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Respectful Maternity Care Interventions in Promoting Quality at Level 5 Health Facilities in Bungoma County, Kenya

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Abstract:
High maternal and newborn mortality is a pressing problem in developing settings. Poor treatment during childbirth contributes directly and indirectly to this problem at 82%. Many women experience disrespectful and abusive treatment during childbirth worldwide which violates their rights. In Kenya 20% of women report to have experienced some form of disrespect and abuse. Bungoma County is among the 15 counties with the worst maternal and newborn health statistics. Maternal mortality rate is 382 per 100,000 live births and newborn deaths 32 per 1,000 live births. Skilled birth attendance is 41.4%. This study was motivated by the poor maternal and newborn indicators, rising incidences of D&A, limited interventional and formal research on respectful maternity care. The study aimed at evaluating maternity care interventions for promoting quality of maternal and newborn care at level 5 health facilities in Bungoma County. Quasi-experimental pre-and-post-comparison study design was used. It involved 71 midwives, 351 mothers and 18 key informants. Sensitization was done using respectful maternity care learning resource package. Analysis was done using statistical package for social sciences (SPSS v. 25.0). Descriptive statistics were presented in graphs, tables, frequencies and percentages. On Inferential statistics, Chi square (X2) was used with 95% confidence interval (CI) to determine associations. P values ≤ 0.05 were considered significant. On statistical testing, Pearson Chi-Square was used to measure relationship between women's experience of care and their socio-demographic characteristics, Wilcoxon Signed Ranks test to measure association between the women's experience of care and midwives' performance and McNemar test to measure the statistical difference before and after the intervention. Qualitative data was analyzed thematically. The baseline prevalence of D&A was 42.2% and 25% post intervention, younger age and lower education aggravated D&A. Autonomy, privacy and confidentiality, absence of birth companionship were major aspects of D&A. Health workforce shortage, inadequate supervision, space and beds, poor provider-patient relationship were factors leading to D&A. Sociodemographic characteristics and experience of D&A- age (X2-26.07, P-0.00), marital status (X2-20.851, P-0.002. Association between self-reported and observation report- privacy and confidentiality (Z- -7.728, P-0.00), communication (Z- -2.132, P-0.033), dignity and respect (Z- -7.599, P-0.00). Correlation Pre-Post intervention- dignity and respect (P-0.002), privacy and confidentiality (P-0.00), communication (P-0.00), autonomy (P- 0.063). Conclusion, incorporate RMC in routine care, deploy more staff, avail equipment and supplies, and enhance support supervision. The study information intends to assist stakeholders in prioritizing policy actions for improving quality of maternal and newborn health outcomes and indicator

Keywords:*Autonomy, Level 5 health facility, dignity, effective, health facility environment, maternity care, maternal mortality ratio, maternal mortality, neonatal mortality ratio, people-centered, perception, quality of care, respectful maternity care, safe, skilled birth attendant, treatment*

1. Background Information

High maternal and newborn mortality and morbidity remains a pressing problem in developing countries (Furuta*et al*., 2014). Maternity care interventions are related to pregnancy, childbirth, and the postpartum period aimed at improving maternal and newborn health outcomes. They include monitoring the health and wellbeing of the mother and baby, health education, and assistance during childbirth. Its components entail Respectful Maternity Care (RMC); Emergency Obstetric and Newborn Care (EmONC); Essential Newborn Care (ENC); Focused Antenatal Care (FANC); and Malaria in Pregnancy (MIP) (Wiegers, 2009). The quality aspects to be put into consideration in order to have an impactful outcome on quality include evidence-based practices for routine care and management of complications; training of healthcare providers; monitoring and evaluation; actionable information systems; effective communication; emotional

support; respect and preservation of dignity; competent motivated personnel; availability of essential physical resources. This study focused on Respectful Maternity care in promoting quality as a component of maternity care. Respectful Maternity Care is not only a crucial component of quality of care, it is a human right (WHO, 2018).

Treatment refersto careduring childbirth that is respectful and responsive to individual women and their families' preferences, needs, and values. It emphasizes the quality of patient experience (Afulani*et al.,* 2017). Poor treatment which entails physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers and health systems conditions and constraints during childbirth contribute both directly and indirectly to maternal and newborn morbidity and mortality. The evidence base on safety, its root causes and contributing factors, as well as the cost-effective solutions to common problems are limited(Esmai*et al.,* 2017). Due to this fact, research on maternal and neonatal care has been acknowledged by the World Health Organization (WHO) Patient Safety Programme as one of the top 20 global research priorities in low-income countries whose economies are in transition (WHO, 2010).

According to WHO's document on trends in maternal and newborn mortality, the goal is to fast-track the lessening of maternal and newborn morbidity and mortality towards the achievement of the SDGs by safeguarding healthy lives and promoting well-being at all levels including global reduction of Maternal Mortality Ratio(MMR) to less than 70/100,000 live births and reduction of Neonatal Mortality Ratio(NMR) to at least as low as 12 per 1000 live births by 2030 (WHO, 2014).

Many women and their babies die as a result of poor care, even after reaching a health facility (Bohren*et al.,* 2014). Accessing labour and childbirth care in health care facilities may not guarantee good quality care. Disrespectful and undignified care is prevalent in many facility settings globally, particularly for underprivileged populations, and this not only violates their human rights but is also a significant barrier to accessing intrapartum care services. There are many anecdotal reports on Disrespect and Abuse which are based on individual accounts rather than on reliable research, There is little formal research done and no normative standard for respectful care (Borhen*et al*., 2015). According to WHO, every woman has the right to the highest attainable standard of health, which includes, the right to dignified, respectful healthcare (WHO, 2014).

In Kenya, maternal and newborn mortality rates are unacceptably high at 400 maternal deaths per 100,000 live births and a neonatal mortality rate of 22 per 1000 live births respectively (WHO/UNICEF, 2014). While this is below the Sub-Saharan average of 640 maternal deaths per 100,000 and 27 neonatal deaths per 1000 live births, Kenya experiences slow progression in maternal and neonatal health (KDHS, 2014).

There is dire need to care for women with complications of pregnancy, childbirth or the immediate postpartum period, including immediate problems of the newborn (Turab*et al.,* 2013). Lack of access to skilled birth attendance by pregnant women and inadequate knowledge and skills of healthcare providers in emergency obstetrics and neonatal care as well as mistreatment of women during childbirth that leads to mismanagement accounts to 90% of deaths (Turab*et al.,* 2013).Bungoma County is ranked 6th amongst fifteen Counties with the highest number of poor reproductive, maternal and neonatal health statistics in Kenya which contributes over 60% of the national level (KNBS/ICF Macro, 2015). At this level of magnitude, improvements in maternal survival by 2030 present a key challenge.

In 2009, the Health Research Program initiated research to generate evidence and focus global attention on disrespect and abuse during facility-based childbirth. As a result of USAID's leadership, these efforts led to a global movement to promote Respectful Maternity Care (RMC) as a human right. Prior to 2009, there was limited documentation of the scope and impact of disrespect and abuse in health facilities during childbirth (WHO, 2014). Advocates suggest that safe motherhood must be expanded beyond the prevention of illness or death to include respect for women's basic human rights including respect for women's autonomy, dignity, feelings, choices and preferences (RMC Council, 2011).

Currently, Respectful Maternity Care is a top priority in the World Health Organization (WHO) recommendations on intrapartum care or a positive childbirth experience. The WHO recommends provision of respectful maternity care in accordance with the human rights-based approach to decrease maternal and newborn morbidity and mortality and improve women's experience of labour and childbirth and address health disparities (WHO, 2018). WHO identified RMC as a key component of quality care in the WHO Quality of MNH Care Framework.RMC continues to gain prominence around the world. Afghanistan, India, Kenya, Malawi, Nepal, and Nigeria integrated RMC into national policy, standards of maternal care, and training of providers (Ramsey *et al.,* 2016). Disrespect and Abuse (D&A) of women during childbirth has recently gained recognition not only as a marker for quality of maternal and newborn care but also as violation of women's basic human rights during childbirth (Freedman *et al.,* 2014).

In a 2010 landscape analysis, Bowser and Hill described seven categories Disrespect and Abuse (D&A) as any form of inhumane treatment or uncaring behavior toward a woman during labor and delivery. Landscape analyses identified seven categories (forms) of abuse and disrespect including: Non-dignified care- harsh tone, harsh language, unkind expression, dirty bedding; Non-confidential care- lack of privacy (no curtains), private information shared; Non-consented care- treatment without permission or knowledge; Physical abuse- slapping, pinching, poking, pushing, beating; Neglect and abandonment- ignored when birth is imminent or pain relief is needed; Discrimination- prejudice based on ethnicity, poverty or HIV status (Bowser and Hill, 2010). Because disrespectful and abusive behaviors and environments degrade the quality of maternal and newborn care, identifying and addressing disrespect and abuse is an important component of cultivating RMC in health facilities.

No woman should be hit, yelled at, or abused in any way during childbirth. However, laboring women in Kenya and elsewhere may experience inhumane treatment at hospitals and clinics. This abuse is key yet overlooked reason that 4 in 10 pregnant women in Kenya deliver at health facilities (KNBS/ICF Macro, 2015). Promoting respect and dignity is a key

component in providing quality care during facility-based childbirth and is becoming a critical indicator of maternal healthcare. Providing quality care requires essential skills and attitudes from healthcare providers, as their role is central to optimizing interventions in maternity settings (Ndwiga *et al.,* 2017).

Undertaking this study through a baseline survey to determine the prevalence of disrespect and abuse, sensitizing midwives on respectful maternity care and finally evaluating the outcome of the intervention in relation to women's experience of care helped in determining the situation of respectful maternity care for promoting quality of maternal and newborn care in Bungoma County hence forming a basis for informing policy on issues that need to be addressed so as to improve on the quality of care. The study will also help in advocacy that will catalyze a movement to protect the safety and dignity of women during childbirth and ensuring RMC is integrated into the broader quality of care movement that may impact positively on the outcomes of maternal and neonatal health hence contributing immensely towards the SDG's vision and the Big 4 Agenda 3 which is Universal Health Coverage (UHC).

1.1. Problem Statement

Despite there being significant improvement in maternal and newborn health as observed between 2000 and 2017, maternal and newborn mortality still continues to be a public health problem globally. An estimated 330,000 women and 3 million newborns lost their lives due to easily preventable pregnancy and child related complications worldwide, 82% of these mortalities were attributed to disrespect and abuse during childbirth (WHO/UNICEF, 2019). In Kenya, maternal and newborn mortalities attributed to substandard care was at 90% (Nyabwa, 2018). Eliminating disrespect and abuse in health facilities during childbirth is an opportunity to improve quality of care and prevent maternal and infant deaths (Miller and Lalonde, 2015).

