondents indicated that it is likely for them to provide clear information about progress of labor. Most (67.5%) of the respondents said it is likely for them to keep medical records and the results of examinations and consultations confidential. Most (62.5%) of the respondents said it is likely for them to perform all interventions with laboring woman’s informed consent. Over half (57.5%) of the respondents cited that it is likely for them to drape the laboring woman’s body during examinations, using sheets.

Table 4. 10: Self-reported practice of preventing mistreatment by midwives

Variable		Unlikely	Neutral	Likely
I do allow the laboring woman to have a companion inside the labor unit	n	10	13	17
	%	25	32.5	42.5
I do not beat the laboring woman if she does not cooperate	n	4	18	18
	%	10	45	45
I do not shout at the laboring woman if she does not cooperate	n	7	10	23
	%	17.5	25	57.5

Table 4.10 shows the self-reported practice of preventing mistreatment by midwives, over half (57.5%) of the respondents said it is likely for them not to shout at the laboring woman if she does not cooperate. Nearly half (45%) of the respondents mentioned that it is likely for them not to beat the laboring woman if she does not cooperate. Few (42.5) of the respondents said it is likely for them to allow the laboring woman to have a companion inside the labor unit.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

5.0 Introduction

This chapter provides an in-depth look at the major findings that emerged out of the research, comparison of the analyzed data with findings from other literature, conclusion, and recommendations.

5.1 Discussions

5.1.1 Knowledge of Midwives on Respectful Maternity Care

The current study found that almost all (97.5%) the respondents indicated they were aware of respectful maternity care. Equally, Bohren et al. (2017) reported that majority of midwives were aware of respectful maternity care.

In the present study majority (82.5%) of the respondents indicated they have ever taken a course covering respectful maternity care. Consistently, Uwamahoro et al., (2019) found that midwives working in maternity services from Masaka district hospital, Kacyiru district hospital and Muhima district hospital were knowledgeable on the RMC, they confirmed that they have had a course covering RMC during their curriculum, they have internal regulation and an orientation form guiding them about what information they need to share with their clients including their right to information, privacy and confidentiality.

In the current study only (40%) of the respondents rightly indicated that according to WHO there exist seven domains used for disrespect and abuse relating to RMC. This finding proves that midwife's knowledge on RMC is inadequate. Similarly, Maharjan et al. (2019) reported that there is still lack of knowledge among respondents regarding RMC. Half of the participants (52.63%) had average level of knowledge regarding RMC. Contrastingly,

Kavitha et al., (2020) found that knowledge assessment regarding RMC, 85% of mothers had moderately adequate and 15% had adequate knowledge. Again, Uwamahoro et al., (2019) found that majority of participants understood well seven rights.

The present study found that respondents had poor knowledge when it came to matching the rights of RMC to their corresponding disrespect and abuse. Similarly, Alageswari et al., (2019) found that majority of 51(85%) midwives had poor knowledge, 9(15%) midwives had moderately adequate knowledge and none of them had adequate knowledge on Respectful Maternity Care.

5.1.2 Attitude of Midwives Towards Respectful Maternity Care

In the current study all (100%) the respondents agreed that clients should not be discriminated because of ethnicity, race or economic situation. Almost all the respondents agreed that there is the need for service providers introduce themselves to women during labor (97.5%), no need to blame mothers during child birth when they cry during contractions (97.5%), permission needs to be sought before any action and practice is taken on client (97.5%) and it is important to provide privacy for client during labor (97.5%). Correspondingly, Uwamahoro et al., (2019) found that midwives had different views on existing kinds of women's mistreatment during childbirth period. They supported that the mothers should be free from any harm during childbirth. The majority agreed that mothers need to be respected and they considered mistreatment as unprofessional practice. Additionally, Shakibazadeh, et al. (2020) reported that promoting respectful care also should be through performing safe care by implementing evidence- based care and women's involvement in their care as well as appropriate environment for women, families and caregivers.