The UN Secretary General Ban Ki-moon made this quote famous by including it in his high-level remarks in 2013.'Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving. We have not yet valued women's lives and health highly enough.' —Professor Mahmoud Fathalla, the words remain true today. How does disrespect and abuse cause maternal deaths? Disrespect and abuse during childbirth reflect this lack of value and remain a largely under-acknowledged, systemic barrier to safe motherhood, as well as a violation of human rights (Bartlett, 2015).

Numerous factors have been identified to be contributing to disrespect and abuse: individual and community-level factors; normalizing disrespect and abuse; lack of legal and ethical foundations to address disrespect and abuse; lack of leadership in this area; lack of standards and accountability; and provider prejudice due to lack of training and resources. There is limited evidence on the effectiveness of interventions to promote RMC or to reduce mistreatment of women during labour and childbirth. Given the complex drivers of mistreatment during facility-based childbirth, reducing mistreatment and improving women's experience of care requires interventions at the interpersonal level between a woman and her health care providers, as well as at the level of the health care facility and the health system (Lazano*et al.,* 2011).

In sub-Saharan Africa, so far five studies have been carried out to measure the prevalence of disrespect and abuse during childbirth and it ranges from 15% to 98% as follows: Kenya-20%; Tanzania-70%; Ethiopia-91.7%; Nigeria- 54.5% and Malawi- 71% (Sarah Hodin, 2017). The high prevalence of disrespect and abuse reported here represent fundamental violations of women's rights and are symptomatic of falling health systems or a health system in crisis. Action is urgently needed to ensure acceptable, quality and dignified care for all women (Sando*et al.,* 2016). In Kenya, only one study has been carried to determine the prevalence rate on disrespect and abuse. Consequently, there is no documented evidence on the prevalence rate of disrespect and abuse in Bungoma County. This study will help in determining the current prevalence rate.

In a landmark ruling in Kenya that was a victory for Respectful Maternity Care, a Kenyan woman was awarded 25,000 USD in compensation by a court in Bungoma, Kenya for the disrespect and abuse she suffered during childbirth in 2013. She had been admitted at Bungoma County Referral Hospital for an induction of labour. Despite a recent national directive instructing all public health care facilities to offer free maternity services, she had to purchase her own induction medication. She received no physical assessment or monitoring during her labour and was told that she was to make her own way to the delivery room if she required medical attention. On arrival to the delivery room, having walked there alone while experiencing intense labour pains, she found that the beds were all taken. She attempted to walk back to the labor room before collapsing and subsequently giving birth on the floor. She then suffered physical and verbal abuse from two nurses who found her there unconscious and were angry that she dirtied the floor with her childbirth. She was ordered to walk to the delivery room, again unsupported, to be examined. She suffered severe emotional trauma following her mistreatment. Sadly, her case is not unusual in Kenya, or in many countries around the globe. The findings of a recent study in Kenya exploring the prevalence of disrespect and abuse (D&A) during childbirth showed that 20% of women reported any form of D&A, and 1 in 5 experienced feeling humiliated during labour (Rhiannon George-Carrey, 2018).

This study is among the first to quantify the prevalence of disrespect and abuse during childbirth, provide an intervention through sensitization of midwives on the maternity care component of Respectful Maternity Care then finally carry out an outcome evaluation. It will help in informing policy on the situation of respectful maternity care in promoting quality of care which would give insight in advocating for better maternal and newborn health services hence improving outcomes.

1.2.Broad Objective

The aim of this study was to evaluate respectful maternity care interventions for promoting quality of maternal and newborn care in level five health facilities in Bungoma County.

1.3. Specific Objectives

- To determine women's experience of care during childbirth at level five health facilities in Bungoma County
- To determine factors contributing to disrespect and abuse during childbirth at level five health facilities in Bungoma County
- To identify strategies for addressing issues affecting respectful maternity care for promoting quality of maternal and newborn care.
- To sensitize midwives on respectful maternity care for promoting quality of maternal and newborn care
- To evaluate post intervention outcomes of respectful maternity care in relation to midwives' practices and women's experience of care

2. Conceptual Framework

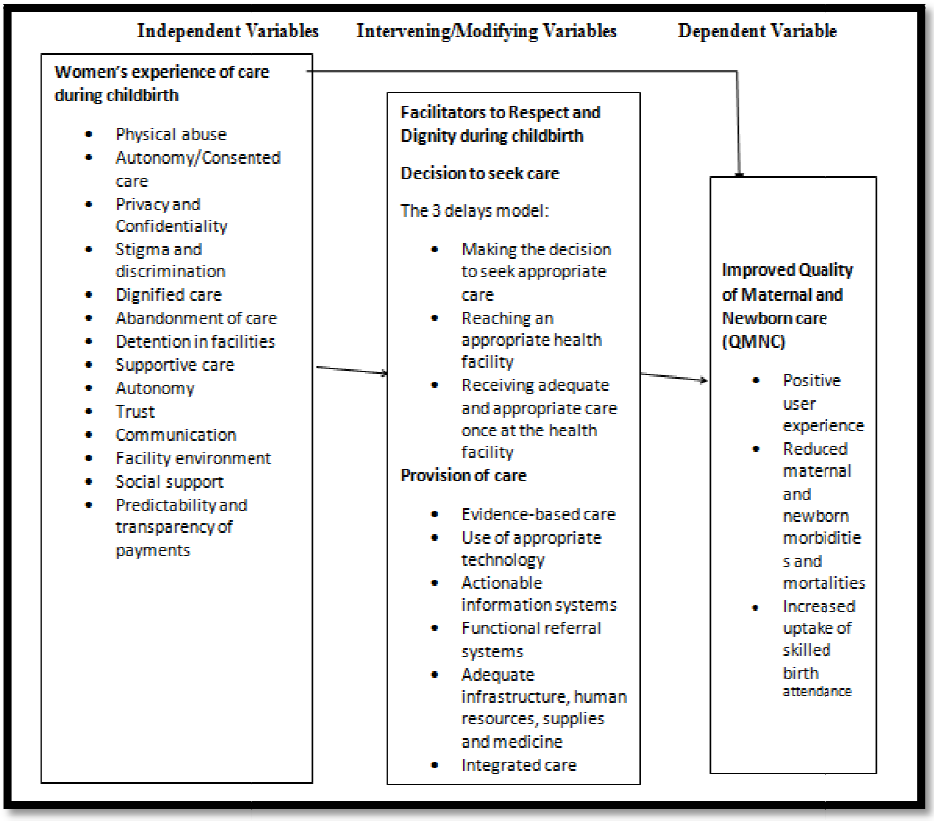

Figure 1: Landscape Analysis of Disrespect and Abuse Framework
Adopted and Modified From Bowser and Hill, 2010 and Thaddeus&Maine, 1994

2.1. Research Design

The study employed a quasi-experimental pre-and-post-comparison study design involving manipulation of independent variables without randomization. It utilized quantitative and qualitative approaches to evaluate change in behavior in relation to treatment of mothers during childbirth in addition to the functionality of healthcare facilities. Quantitative data was collected from midwives on respectful maternity care practices through performance standards assessment tool and checklist. Qualitative data was collected from midwives who had not participated in phases 1 and 2 through focused group discussion. Exit interviews and in-depth interviews were performed on postnatal mothers. This was done at the baseline and evaluation phases. Training of midwives and sensitization of pregnant mothers at antenatal care clinic was done using respectful maternity care learning resource package and case studies. Decision makers were exposed to key informant interviews. An assessment tool/checklist was also used to assess on the availability of infrastructure, equipment and supplies at baseline. Midwives and pregnant mothers were then trained and sensitized on respectful maternity care basing on the baseline findings and evaluation of outcomes carried out after the training intervention/treatment. Postnatal mothers were exposed to a pre and post respectful maternity care experience exit interview tool. Key informant interviews were conducted on facility decision makers including the hospitals' superintendents, directors of nursing services and maternity departmental heads. Comparison was done on the subjects in relation to the outcome of interest prior to and after the exposure. If post-treatment outcomes differ significantly from pre-treatment outcomes, a case can be made that the intervention/treatment was the cause of change.
The study was carried out in three phases as follows:

2.1.1. Phase 1: Baseline Survey

- Determination of the socio-demographic characteristics of the midwives and mothers
- Observation of midwives' respectful maternity care practices in the care of mothers and newborns
- Identification of the infrastructural factors (facilities, human resources, policy) impacting on respectful maternity care
- Finding out the experiences by postnatal mothers on respectful maternity care practices offered by midwives
- Identifying ways of addressing issues affecting respectful maternity care for promoting quality

2.1.2. Phase 11: Intervention

- Development of training modules was adopted from the Population Council of Kenya Respectful Maternity Care Resource Package: Facilitator's Guide. (The resource package designed to support health facility managers, healthcare providers and communities to confront disrespect and abuse during facility-based childbirth and to promote respectful maternity care).
- Development of evaluation guidelines
- Sensitization of midwives and mothers on respectful maternity care with more emphasis on promoting quality of maternal and newborn care

2.1.3. Phase III: Evaluation

- Appraisal of the training outcomes on respectful maternity care in relation to midwives' practices and women's experience of care.

2.2. Study Area

The study was conducted in maternity units of level 5 health facilities in Bungoma County. These are County referral health facilities that provide Comprehensive Emergency Obstetric and Newborn Care services, more commonly known as CEmONC. The interventions, also known as signal functions include parenteral administration of antibiotics, parenteral administration of uterotonics, parenteral administration of anticonvulsants, manual removal of the placenta, removal of retained products of conception, assisted vaginal delivery, neonatal resuscitation, caesarean section and blood transfusion.

The study area was Bungoma County due to the high burden of maternal mortalities (382/100,000) live births and 32 neonatal deaths per 1000 live births that makes it to be among the 15 counties with poor maternal indicators as well as no research base on promoting respectful maternity care (KNBS/ICF Macro, 2015).

According to Kenya's Demographic and Health Survey 2008-09, facility-based deliveries were low at 26% compared to the national average of 44% (KNBS/ICF, 2010). In KDHS 2014, facility-based deliveries improved to 41.4% compared to the national average of 61% hence having utilization of Unskilled Birth Attendance (UBA) at 58.6% (KNBS/ICF Macro, 2015). This shows an upward trend though at a slow pace.

Bungoma is located in the Western part of Kenya, about 408.9 kilometers from Nairobi, the capital city of Kenya. The county has a total population of 1,375,063, with a female population of 703,515. It covers an area of 3,593 km^2, with a population density of 382.7 people per km^2. The County's population lives below the poverty line (52.9%) meaning that people affected cannot afford basic necessities like food, shelter, and clothing (BCFS, 2016). Bungoma County is generally rural and largely relying on agriculture. The cash crop is mainly sugarcane and food crops which include maize, beans, groundnuts, sweet potatoes, cassava, millet, and peas. Most people are Christians of the catholic faith (BCFS, 2016).

The Crude Birth Rate in the County is 51.4 per 1, 000, and the Crude Death Rate (CDR) is 12.3 per 1000. The maternal mortality ratio is 382 deaths per 100,000 live births and neonatal mortality ratio of 32 deaths per 1,000 live births which is far worse than the national rate of 362 deaths per 100,000 live births and 22 per 1,000 live births respectively. Women of reproductive age comprise of 22% of the female population, which is 154,773. Estimated births/Total Fertility Rate is at 5% of the population of women in the reproductive age hence the target population will be 7,739 (KNBS/ICF Macro, 2015).

2.3. Target Population

The target population comprised of 146 midwives working in the maternity units (71 from Bungoma County Referral Hospital and 75 from Webuye County Hospital respectively), antenatal mothers, postnatal mothers who had given birth in the comprehensive health facilities three days preceding the study and Key informants including hospital administrators, medical superintendents, Directors of Nursing Services, gynecologists, and departmental in-charges in the following departments- maternity, Maternal and Child Health clinics (MCH), outpatient, laboratory, pharmacy and security from the two health facilities. Focus group discussions and in-depth interviews were also administered to selected midwives and postnatal mothers for triangulation.

2.4. Sample Size Determination

A target population of 146 midwives working in maternity units of the level five health facilities in Bungoma County were included for phase one and two.

A sample for phase one was obtained using guidelines given by Nasiuma (2001).

$$n = \frac{NC^2}{c^2 + (N-1)e^2}$$

Where n= population
c= coefficient of variation which is ≤30%
e= standard error

Taking a coefficient variation of (SD ÷ Mean ×100) i.e., 4 ÷ 16 ×100= 25% and a standard error of 0.03 out of a target population of midwives working in maternity units of level five health facilities in Bungoma County (146) distributed as follows: Bungoma county referral hospital (71) and Webuye county hospital (75) respectively, a sample size of 35 and 36 respondents was obtained from Bungoma hospital and Webuye hospital respectively. 25% coefficient of variation was used to ensure that the sample was wide enough to justify the results being generalized for the two hospitals.

Bungoma County Referral Hospital
Population is 71(N)
C= 25%
E= 0.03
N (Sample) =?

$$n = \frac{71*0.25^2}{0.25^2 + (71-1)0.03^2}$$

$$n = \frac{4.4375}{0.0625+ 0.063}$$

n= 35.36
hence, we take n=35 respondents
Webuye County Hospital

$$n = \frac{75*0.25^2}{0.25^2 + (75-1)0.03^2}$$

$$n = \frac{4.6875}{0.0625+ 0.0666}$$

n= 36.31
hence, we take n=36 respondents
Postnatal Mothers

The target population size for postnatal mothers is less than 10,000 thus the formula below was used to determine the sample size (*Fisher et al*., 1991; cited in Kothari, 2004).

$$n= \frac{z^2pq}{d^2}$$

n= the desired sample size
z= the standard normal deviate, which corresponds to 95% confidence level (1.96).
p= the proportion in the target population estimated to have the particular characteristic being studied. In this study, *p* was the proportion of women who had delivered in health facilities which was estimated at 41.4%. Hence P was 0.414.
q= 1.0- p
d= degree of accuracy desired, usually set at 0.05

$\frac{1.96^2 \times 0.414 \times 0.586}{0.05^2}$ = 367. Hence the sample size was 367.

Adjusting for smaller sample size and reducing the sampling error margin, the second formula was used as follows:
nf= the desired sample size (when the population is less than 10,000)
N= the estimate of the target population size (4176)

$$nf = \frac{n}{[1+(n/N)]}$$

$$nf = \frac{367}{[1+(367/7739)]} = 350.5$$

Hence the sample size was 351 for exit interview that was finally adjusted for an anticipated non-response rate of 3% according to Gary P.R. 2007 to 360 divided equally between Bungoma County Referral Hospital (180) and Webuye County Hospital (180) respectively.

2.5. Data Collection Methods and Procedure

The study participants were midwives, mothers and key informants from the maternity units of Bungoma County Referral Hospital and Webuye County Hospital in Bungoma County respectively. The study was in three phases.

Phase one involved a baseline assessment on midwives' practice on respectful maternity care and postnatal mothers' experiences on respectful maternity care during childbirth. A total of 71 midwives (35 from Bungoma County Referral Hospital and 36 from Webuye County Hospital), 351 postnatal mothers and eighteen key informants were

involved in the study (9 from Bungoma County Referral Hospital and 9 from Webuye County Hospital). They included the hospital administrators, medical superintendents, Directors of Nursing Services, gynecologists, and departmental in-charges in the following departments- maternity, Maternal and Child Health clinics (MCH), outpatient, laboratory, pharmacy and security. During this phase, data was collected using an interview checklist/standards performance tool (knowledge, practice and confidence), exit interview questionnaire (experience questionnaire), focused group discussion, in-depth interview and key informant interviews. Data was collected by four research assistants at the level of degree in nursing and they were licensed by the Nursing Council of Kenya. This category was selected because they have the cognitive, affective and psychomotor skills in nursing and more in the process of childbirth. The main objective of this phase was to identify skills and knowledge gaps in the area of respectful maternity care in improving the Quality of Maternal and Newborn Care.

2.6. Data Collection Tools/Instruments

Data for phase one was collected using two types of questionnaires (knowledge, practice and experience questionnaires respectively) (Oppenheim 2009). The researcher administered standard performance tool/interview checklist and focused group discussion for mothers; exit interviews and focus group discussion for mothers; and key informant interviews. Questionnaires were selected because if self-administered they would save time for the researcher, give the respondents freedom of expression, and it took a short time to gather a lot of information that may yield forthright responses if anonymous and they also give a standard format for gathering information (Taylor *et al.,* 2007).

Exit interview for postnatal mothers was formulated to collect demographic data, information on treatment of mothers during childbirth (experience of care) and facilitators to respect and dignity during childbirth that can impact of promoting respectful maternity care. This was guided by the conceptual framework and the study objectives. In-depth interview guide was used to collect information from selected midwives and post-natal mothers and key informant interviews administered to decision makers for triangulation. The research instruments were prepared in English.

2.7. Data Analysis and Presentation

Descriptive statistics were used to analyze the research data and the analysis was guided by the objectives of the study. All the analysis was done using statistical package for social sciences (SPSS v. 25.0). Descriptive statistics were presented in graphs, tables, frequencies and numerations. Qualitative data was analyzed thematically.

3. Results

3.1. Introduction

This chapter presents the results of data collected from the respondents and analyzed in the study area. The results included the socio-demographic characteristics of respondents and maternity care interventions specifically on respectful maternity care aimed at promoting quality at level five health facilities in Bungoma County, Kenya.

To examine individual effects of various explanatory variables on respectful maternity care, data obtained was coded, entered, cleaned and analyzed using SPSS v. 25.0 and exported to Microsoft-excel for presentation. Chi square (X^2) was used to assess if there was significant relationship between independent variables and women's experience of care. P values of ≤ 0.05 were considered significant. Pearson Chi-Square was used to measure relationship between women's socio-demographic characteristics and their experience of care. Wilcoxon Signed Ranks test was used to measure association between the exit interview on mothers' experience of care and observation of midwives' performance during delivery. The study targeted 360 women, 40 midwives and 8 key informants, who all responded to the items in the data collection tools. Mugenda and Mugenda (2003) declares that a response rate of 50% is adequate for analysis and reporting. The return rate was 100% hence statistically acceptable for analysis.

3.2. Phase 1 Results (Findings from Baseline Survey-Exit interview, Performance Observation, FGD, KII)

The pre-intervention survey was completed by 360 post-natal mothers (180 from Bungoma County Referral Hospital and 180 from Webuye County Hospital) by using exit interview, Performance observation of 80 midwives divided equally between the two hospitals, 10 Focus Group Discussion for postnatal mothers who had not participated in the exit interview, 10 Key informant interviews divided equally between the two hospitals and 10 in-depth interviews targeting midwives from the two hospitals. All the tools were returned representing 100% response rate.

3.2.1. Socio-Demographic Characteristics of the Study Population

The total number of mothers interviewed was 360. They were interviewed on their age, marital status, educational level and literacy levels in reading and writing.

The mean age of respondents was 22 ± 4.1 years ranging from 15-49 years age group who are Women of Reproductive Age (WRA) hence justifying the grouping of the younger women 15-19 years of age since they are usually a special group that is mostly vulnerable. Majority of the women were aged 20-29 years at 44% of whom 62% experienced some form of disrespect and abuse followed by 31.6% in the 30-39 age group of whom 49% experienced some form of disrespect and abuse. Respondents aged 15-19 years were 15.8% of whom 100% experienced some form of disrespect and abuse while those aged 40-49 years were 8.6% of whom 6% experienced some form of disrespect and abuse.

Majority of the women, 52.5% were married of which 51.8% experienced some form of disrespect and abuse while 26.7 % of the women were single of whom 42.7% experienced some form of disrespect and abuse. 20.8% of the women were divorced/separated of whom 20% experiences some form of disrespect and abuse.

Majority of the respondents had a college and above level of education at 38.6% of whom 38.2% experienced some form of disrespect and abuse followed by those with post-primary/vocational/secondary level of education at 37.3% of whom 53.7% experienced some form of disrespect and abuse. Respondents who had primary or less level of education were 24.1% of whom 71.2% experienced some form of disrespect and abuse

Majority of the women were not employed at 58% of whom 55.5% experienced some form of disrespect and abuse followed by those who were employed at 30% of whom 25% experienced some form of disrespect and abuse. Women who were self-employed were 12% of whom 27.9% experienced some form of disrespect and abuse.

The study used the term number of children instead of parity since it entails putting viability into consideration which was not in the researcher's interest. 60% of the respondents had 1-2 children of whom 50.9% experienced some form of disrespect and abuse followed by those who had 3-5 children at 60% of whom 50.9% experiencing some form of disrespect and abuse. 10% had >5 children of whom 22% experienced some form of disrespect and abuse.

Majority of the women were getting a monthly income of <5,000 at 51% of whom 90% experienced some form of disrespect and abuse. Those earning a monthly income between ksks. 5000-10,000 were at 38% of whom 84% experienced some form of disrespect and abuse and those earning a monthly income >10,000 were at 11% of whom 29% experienced some form of disrespect and abuse.

Majority of respondents were from the Christian religion at 99% of whom 80% experienced some form of disrespect and abuse and 4% were Muslims at 1% of whom 25% experienced some form of disrespect and abuse (Table 1).