5.1.3 Self-Reported Practice of Respectful Maternity Care by Midwives

In the current study most of the respondents indicated that it is likely for them to warmly welcome a woman in labor (75%) and introduce themselves to the laboring woman (70%). Similarly, A recent study by Thompson, et al., (2020) found that majority of the respondents warmly welcomed laboring women and also introduced themselves to these women. They added that these measures enhance the emotional well-being of the laboring woman.

Majority (75%) of the respondents indicated that it is likely for them to provide clear information about progress of labor. Most (67.5%) of the respondents said it is likely for them to keep medical records and the results of examinations and consultations confidential. Consistently, Ige and Cele, (2021) found that all the midwives claimed to be providing respectful maternity care and showed willingness to support provision of respectful maternity care. This was done through provision of information on labor and ensuring medical records are kept properly.

The present study found that over half (57.5%) of the respondents said it is likely for them not to shout at the laboring woman if she does not cooperate. Nearly half (45%) of the respondents mentioned that it is likely for them not to beat the laboring woman if she does not cooperate. Few (42.5%) of the respondents said it is likely for them to allow the laboring woman to have a companion inside the labor unit. Consistently, Ige and Cele, (2021) revealed other aspects of respectful maternity care poorly provided by midwives, included verbal abuse, physical abuse, privacy and allowing birth companion.

5.2 Conclusion

Awareness of midwives on respectful maternity care was high. They demonstrated low knowledge on the various rights of RMC and their corresponding category of disrespect and abuse. Midwives demonstrated good attitudes towards respectful maternity care. There is a

good self-reported practice of respectful maternity care by midwives. The leading self-reported practice of respectful maternity care was emotional support.

5.3 Recommendations

Based on the findings of the study, the following recommendations were made;

1. The management of the hospital should organize frequent training of midwives on respectful maternity care. Education is one strategy to promote respectful maternity care among care providers in facility-based childbirth.
2. Ministry of Health of Ghana should create greater awareness with the public on the levels of RMC that they should create systems to handle and address complaints.
3. MOH should consider the role of quality improvement approaches that incorporate providers behavior on compassionate and respectful care needs to be implemented across facilities in Ghana.
4. Future research should examine the impact of the workshops both on sustaining attitudinal changes of the providers and on the experiences of pregnant women receiving health care services.

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APPENDICES

QUESTIONNAIRE

Dear Respondent,

This questionnaire is designed to collect data on the topic: “Knowledge, attitude and practices of respectful maternity care among midwives in Holy Family Hospital, Berekum”

You are kindly requested to answer the questions below by indicating a tick [] or writing the appropriate answer when needed. Confidentiality will be observed therefore your name will not be disclosed in this research. Please answer the questions as frank and possible.

A. Socio-Demographic Data

1. Age (years)

(a) 21-30 [] (b) 31-40 [] (c) above 40 []

2. Marital status

(a) Married [] (b) Single [] (c) Divorced [] (d) Widowed []

3. Educational level

(a) Degree [] (b) Diploma [] (c) Certificate [] (d) Other (specify):

.....

4. Religion

(a) Christian [] (b) Muslim [] (c) Other (specify):

5. Current workplace

(a) Labour [] (b) Maternity [] (c) Other (specify):

6. Years of Practice

(a) One-Five [] (b) Six-Ten [] (c) > 10 []