Independent Variables	**Frequency n= 360 (%)**	**Experience of Any Form of D&A (%)**
Age of respondents	Mean age = 22±4.1	
15-19	57 (15.8)	57 (100%)
20-29	158 (44)	98 (62%)
30-39	114 (31.6)	80 (49%)
40-49	31 (8.6)	2 (6%)
Marital Status		
Married	189 (52.5)	98 (51.8%)
Single	96 (26.7)	41 (42.7%)
Divorced/separated	75 (20.8)	15 (20%)
Education Level		
Primary or less	87 (24.1)	62 (71.2%)
Post primary/Vocational/ Secondary	134 (37.3)	72 (53.7%)
College and above	139 (38.6)	56 (40.2%)
Occupation		
Employed	108 (30)	27 (25%)
Self employed	43 (12)	12 (27.9%)
Not employed	209 (58)	116 (55.5%)
Number of Children		
• 1-2	216 (60)	110 (50.9%)
• 3-5	108 (30)	42 (38.8%)
• >5	36 (10)	8 (22%)
Monthly Income (Kshs)		
• <5000	182 (51)	164 (90%)
• 5000-10,000	137 (38)	115 (84%)
	41 (11)	12 (29%)
• >10,000		
Religion		
Christian	356 (99)	285 (80%)
Muslim	4 (1)	1 (25%)

Table 1: Socio-Demographic Characteristics of the Respondents

3.2.2. Treatment of Mothers during Childbirth (Experience of Care/Respectful Maternity Care)

Three tools were used to assess women's experience of care during childbirth which were patients' exit interview that was administered to mothers after delivery, observation checklist which was used to observe midwives while conducting delivery and Focus Group Discussion administered to postnatal mothers who had not taken part in the exit interview.

3.2.2.1. Patient Exit Interview

This tool collected information on women's experience of care and it addressed issues to do with dignity and respect; privacy, autonomy and confidentiality; communication; supportive care; facility environment and transparency of payments.

3.2.2.2. Dignity and Respect

Majority of the respondents at 86.4% said that the doctors, nurses or other healthcare providers introduced themselves to them when they first came to see them during their time in the facility while 13.6% reported that the doctors, nurses or other healthcare providers did not introduce themselves. 89.2% reported that the doctors, nurses, or other healthcare providers called them by name while 10.8% reported to have not been called by name. Majority of the respondents 93.6% reported to have felt respected by the doctors, nurses, or other health staff at the facility while 6.4% reported that they did not feel respected.

Majority of the respondents said that the doctors, nurses, or other staff at the facility treated them in a friendly manner at 92.7% while 7.3% said that they were not treated in a friendly manner. 93.6% said that they felt cared for by the doctors, nurses or other staff at the facility while 6.4% said that they did not feel care for. Majority of the respondents said that they were not shouted at, scolded, insulted, threatened or talked to rudely by the doctors, nurses, or other health providers at 93.6% while 6.4% reported to have been shouted at, scolded, insulted, threatened or talked to rudely.

96.9% said that they were not treated roughly like pushed, beaten, slapped, pinched, physically restrained or gagged while 3.1% reported to have been treated roughly. Majority of the respondents said that they were not forced to stay at the facility against their will or because they could not be able to pay the hospital bill at 97.5% while 2.5% reported to have been forced to stay at the facility against their will (Table 2)

4.8% of the respondents experienced a high level of dignity and respect, 90.4% experienced a moderate level of dignity and respect while 4.8% experienced a low level of dignity and respect (Table 3).

Focused Group Discussion was also carried out on postnatal mothers who had not participated in the exit interview to find out their experience on dignity and respect

'I was satisfied with the services I was offered. The doctors and nurses were very caring.' said an FGD participant

*'I received unfriendly and insensitive treatment when I told the nurse to allow my mother-in-law help me carry the baby since I was still in pain due to cesarean section and she scolded me saying that she is not the one who told me to get pregnant so as to come in the hospital to disturb them.'*said an FGD participant

'I was harassed because my baby's injection line came out' said an FGD participant

Statement	Yes	No	Total
Did the doctors, nurses or other healthcare providers introduce themselves to you?	311	49	360
	86.4%	13.6%	100.0%
Did the doctors, nurses, or other healthcare providers call you by your name?	321	39	360
	89.2%	10.8%	100.0%
Can you say that you felt respected by the doctors, nurses, or other staff at the facility?	337	23	360
	93.6%	6.4%	100.0%
Can you say that the doctors, nurses, or other staff at the facility treated you in a friendly manner?	332	26	358
	92.7%	7.3%	100.0%
Did you feel cared for by the doctors, nurses, or other staff at the facility?	334	23	357
	93.6%	6.4%	100.0%
Were you shouted at, scolded, insulted, threatened or talked to rudely by the doctors, nurses, or other health providers?	23	336	359
	6.4%	93.6%	100.0%
Were you treated roughly like pushed, beaten, slapped, pinched, physically restrained or gagged?	11	349	360
	3.1%	96.9%	100.0%
Were you forced to stay at the facility against your will because you could not pay your bill?	9	351	360
	2.5%	97.5%	100.0%

Table 2: Dignity and Respect

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	18	4.8	4.8	4.8
Moderate	325	90.8	90.8	95.6
Low	17	4.4	4.4	100.0
Total	360	100.0	100.0	

Table 3: Cumulative Rating of Dignity and Respect

3.2.2.3. Privacy, Autonomy and Confidentiality

Majority of the respondents reported that they did not feel like other people not involved in their care could hear their discussion while speaking to the doctors, nurses or other staff at the facility at 62% while 38% reported that their discussion could be heard by other people not involved in their care

95% reported that while being examined in the labor room they were covered up with a cloth or blanket or screened with a curtain to ensure they did not feel exposed while 5% reported to have not been covered or screened with a curtain. 96% thought that their health information was or would be kept confidential at the health facility while 4% thought that their health information would not be kept confidential.

Majority of the respondents said that the doctors, nurses or other staff did not involve them in decision making about their care at 94% while 6% said that they involved them in decision making about their care

Majority of the respondents at 98% reported that permission or consent was not obtained from them by the doctors, nurses or other staff at the facility before doing procedures and examinations on them while 2% reported that permission or consent was obtained.

98% of the respondents reported that they were not allowed to be in the position of their choice during delivery while 2% reported to have been allowed to be in the position of their choice during delivery (Table 4)

Cumulatively on the experience of privacy, autonomy and confidentiality, 3.4% rated it highly, 87.5% rated it moderately while 9.1% rated it to be low (Table 5).

'My information was kept confidential and the nurses were supportive, friendly and calm'said an FGD participant.

'While in labour, I was neither asked for consent during examinations nor informed on my progress of labour'said an FGD participant

'There is no privacy due to inadequate bed capacity which forces mothers to share beds alongside their newborn babies' said a midwife

Statement	Yes	No	Total
While speaking to the doctors, nurses, or other staff at the facility, did you feel other people not involved in your care could hear your discussion?	138	222	360
	38%	62%	100%
While being examined in the labor room, were you covered up with a cloth or blanket or screened with a curtain to secure you did not feel exposed?	341	19	360
	95%	5%	100%
Do you think your health information was or will be kept confidential at this facility?	344	16	360
	96%	4%	100%
Did the doctors, nurses, or other staff at the facility involve in decision making about your care	22	338	360
	6%	94%	100%
Was permission or consent obtained from you by the doctor's nurses or other staff and the facility before doing procedures and examination on you	9	351	360
	2%	98%	100%
Were you allowed to be in the position of your choice during delivery	9	351	360
	2%	98%	100%

Table 4: Autonomy, Privacy and Confidentiality

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	13	3.4	3.4	3.4
Moderate	330	87.5	87.5	90.9
Low	17	9.1	9.1	100.0
Total	360	100.0	100.0	

Table 5: Cumulative Experience of Autonomy, Privacy and Confidentiality

3.2.2.4. Communication

Majority of the respondents at 98% reported that doctors, nurses or other staff at the facility spoke to them in a language that they could understand while 2% reported that were not spoken to in a language they could understand. 90% of the respondents said that the doctors and nurses explained to them why they were doing examinations and procedures on them while 10% reported that they were not explained to why examinations and procedures were being done on them. 88% of the respondents reported that the doctors and nurses explained to them why they were giving them any medication while 12% reported that they were not explained to why they were being given any medication. Majority of the respondents at 88% said that they felt that they could ask doctors, nurses and other staff at the facility any questions they had while 12% reported that they did not feel like they could ask questions they had. (Table 6)

Cumulatively 95.3% of the respondents had a positive experience when it comes to communication while 4.7% experienced communication moderately (Table 7).

'The nurses were very supportive; they gave me a lot of health education on baby care. It was the best experience ever' said an FGD participant.

'I can say that most of the doctors and nurses are good apart from a few who have negative attitude' said an FGD participant

'I was not informed which medication my baby and I were being given. I was even at one time asked which medication I was on yet I did not have any idea' said an FGD participant.

'My baby was taken to nursery without being told the reason why. He stayed there for 24 hours without me seeing him' said an FGD participant

'I wish I could report my dissatisfaction but because a weak person has no right, I will just let it go' said an FGD participant

Statement	Yes	No	Total
Did the doctors, nurses, or other staff at the facility could speak to you in a language you would understand?	351	9	360
	98%	2%	100%
Did the doctors and nurses explain to you why they were doing examinations or procedures on you?	323	37	360
	90%	10%	100%
Did the doctors and nurses explain to you why they were giving you any medicine?	314	44	358
	88%	12%	100%
Do you feel you could ask the doctors, nurses or other staff at the facility any questions you had?	316	44	360
	88%	12%	100%

Table 6: Communication

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	341	95.3	95.3	95.3
Moderate	19	4.7	4.7	100.0
Low	17	9.1	9.1	100.0
Total	360	100.0	100.0	

Table 7: Cumulative Experience on Communication

3.2.2.5. Supportive Care

Majority of the respondents said that the doctors and nurses at the facility asked them about how they were feeling at 93% while 7% were not asked how they were feeling. 88% of the respondents said that the doctors, nurses or other staff in the facility addressed their anxiety and fears while 12% said that their fears and anxieties were not addressed.

82% of the respondents said that the doctors and nurses asked them how much pain they were in while 18% said that they were not asked how much pain they were in. Majority of the respondents at 77% reported that the doctors and nurses did everything they could to help control their pain while 23% reported that their pain was not controlled.

Majority of the respondents at 94% felt that the doctors, nurses or other staff at the facility paid attention while 6% felt that they did not pay attention. 89% of the respondents said that when they felt hungry/thirsty, they were allowed to eat and drink while 11% were not allowed to eat and drink when they felt hungry/thirsty (Table 8)

83.6% said that they were allowed to stay with someone whom they wanted to stay with them during labour while 16.4% said that they were not allowed. Majority of the respondents at 54.2% said that they were not allowed to have a birth companion stay with them during delivery while 45.8% said that they were allowed to have a birth companion during delivery (Table 9 and 4.10)

Cumulatively the experience of supportive care was highly rated at 90%, moderate rating was at 8.1% while low rating was at 1.9% (Table 11).

'This was my first time to deliver and I felt very much supported by the nurses. God bless them' said an FDG participant.

Statement	Yes	No	Total
Did the doctors and nurses at the facility talk to you about how you were feeling?	334	26	360
	93%	7%	100%
Did the doctors, nurses, or other staff in the facility support your anxiety and fears?	317	43	360
	88%	12%	100%
Did the doctors and nurses ask how much pain you were in?	294	66	360
	82%	18%	100%
Do you feel the doctors or nurses did everything they could to help control your pain?	277	83	360
	77%	23%	100%
When you needed help did you feel the doctors, nurses or other staff at the facility paid attention?	339	21	360
	94%	6%	100%
Did the doctors and nurses pay attention to you during your stay at the facility?	340	20	360
	94%	6%	100%
When you felt hungry/thirsty, were you allowed to eat or drink?	320	39	359
	89%	11%	100%

Table 8: Supportive Care

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	301	83.6	83.6	83.6
Moderate	59	16.4	16.4	100.0
Low	17	9.1	9.1	100.0
Total	360	100.0	100.0	

Table 9: Presence of a Birth Companion during Labour

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	165	45.8	45.8	45.8
Moderate	195	54.2	54.2	100.0
Low	17	9.1	9.1	100.0
Total	360	100.0	100.0	

Table 10: Presence of a Birth Companion during Delivery

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	323	90.0	90.0	90.0
Moderate	29	8.1	8.1	98.1
Low	8	1.9	1.9	100.0
Total	360	100.0	100.0	

Table 11: Cumulative Experience of Supportive Care

3.2.2.6. Facility Environment

Majority of the respondents at 90% said that there were enough staff in the facility to care for them while 10% said that there were no enough staff. 54% reported that the labour and postnatal wards at the facilities were crowded while 46% said that they were not crowded. 99% said water was available in the facility while 1% said that water was not available. 100% said that electricity was available in the facility. In overall 98% said that they felt safe in the facility while 2% said that they did not feel safe (Table 12)

Cumulatively 95.5% had a positive experience on facility environment while 4.5% (Table 4.13).

'We are forced to share beds together with our newborns which is can expose us to infections such as Corona and the toilets are sometimes dirty' said an FGD participant.

Statement	Yes	No	Total
Was there enough health staff in the facility to care for you?	324	36	360
	90%	10%	100%
Considering the Labor and postnatal wards, do you feel the health facility was crowded?	195	165	360
	54%	46%	100%
Was water available in the facility?	358	2	360
	99%	1%	100%
Was electricity available in the facility?	360	0	360
	100%	0%	100%
In overall, can you say that you felt safe in the health facility?	351	9	360
	98%	2%	100%

Table 12: Facility Environment

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	343	95.5	95.5	95.5
Moderate	17	4.5	4.5	100.0
Low	8	1.9	1.9	100.0
Total	360	100.0	100.0	

Table 13: Cumulative Experience on Facility Environment

3.2.2.7. Overall Rating by the Respondents

Majority of the respondents at 62.8% were satisfied with the services offered at the facility followed by 19.4% who were very satisfied. 15.3% were neither satisfied nor dissatisfied, 1.9% were dissatisfied while 0.3% were very dissatisfied (Table: 4.14).

40.8% of the respondents rated the level or quality of care as good, 37.7% rated the quality of care as fair, 16.4% rated the quality of care as very good while 3.1% rated the quality of care as excellent (Table 15)

68.9% said they would definitely deliver in the same facility again, 28.1% said that they would somewhat deliver in the same facility again while 3% said that they would not deliver in the same facility again (Table 16)

69.8% said that they would definitely recommend to another woman to deliver in the facility, 24.4% said that they would somewhat recommend to another woman to deliver in the facility while 5.8% said that they would not recommend to another woman to deliver in the facility (Table 17)

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Neither Satisfied Nor Dissatisfied	55	15.3	15.3	15.3
Satisfied	226	62.8	62.8	78.1
Very Satisfied	70	19.4	19.4	97.5
Dissatisfied	7	1.9	1.9	99.4
Very Dissatisfied	2	.6	.6	100.0
Total	360	100.0	100.0	

Table 14: Rating of the Level of Satisfaction with the Services Offered at the Facility

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Fair	143	39.7	39.7	39.7
Good	147	40.8	40.8	80.6
Very good	59	16.4	16.4	96.9
Excellent	11	3.1	3.1	100.0
Total	360	100.0	100.0	

Table 15: Rating on the Level/Quality of Care Offered at the Facility

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Yes, Somewhat	101	28.1	28.1	28.1
Yes, Definitely	248	68.9	68.9	96.9
No	11	3.0	3.0	100.0
Total	360	100.0	100.0	

Table 16: Choice to Deliver in the Same Facility Again

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Yes, Somewhat	88	24.4	24.4	24.4
Yes, Definitely	251	69.7	69.7	94.2
No	21	5.8	5.8	100.0
Total	360	100.0	100.0	

Table 17: Recommendation to another Woman to Deliver in the Facility

3.2.2.8. Prevalence of Disrespect and Abuse

57.8% rated highly the user experience of care, 36.6% rated moderately the user experience of care while 5.6% rated low the positive user experience of care. The prevalence of experiencing any form of disrespect and abuse at baseline was at 42.2% (Table 18)

	Dignity and Respect	Autonomy, Privacy and Confidentiality	Communication	Supportive Care	Facility Environment	Cumulative Prevalence of D&A (%)- divided by 5
Highly	4.8	3.4	95.3	90.0	95.5	57.8
Moderate	78.2	87.5	4.7	8.1	4.5	36.6
Low	17	9.1	0	1.9	0	5.6

Table 18: Prevalence of Disrespect and Abuse at Baseline

3.2.2.9. Performance Standards Observation Checklist

Observation of midwives while conducting deliveries was done to assess the practice of respectful maternity care. The aspects looked at included protection from physical harm or ill treatment, protection of the woman's rights to informed consent and choice/preference, protection of privacy and confidentiality, treatment of woman with dignity and respect and not leaving the woman without care. In-depth interview for midwives was also carried out for triangulation.

3.2.2.10. Protection from Physical Harm or Ill Treatment

Majority of the midwives at 99% did not use physical force or harsh behavior on the women including slapping or hitting while 1% used physical force or harsh behavior. 85% of the midwives did not physically restrain women while 15% physically restrained women. 80% of the midwives exhibited a caring attitude and touched the women in a culturally appropriate way while 20% did not exhibit a caring attitude and touched the women in a culturally inappropriate way.
Majority of the midwives at 99% did not separate women from their babies unless medically necessary while 1% separated the woman from her baby when it was not medically necessary. 94% of the midwives did not deny the women food or fluid during labour unless necessary while 6% denied the women food or fluid while in labour when it was not necessary. 91% of the midwives provided comfort/pain relief to the women during labour as necessary while 9% did not provide comfort/pain relief as necessary (Table 19)

Cumulatively 95% of the midwives highly protected the women from physical harm or ill treatment, 3.8% moderately protected the women while from physical harm or ill treatment while 1.3% had a low rating in protecting the women from physical harm or ill treatment (Table 20).
'Physical harm or ill treatment occurs sometimes due to clients' negative attitude and lack of understanding of the service being provided especially if the client declines to be assisted and does not cooperate even after counselling on the service to be provided'said a nurse midwife.

'In this facility service providers have good relationship with their clients; hence no disrespectful treatment is allowed during childbirth. In cases where there is disrespect and abuse, the service provider is given a verbal warning and later on written a letter through the hospital management committee and if there's no change, action is taken' said a nurse midwife

Statement	Yes	No	Total
Does not use physical force or harsh behavior on the woman including slapping or hitting	79	1	80
	99%	1%	100%
Does not physical restrain woman	68	12	80
	85%	15%	100%
Exhibits a caring attitude and touches the woman in a culturally appropriate way	64	16	80
	80%	20%	100%
Woman is not separated from her baby unless medically necessary	79	1	80
	99%	1%	100%
Woman in labor is not denied food or fluid unless necessary	75	5	80
	94%	6%	100%
Comfort/pain relief is provided as necessary	73	7	80
	91%	9%	100%

Table 19: Protection from Physical Harm or ill Treatment

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	76	95.0	95.0	95.0
Moderate	3	3.8	3.8	98.8
Low	1	1.3	1.3	100.0
Total	80	100.0	100.0	

Table 20: Cumulative Rating on the Protection from Physical Harm or ill Treatment

3.2.2.11. Protection of the Woman's Right to Informed Consent and Choice/Preference

89% of the midwives introduced themselves to the women and their companions while 11% did not introduce themselves to the women and their companions. 75% of the midwives encouraged the companions to remain with the women whenever possible while 25% did not encourage the companions to remain with the women whenever possible.
72% of the midwives encouraged the women and their companions to ask questions and responded to the questions with promptness, politeness and truthfulness while 28% did not encourage the women and their companions to ask questions and did not respond with promptness, politeness and truthfulness. 91% of the midwives explained to the women what was being done and what to expect all through labour and delivery while 9% did not explain to the women what was being done and what to expect all through labour and delivery.

80% of the midwives gave the women periodic updates on the status and progress of labour while 20% did not give the women periodic updates on the status and progress of labour. 81% of the midwives allowed the women to move around during labour while 19% did not allow the women to move around during labour.

Majority of the midwives at 58% did not allow the women to assume the position of their choice during delivery while 42% allowed the women to assume the position of their choice during delivery. 91% of the midwives obtained consent or permission from the women before any procedure while 9% did not obtain consent or permission from the women before any procedure (Table 21).

Cumulatively 82.5% of the midwives highly protected the women's rights to informed consent and choice or preference, 16.3% moderately protected the women's rights to informed consent and choice or preference while 1.3% rated low in the protection of women's rights to informed consent and choice or preference (Table 22).