B. Knowledge of Midwives on Respectful Maternity Care

7. Are you aware of respectful maternity care?

- (a) Yes (b) No
8. Have you ever taken a course covering RMC?
- (a) Yes (b) No
9. According to WHO, how many domains are used for disrespect and abuse relating to RMC?
- (a) Nine (b) Seven (c) Six (d) Five (e) Don't know
10. Match the following rights to their corresponding category of disrespect and abuse by indicating the correct answer among the options provided.
- i. Right to timely health care
- (a) Physical abuse (b) Abandonment (c) Non-confidential care
- ii. Freedom from harm and ill treatment
- (a) Non-confidential care (b) Abandonment (c) Physical abuse
- iii. Confidentiality and privacy
- (a) Physical abuse (b) Abandonment (c) Non-confidential care
- iv. Liberty, autonomy, self-determination, and freedom from coercion
- (a) Denial of care (b) Detention in facility (c) Non-confidential care
- v., Informed consent and refusal, and respect for choices
- (a) Non-dignified care (b) Non-consented care (c) Non-confidential care
- vi. Dignity and respect
- (a) Non-dignified care (b) Non-consented care (c) Non-confidential care
- vii. Right to information
- (a) Physical abuse (b) Abandonment (c) Non-consented care

C. Attitude of Midwives Towards Respectful Maternity Care

11. There is the need for service providers introduce themselves to women during labor

- (a) Agree (b) Disagree (c) Don't know
12. No need to blame mothers during child birth when they cry during contractions
- (a) Agree (b) Disagree (c) Don't know
13. It is important to address client in labour with their name
- (a) Agree (b) Disagree (c) Don't know
14. Clients should be allowed to choose their type of delivery
- (a) Agree (b) Disagree (c) Don't know
15. Clients should not be discriminated because of ethnicity, race or economic situation
- (a) Agree (b) Disagree (c) Don't know
16. Permission needs to be sought before any action and practice is taken on client
- (a) Agree (b) Disagree (c) Don't know
17. It is important to provide privacy for client during labor
- (a) Agree (b) Disagree (c) Don't know

D. Self-Reported Practice of Respectful Maternity Care midwives

18. In your opinion, what examples of respectful maternity care aspects is been practiced by you? Indicate your likelihood of practice.

Giving emotional support

- a. I welcome laboring woman warmly.
- (a) Unlikely (b) Neutral (c) Likely
- b. I introduce myself to the laboring woman.
- (a) Unlikely (b) Neutral (c) Likely
- c. I use the name preferred by a laboring woman.
- (a) Unlikely (b) Neutral (c) Likely
- d. I support laboring woman to be in her desired birthing position.
- (a) Unlikely (b) Neutral (c) Likely

Providing safe care

e. I keep medical records and the results of examinations and consultations confidential.

(a) Unlikely (b) Neutral (c) Likely

f. I drape the laboring woman's body during examinations, using sheets.

(a) Unlikely (b) Neutral (c) Likely

g. I perform all interventions with laboring woman's informed consent.

(a) Unlikely (b) Neutral (c) Likely

h. I provide clear information about progress of labor

(a) Unlikely (b) Neutral (c) Likely

Preventing mistreatment

i. I do allow the laboring woman to have a companion inside the labor unit.

(a) Unlikely (b) Neutral (c) Likely

j. I do not beat the laboring woman if she does not cooperate.

(a) Unlikely (b) Neutral (c) Likely

k. I do not shout at the laboring woman if she does not cooperate.

(a) Unlikely (b) Neutral (c) Likely

NATIONAL CATHOLIC HEALTH SERVICE (DIOCESE OF SUNYANI)
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Ghana, W/Afri
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October 28, 2022

Date

The Administrator
Holy Family Hospital
Berekum

Dear Administrator

PERMISSION TO CONDUCT RESEARCH

I wish to introduce to you the under-listed names of final-year students of the College:

1. Gyang Febiri Eunice
2. Adinkra Winnifred
3. Quaicoo Asante Esther

As part of the pre-requisite for the award of Diploma in Midwifery, they are to conduct a research study, hence the data collection on "Knowledge, Attitude and Practices of Respectful Maternity Care among Midwives in Holy Family Hospital, Berekum."

I would be grateful if you could assist them with any material or help they may need to accomplish this task.

Thank you.

Yours faithfully

Ernestina Mensah
Supervisor

For: Principal