'We sometimes experience challenging interactions with clients whereby one may decline to undergo a caesarean section or vaginal examination even after counselling on why it has to be done and the risks involved if it is not done. Some clients have a negative attitude and hence do not listen or adhere to our advice' said a nurse midwife

'Communication barrier or not giving adequate information to the client sometimes leads to them not signing the consent form for caesarean section' said a nurse midwife

Statement	Yes	No	Total
Health provider introduces him/herself to the woman and her companion	71	9	80
	89%	11%	100%
The companion is encouraged to remain with the woman whenever possible	60	20	80
	75%	25%	100%
The woman and her companion are encouraged to ask questions. Questions are responded to with promptness, politeness and truthfulness	58	22	80
	72%	28%	100%
Questions are responded to with promptness, politeness and faithfulness	66	14	80
	82%	18%	100%
The woman is explained to what is being done and what to expect all through labour and birth	73	7	80
	91%	9%	100%
Periodic updates on status and progress of labour are given	64	16	80
	80%	20%	100%
The woman is allowed to move around during labour	65	15	80
	81%	19%	100%
The woman is allowed to assume position of choice during delivery	34	46	80
	42%	58%	100%
Consent or permission is obtained before any procedure	73	7	80
	91%	9%	100%

Table 21: Protection of the Woman's Right to Informed Consent and Choice/Preference

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	66	82.5	82.5	82.5
Moderate	13	16.3	16.3	98.8
Low	1	1.3	1.3	100.0
Total	80	100.0	100.0	

Table 22: Cumulative Protection women's Rights to Informed Consent and Choice/Preference

3.2.2.12. Protection of Privacy and Confidentiality

76% of the midwives kept the patients' files in locked cabinets with limited access while 24% of the midwives did not keep the patients' files in locked cabinets with limited access. 94% of the midwives used curtains or other barriers to protect women during examinations and birthing process while 6% did not use curtains or other barriers to protect women during examinations or birthing process. 79% of the midwives used drapes or covering appropriately to protect women's privacy while 21% did not use drapes or covering appropriately to protect women's privacy (Table 23)
Cumulatively 87.5% of the midwives protected the women's privacy and confidentiality while 12.5% did not protect the women's privacy and confidentiality (Table 24)

Statement	Yes	No	Total
Confirmation by the observer that the patient files are stored in locked cabinets with limited access	61	19	80
	76%	24%	100%
Curtains or other visual barriers are used to protect woman during examinations and birthing processes	75	5	80
	94%	6%	100%
Drapes or covering are used appropriately to protect woman's privacy	63	17	80
	79%	21%	100%

Table 23: Protection of Privacy and Confidentiality

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	70	87.5	87.5	87.5
Moderate	10	12.5	12.5	100.0
Total	80	100.0	100.0	

Table 24: Cumulative Rating on Protection of Privacy and Confidentiality

3.2.2.13. Treatment of Women with Dignity and Respect

Majority of the midwives at 84% spoke politely to the women and birth companions while 13% did not speak to the women and birth companions politely. 52% of the midwives allowed the women and the birth companions to observe cultural practices as much as possible while 48% did not allow the women and birth companions to observe cultural practices as much as possible. 95% of the midwives did not insult, intimidate, threaten or coarse women or their birth companions while 5% insulted, intimidated, threatened or coursed women and their birth companions (Table 25)

Cumulatively 85% of the midwives highly practiced dignity and respect towards the women and their birth companions while 15% did not practice dignity and respect towards the women and their birth companions (Table 26).

'When the workload is too much you have to take the shortest time possible per client in order to serve all of them hence leading to subsidized care that may be equated to disrespect and abuse but sometimes it's not our wish' said a midwife

'Some service providers disrespect and abuse clients as a result of being provoked by them. Some tend to project to clients due to too much workload,' said a midwife

'Some cultural factors make some women to be treated with disrespect and abuse. For instance there are those who come along with traditional herbs and keep on licking during labour. Yes culture ought to be respected but some cultures are detrimental. The moment I realize that a mother is using herbs I handle her roughly' said a nurse midwife

'Some providers treat clients with disrespect and abuse because they have 'god fathers' who work in the top offices hence feel like they can bulldoze others since nothing can be done to them' said a nurse midwife

Statement	Yes	No	Total
The woman and companion are spoken to politely.	67	13	80
	84%	16%	100%
The woman and the companion are allowed to observe cultural practices as much as possible.	42	38	80
	52%	48%	100%
The woman or her companion are not insulted, intimidated, threatened or coursed.	76	4	80
	95%	5%	100%

Table 25: Treatment of the Woman with Dignity and Respect

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	68	85.0	85.0	85.0
Moderate	12	15.0	15.0	100.0
Total	80	100.0	100.0	

Table 26: Cumulative Rating on Treatment of Women with Dignity and Respect

3.2.2.14. Woman is not Left without Care/Unattended

91% of the midwives encouraged the women to call if needed while 9% did not encourage women to call them if needed. 78% of the midwives responded quickly to women's calls while 22% did not respond quickly to women's calls. 79% never left the women alone or unattended while 21% left the women alone or unattended (Table 27).

Cumulatively 83.8% of the midwives rated highly on not leaving the women without care while 16.3% rated moderately on not leaving the women without care (Table 28)

'More staff should be deployed to avoid a client being left without care or unattended. Sometimes we have more the six women in labour with only two nurses on duty. This is very overwhelming. Service providers should also be motivated to boost attitude since we work under a lot of pressure that leads to burnout hence having a negative impact on patients said a nurse midwife

Statement	Yes	No	Total
The woman is encouraged to call if needed.	73	7	80
	91%	9%	100%
The mid wife comes quickly when woman calls.	62	18	80
	78%	22%	100%
The woman is never left alone or unattended.	63	17	80
	79%	21%	100%

Table 27: Women are on no Occasion Left without Care/Unattended

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Highly	67	83.8	83.8	83.8
Moderate	13	16.2	16.2	100.0
Total	80	100.0	100.0	

Table 28: Cumulative Rating on not Leaving Women without Care/Unattended

3.2.3 Factors Contributing to Disrespect and Abuse during Childbirth

Factors contributing to disrespect and abuse during childbirth were assessed in Bungoma County Referral and Webuye County hospitals respectively through the use of a health facility checklist that looked into facility infrastructure and management that included the general appearance of the facility, sanitation, referral system and supervision. Staffing profile was also established as well as staff trainings. The checklist also looked at the workload, record keeping and the provision of Emergency Obstetric and Newborn Care (EmONC) signal functions.

They were also established through Focused Group Discussions with postnatal; mothers who had not participated in the exit interviews as well as through in-depth interviews with midwives and Key Informant Interviews.

The general appearance of the facilities was satisfactory. On infrastructure (water, state of buildings, power source, equipment), the state of buildings was good and safe with water and power source readily available but the beds were inadequate to accommodate the number of mothers who came to deliver in the two facilities and this was depicted by women sharing beds together with their newborns and privacy was not adhered to as there were no curtains in some units.

Sanitation (cleanliness and waste disposal, toilets and hand washing facilities) was well adhered to with proper waste disposal. Hand washing sinks were readily available although the toilets were not very clean. The referral system (communication, telephone, transport and radio system) was fully functional with channels of communication flowing well at all levels. Periodic and continuous supervisory visits were carried out by the medical superintendents, directors of nursing services and the Nursing Council of Kenya but reports to that effect could not be availed.

On staffing profile in relation in relation to Maternal and Newborn Health services (MNH), it was found that the staff skill mix was adequate with Bachelor of Science in Nursing Nurses (BScN) 2 in Webuye County Hospital and 4 in Bungoma County Referral Hospital. Registered nurses/midwives with diploma were 31 at Webuye County Hospital and 14 at Bungoma County Referral Hospital respectively. Enrolled nurses were 3 at Webuye County Hospital and 2 at Bungoma County Referral Hospital. The nurse-patient ratio was inadequate. The facilities were always full with mothers who came to deliver but the nurses were few. Bungoma County Referral Hospital had 20 qualified nurses while Webuye County Hospital had 36.

Majority of the nurses working in the maternity unit had more than 5 years working experience with Webuye County hospital having 26 nurses and Bungoma County Referral Hospital having 12 nurses. Nurses with 3-5 years working experience were 9 at Webuye County Hospital and 8 at Bungoma County Referral Hospital respectively. Only 1 nurse had <1 year working experience from Webuye County hospital.

Staff training was adequately done at both Bungoma County Referral Hospital and Webuye County Hospital. The facilities conducted Continuous Professional Medical Education (CMEs) as well as some staff were undergoing On Job Training (OJT) on Maternal and Newborn Health.

The priority training needs on maternal and newborn health for staff at Webuye County Hospital were newborn resuscitation and management of obstetric emergencies (Pre-eclampticToxaemia (PET), Post-Partum Hemorrhage (APH) and Antepartum Hemorrhage (APH) while priority training needs at Bungoma County Referral Hospital were conducting breech delivery, neonatal resuscitation and cord prolapse.

Majority of nurses at Webuye County Hospital had undergone trainings in key thematic areas on maternal and newborn health. 100% had undergone trainings on Emergency Obstetric and Newborn Care (EmONC), Essential Newborn Care (ENC), Focused Antenatal care (FANC) and Malaria in Pregnancy (MIP). 0% had undergone training on Respectful Maternity Care (RMC). In Bungoma County Referral Hospital, 20% had undergone training on EmONC, 15% on ENC, 25% on FANC, 15% on MIP and 30% on RMC. It was noted that the nurses get reshuffled to other departments after undergoing the trainings which was the reason for the low percentages.

Generally the staff were fairly deployed in both facilities but the there was a staff shortage to cater adequately for the huge patient population. Webuye County Hospital had an average number of 310 deliveries per month while Bungoma County Referral Hospital had an average of 350 deliveries per month. Webuye County Hospital had an average of 12 neonatal deaths per month while Bungoma County Referral Hospital had 10 neonatal deaths per month. During the baseline period (January, February, March, 2012), Webuye County Hospital reported 2 maternal deaths while Bungoma County Referral Hospital did not report any maternal death. Webuye County Hospital conducts an average of 350 caesarean sections per month while Bungoma County Referral Hospital conducts an average of 417 caesarean sections per month. Both Webuye County Hospital and Bungoma County Referral Hospital provided Emergency Obstetric and Newborn Care (EmONC) signal functions plus other services which included administration of antibiotics, anticonvulsants and oxytocics; assisted vaginal delivery; manual removal of the placenta; removal of retained products of conception, newborn resuscitation; blood transfusion and cesarean section. They also provided Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT), Post-partum Family Planning (PFP) and Kangaroo Mother Care (KMC).

The referral system at both Bungoma County Referral Hospital and Webuye County Hospital was commendable in terms of timeliness, communication, transport, documentation and feedback. Documentation was well done in both facilities. The records were available, in use and up to date these included partograph, labour and delivery register, monthly reporting forms, referral forms, birth notification forms and maternal death notification forms. Both facilities conducted maternal and newborn death audits, documentation was available and correctly filled.

On the general recommendations, the status of the facilities was generally satisfactory but there is need to deploy more staff to cater for the large patient population so as to provide efficient and quality care to mothers and newborns, the use of the nursing process in the care of patients had gone down hence its use ought to be overemphasized, there is also need

for continuous performance of Training Needs Assessment (TNA) and addressing the trainings in the gaps identified (Table 29)

The three delays model which include delay to decide to get to a health facility, delay to reach a health facility once one decides to go to a health facility and finally delay to receive appropriate care once at the health facility. Delays 1 and 3 play a role in respectful maternity care. During Focused Group Discussion with postnatal mothers who had not participated in the exit interview, it was found that majority of the women labored for too long at home some even up to 4 days before deciding to go to hospital. They mainly decided to seek medical help after sensing risk of death due to prolonged labour.

'I labored at home for 4 days because I did not want to go to hospital for fear of undergoing operation. I knew that the moment I went to hospital then they were going to operate on me since I was operated on in my previous pregnancy and I did not want that to happen again'said an FGD participant

'I came to hospital after laboring at home for two days before I decided to come to hospital. On arrival, the doctors and nurses attended to me very fast. In 30 minutes I was already examined then they told me that the baby was tired and so I needed to be taken to theatre which was done promptly. I can say that the nurses and doctors are very supportive and caring' said an FGD participant.

'I labored at home for 1 day then decided to come to hospital on a bodaboda accompanied by my mother in-law. I was attended to fast. After examination I was told that I had poor progress of labour and that the baby was getting tired and so I had to go for operation. The nurse prepared me and took me to theatre. On reaching theatre what happened at the theatre door really hurt me. The nurse in theatre refused to receive me saying that the doctor is not there and that I had not been prepared adequately. It hurt me so much 'sobbing' because I was in a lot of pain and saw myself dying together with the baby yet they were arguing in my presence. I stayed for 1 hour at the theatre door before being taken inside. My mother-in-law also felt so bad'said an FGD participant

'A good number of women labours at home for too long without deciding to come to hospital. The poor road infrastructure also delays them to reach the facility on time. By the time they arrive in the facility it's usually a bit late since most of them end up in theatre for caesarean section due to previous scar, fetal distress, prolonged labour, obstruction of labour or even impending uterine rupture' said a nurse midwife

	Webuye County Hospital	**Bungoma County Referral Hospital**
PART A: Facility Infrastructure And Management		
1. General Appearance Of The Facility	Good	Good
I) Infrastructure (Water, State Of Buildings, Equipment, Power Source) And Sanitation	Fair	Fair-
2. Is There A Functional Referral System? (Communication, Telephone, Transport And Radio System)	Fully Functional	Fully Functional
3. Are There Regular Supervision Visits And Who Conducts Them? Any Reports?	Yes But Reports Could Not Be Availed	Yes But Reports Could Not Be Availed
PART B: STAFFING PROFILE		
Skill Mix	Skill Mix Was Adequate But Nurse: Patient Ratio Was Inadequate	Skill Mix Was Adequate But Nurse: Patient Ration Was Inadequate
PART C: STAFF TRAINING		
I) Priority Training Needs For Staff In Relation To Maternal And Newborn Health?	1.Newborn Resuscitation 2.Management Of Obstetric Emergencies (PET, PPH,APH) 3.RMC	1.ConductingBreech Delivery 2. Neonatal Resuscitation 3. Cord Prolapse 4. RMC
Are The Emonc Services Offered In The Maternity Unit?:	Yes	Yes
4. Observe And Comment On Infection Prevention Practices In The Maternity Unit	Infection Prevention And Control (IPC) Adhered To	Infection Prevention And Control (IPC) Is Adhered To
6. Check For The Following Records (Comment If Correctly Filled And Up To Date):	All Patient Documentation Was Available And Up To Date	All Patient Documentation Was Available And Up To Date

Table 29: Maternal andNewborn Health Facility Assessment Checklist

3.2.4. Strategies for Addressing Issues Affecting Respectful Maternity Care for Promoting Quality of Maternal and Newborn Care

Strategies for addressing issues affecting respectful maternity care for promoting quality of maternal and newborn care were assessed qualitatively using Key informant Interviews and in-depth interviews from decision makers and senior nurse/midwives respectively

'What hinders provider relationship with clients is negative attitude towards each other' said a nurse midwife
'Too much workload makes us develop burnout which may propel poor provider-client relationship that subjects women to disrespectful and abusive treatment during childbirth' said a nurse midwife

'There is minimal supervision from MOH and thus no effect on the staff behavior, like the department I'm working in, the few staff available have passion to serve with or without supervision. Workload is the main problem thus leading mostly to inadequate documentation of work well done. Also due to the high workload, there is minimal interaction between the client and the provider thus less information to the client on her health needs and concerns' said a nurse midwife

'The leadership and supervision by the CHMTs, SCHMTs and health managers provide accountability and quality checks. We have a Quality Assurance team in place which carries out monthly reviews and gives feedback to the providers for quality improvement' said a nurse midwife

'Governance of health the health facility affects the behavior of staff negatively since they don't supervise, there is no motivation such as promotion which takes too long hence lowering self-esteem and leading to burnout' said a nurse midwife

'Since devolution of the Ministry of Health, things have not been good at all because supervisors in the ministry are elected politically even if they are not qualified for the job they are nominated. For example, imagine a teacher given responsibility in the Ministry of Health, that's disaster! There's too much work but shortage of human resource' said a nurse midwife

'CHMTs, SCHMTs and health managers provide accountability procedures and check standards of quality of care through supportive supervision as they assess how the care is being provided in relations to the standard operating procedures and together, they analyze the quality of care, identify the gaps and help the staff come up with solutions to the gaps identified' said a nurse midwife

'CHMTs, SCHMTs and health managers do not check standards of quality of care effectively because supervision is done hurriedly and sometimes some leaders intimidate the service providers' said a nurse midwife

'Harsh and problem searching supervision demotivates the providers and this affects service provision' said a nurse midwife

'Evaluation to assess the effectiveness of the measures put in by the Ministry of Health to lessen the occurrence of disrespect and abuse in the health system in general has not been done' said the director if nursing services

'More staff should be employed so as to promote quality care, avoid change overs and promote specialization in line of duty, adequate resources especially non-pharmaceuticals should be provided so as to serve clients better and there should be standby ambulances to ferry clients to hospital so as to avoid delays'said a nurse midwife
'To improve provider-client relationship during childbirth, the provider should be motivated and recognized for work well done through promotions and salary increments, retreats etc., Its really demoralizing when newly employed nurses get promoted while some of us are still in the same job group for many years, mothers should be given a motivation package (mama baby pack), provision of refresher courses for providers, adequate supplies should be availed to avoid moving up and down looking for gloves and other supplies' said a nurse midwife

'What health providers should consider in order to make women feel respected and well treated while providing care includes welcoming them and using screens for privacy and confidentiality, listening to the clients' needs, giving feedback on findings after examination, listening to the clients' concerns, being empathetic, carrying out adequate history taking to know the client better and considering each client as special' said a nurse midwife

'Mechanisms should be put in place for feedback both positive and negative in relation to services provided. Good interpersonal relationship between the client and provider should be encouraged and initiated by the provider through creating good rapport with the client' said a nurse midwife

'Disciplinary measures should be taken fairly against any provider who disrespects and abuses clients' said a nurse midwife

'There should be regular monitoring and supervision by management so as to enhance quality maternal and newborn care' said a nurse midwife

'There should be adequate education of mothers during ANC visits so as to allay myths and misconceptions, ensure they seek medical care in good time and not laboring at home for too long then come to the hospital when there are complications, as well as allay negative attitude towards providers which may make them to be disrespected and abused' said a nurse provider

'It should be ensured that each provider is equipped with correct skills (cognitive, psychomotor and affective) that will ensure quality patient care'said a nurse midwife

'Family centered care should be involved to enhance family support. Birth companions should be allowed to be with the client when in labour' said a nurse midwife

'Adequate supportive supervision motivates the providers and helps them identify the gaps and come up with solutions to the gaps identified' said a nurse midwife

'There should be continued sensitization of providers on respectful maternity care' said a nurse midwife

'The Ministry of Health in conjunction with the CHMT and SCHMT are advocating for respectful care that is emphasizing on implementation of rights-based approach in maternity care,' said a medical superintendent

'To evaluate the effectiveness of measures put in place to lessen the occurrence of disrespect and abuse in the health system in general' said the director of nursing services

'The possible ways for lowering disrespect and abuse in our health facilities are staff's change of attitude and sensitizing on patient's rights and on dignity and respect' said the maternity nurse in-charge

'The resolution for curbing disrespect and abuse may include sensitization on respectful maternity care, employment of more human resource, involving birth companions as well as male involvement,' said the medical superintendent

'Yes, government's institutional rules, procedures and structures influence the maternity and delivery practices in that there are policies that provide the necessary dissection in maternity and delivery practices through free maternal and neonatal health policy covered under the Linda Mama and Linda Mtoto. This ensures that mothers are attended to from the antennal to the postnatal period which has improved access to services. The hospital has adapted well by ensuring the services are planned for and clients are well served,' said the medical superintendent

'Interventions to lower disrespect and abuse during childbirth in health facilities are adequate as all staff are held to account as per the code of regulations governing the service and professional bodies governing the practice, Nursing Council and Medical Practitioners and Dentist Council etc.'said the hospital administrator

'All structures i.e., community, health facilities, CHMT/SCHMT, the national level, GOK structures, professional associations should ensure that administrative justice is obtained. Professional associations should provide peer review in ensuring that all the professionals are held to account. Legal address mechanisms should also provide mechanisms to ensure that victims get justice,'said the medical superintendent

'Resolutions that can help in curbing possible drivers of disrespect and abuse may include adhering to the code of regulations, staff motivation by promotion and redesignation, adhering to working hours schedules and provision of adequate resources through budgeting and resource mobilization,' said the medical superintendent

'Use of exit interviews, provision of suggestion boxes and availing hospital phone number to the public are some of the interventions we have put in place so that our clients can share with us their experience of care both negative and positive' said the maternity department nurse in-charge

'Interviews should be carried out like provider-oriented efficiency exercise to establish what makes them disrespect and abuse patients. Communication should be strengthened by orienting or sensitizing staff on how to enhance common understanding with their clients. More staff should be deployed and motivated e.g., through team building and finally there should be improvement on linkage network and feedback' said the director of nursing services

3.2.5. Relationship between Women's experience of Care and their Socio-demographic Characteristics

Pearson Chi-Square that is used to show whether or not there is a relationship between two categorical variables was used to measure association between women's socio demographic characteristics (Age, marital status, education level) and experience of care during childbirth (dignity and respect, privacy and confidentiality, communication, supportive care, facility environment). P-Value of <0.05 showed association between socio demographic characteristics and experience of care.

Pearson Chi-Square showed a significant relationship between age and dignity and respect with a P value of 0.000 hence rejecting the null hypothesis making it an alternate hypothesis. Age was highly likely to influence the experience of dignity and respect with a likelihood ratio of 25.290. There was a significant relationship between marital status and experience of dignity and respect with a P value of 0.002. Marital status was 21.926 highly likely to influence dignity and respect. There was a significant relationship education level and experience of dignity and respect with a P value of 0.049. Education level had a moderate increase in the experience of dignity and respect with a likelihood ratio as 9.196 (Table 30)

There was a significant relationship between age and experience of privacy and confidentiality with a P value of 0.047 hence rejecting the null hypothesis. There was a moderate increase in the likelihood ratio at 8.638. There was no significant relationship between marital status and privacy and confidentiality with a P value of 0.727. There was a small increase in the likelihood ratio at 4.994. There was no significant relationship between education level and experience of privacy and confidentiality with a P value of 0.665. There was a small increase in the likelihood ratio at 2.889 (Table 30)

There was no significant relationship between age and experience in communication with a P value of 0.327 hence accepting the null hypothesis. There was a small increase in the likelihood ratio at 3.244. There was no significant relationship between marital status and experience in communication with a P value of 0.285. There was a small increase in the likelihood ratio at 3.412. There was a significant relationship between age and education level with a P value of 0.052. There was a moderate increase in the likelihood ratio at 6.724 (Table 30)

There was a significant relationship between age and experience of supportive care with a P value of 0.001. There was a large increase in the likelihood ratio with a P value of 21.044. There was a significant relationship between marital status and experience of supportive care with a P value of 0.001 with a large increase in the likelihood ratio at 22.089. There was a significant relationship between education level and experience of supportive care with a P value of 0.056 with a moderate increase in the likelihood ratio at 9.313 (Table 30).

Sociodemographic characteristic	Chi-square Value	df	P Value
Dignity and Respect			
Age	0.000**	6	26.047
Marital status	0.002**	6	20.851
Education Level	0.083	4	0.083
Privacy and Confidentiality			
Age	0.0317*	6	7.037
Marital Status	0.727	6	3.630
Education Level	0.665	4	2.387
Communication			
Age	0.327	3	3.452
Marital status	0.285	3	3.789
Education level	0.052*	2	5.899
Supportive Care			
Age	0.001**	6	22.557
Marital status	0.001**	6	21.741
Education level	0.056	4	9.201
Facility Environment			
Age	0.315	3	3.543
Marital status	0.306	3	3.614
Education level	0.760	2	0.548

Table 30: Pearson Chi-Square of Women's Experience of Care and their Socio-demographic Characteristics

3.2.6. Relationship between how Mothers are treated during Childbirth and their Self-Reported experience of Care

Wilcoxon Signed Ranks test which is a nonparametric test that compares two paired groups to determine if two or more sets of pairs are different from one another in a satisfactorily significant manner was used to measure association between how mothers were treated during childbirth through the observation checklist and there self-reported experience of care through exit interview. The following aspects were measured: privacy and confidentiality; communication; dignity and respect; and supportive care.

There was a significant relationship on privacy and confidentiality between how mothers were treated through the observation checklist and there self-reported experience of care through exit interview with a P-value of 0.00. There was a significant relationship on communication between how mothers were treated through the observation checklist and there self-reported experience of care through exit interview with a P-value of 0.033. There was a significant relationship on dignity and respect between how mothers were treated through the observation checklist and there self-reported experience of care through exit interview with a P-value of 0.000. There was no significant relationship on supportive care between how mothers were treated through the observation checklist and there self-reported experience of care through exit interview with a P-value of 0.225 (Table 31).

Variable	Wilcoxon Signed Ranks Test	
	z	Asymp. Sig. (2-tailed)
Privacy and confidential – Protection of privacy and confidentiality	-7.728[b]	.000***
Communication – protection women's rights	-2.132[b]	.033**
Dignity and respect - Treatment of women with dignity and respect	-7.599[b]	.000***
Supportive care – Provision of equitable care free of discrimination	-1.213[b]	.225

Table 31: Wilcoxon Signed Ranks Test Results

3.3 Phase III Results (Findings from Evaluation-Exit interview, Performance Observation)

Phase III (Evaluation) was completed by 360 post-natal mothers (180 from Bungoma County Referral Hospital and 180 from Webuye County Hospital) by using exit interview, performance observation was carried out on 80 midwives divided equally between the two hospitals. All the tools were returned representing 100% response rate.

3.3.1. Treatment of Mothers during Childbirth (Experience of Care/Respectful Maternity Care)

Three tools were used to assess women's experience of care during childbirth which were patients' exit interview that was administered to mothers after delivery, observation checklist that was used to observe midwives while conducting delivery.

3.3.1.1. Patient Exit Interview

This tool collected information on women's experience of care and it addressed issues to do with dignity and respect; privacy, autonomy and confidentiality; communication; supportive care; facility environment; and transparency of payments.

3.3.1.2. Dignity and Respect

Majority of the respondents at 94% said that the doctors, nurses or other healthcare providers introduced themselves to them when they first came to see them during their stay in the facility while 6% reported that the doctors, nurses or other healthcare providers did not introduce themselves. 96% reported that the doctors, nurses or other healthcare providers called them by name while 4% reported to have not been called by name. Majority of the respondents at 95% reported to have felt respected by the doctors, nurses, or other health staff at the facility while 5% reported that they did not feel respected.

Majority of the respondents said that the doctors, nurses, or other staff at the facility treated them in a friendly manner at 93% while 7% said that they were not treated in a friendly manner. 94% said that they felt cared for by the doctors, nurses, or other staff at the facility while 6% said that they did not feel cared for. Majority of the respondents said that they were not shouted at, scolded, insulted, threatened or talked to rudely by the doctors, nurses, or other health providers at 94% while 6% reported to have been shouted at, scolded, insulted, threatened or talked to rudely.

97% said that they were not treated roughly like pushed, beaten, slapped, pinched, physically restrained or gagged while 3% reported to have been treated roughly. Majority of the respondents said that they were not forced to stay at the facility against their will or because they could not be able to pay the hospital bill at 98% while 2% reported to have been forced to stay at the facility against their will (Table 32).

4.7% of the respondents experienced a high level of dignity and respect, 93.3% experienced a moderate level of dignity and respect, while 1.9% of the respondents experienced a low level of dignity and respect (Table 33).

Statement	Yes	No	Total
Did the doctors, nurses or other healthcare providers introduce themselves to you when they first came to see you during your time in the health facility	338	22	360
	94%	6%	100%
Did the doctors, nurses, or other healthcare providers call you by your name?	346	14	360
	96%	4%	100%
Can you say that you felt respected by the doctors, nurses, or other staff at the facility?	343	17	360
	95%	5%	100%
Can you say that the doctors, nurses, or other staff at the facility treated you in a friendly manner?	334	26	360
	93%	7%	100%
Did you feel cared for by the doctors, nurses, or other staff at the facility?	338	22	360
	94%	6%	100%
Were you shouted at, scolded, insulted, threatened or talked to rudely by the doctors, nurses, or other health providers?	20	340	360
	6%	94%	100%
Were you treated roughly like pushed, beaten, slapped, pinched, physically restrained or gagged?	11	349	360
	3%	97%	100%
Were you forced to stay at the facility against your will because you could not pay your bill?	8	352	360
	2%	98%	100%

Table 32: Dignity and Respect

Category	Frequency	Percent	Valid Percent	Cumulative Percent
High	17	4.7	4.7	4.7
Moderate	336	93.3	93.3	98.1
low	7	1.9	1.9	100.0
Total	360	100.0	100.0	

Table 33: Cumulative Rating of Dignity and Respect

3.3.1.3. Privacy, Autonomy and Confidentiality

Majority of the respondents reported that they did not feel like other people not involved in their care could hear their discussion while speaking to the doctors, nurses or other staff at the facility at 68% while 32% reported that their discussion could be heard by other people not involved in their care.

96% reported that while being examined in the labor room they were covered up with a cloth or blanket or screened with a curtain to ensure they did not feel exposed while 4% reported to have not been covered or screened with a curtain. 97% thought that their health information was or would be kept confidential at the health facility while 3% thought that their health information would not be kept confidential.

Majority of the respondents at 96% said that the doctors, nurses or other staff involved them in decision making about their care while 4% said that they were not involved in decision making about their care. Majority of the

respondents at 86% reported that permission/consent was obtained from them by the doctors, nurses or other staff before doing procedures and examinations on them while 14% reported that permission or consent was not obtained
57% reported that they were allowed to be in a position of their choice during delivery while 43% reported to have not been allowed to be in a position of their choice during delivery (Table 34)

Cumulatively on the experience of privacy, autonomy and confidentiality, 95% rated it highly while 5% rated it moderately (Table 35).

Statement	Yes	No	Total
While speaking to the doctors, nurses, or other staff at the facility, did you feel other people not involved in your care could hear your discussion?	117	243	360
	32%	68%	100%
While being examined in the labor room, were you covered up with a cloth or blanket or screened with a curtain to secure you did not feel exposed?	345	15	360
	96%	4%	100%
Do you think your health information was or will be kept confidential at this facility?	348	12	360
	97%	3%	100%
Did the doctors, nurses, or other staff at the facility involve in decision making about your care	345	15	360
	96%	4%	100%
Was permission or consent obtained from you by the doctor's nurses or other staff and the facility before doing procedures and examination on you	308	52	360
	86%	14%	100%
Were you allowed to be in the position of your choice during delivery	205	155	360
	57%	43%	100%

Table 34: Autonomy, Privacy and Confidentiality

Category	Frequency	Percent	Valid Percent	Cumulative Percent
High	343	95.3	95.3	95.3
Moderate	17	4.7	4.7	100.0
Total	360	100.0	100.0	

Table 35: Cumulative Experience of Autonomy, Privacy and confidentiality

3.3.1.4. Communication

Majority of the respondents at 99% reported that doctors, nurses or other staff at the facility spoke to them in a language that they could understand while 1% reported that they were not spoken to in a language they could understand. 95% of the respondents said that the doctors and nurses explained to them why they were doing examinations and procedures on them while 5% reported that they were not explained to why examinations and procedures were being done on them.

94% of the respondents reported that the doctors and nurses explained to them why they were giving them any medication while 6% reported that they were not explained to why they were being given any medication Majority of the respondents at 90% said that they felt that they could ask doctors, nurses and other staff at the facility any questions they had while 10% reported that they did not feel like they could ask questions they had (Table 36)
Cumulatively 99% of the respondents had a positive experience when it comes to communication while 1% experience communication moderately (Table 37).

Statement	Yes	No	Total
Did the doctors, nurses, or other staff at the facility speak to you in a language you would understand?	356	4	360
	99%	1%	100%
Did the doctors and nurses explain to you why they were doing examinations or procedures on you?	343	17	360
	95%	5%	100%
Did the doctors and nurses explain to you why they were giving you any medicine?	340	20	360
	94%	6%	100%
Do you feel you could ask the doctors, nurses or other staff at the facility any questions you had?	325	35	360
	90%	10%	100%

Table 36: Communication

Category	Frequency	Percent	Valid Percent	Cumulative Percent
High	358	99.4	99.4	99.4
Moderate	2	.6	.6	100.0
Total	360	100.0	100.0	

Table 37: Cumulative Experience on Communication

3.3.1.5. Supportive Care

Majority of the respondents said that the doctors and nurses at the facility asked them about how they were at 94% while 6% were not asked how they were feeling. 89% of the respondents said that the doctors, nurses or other staff in the facility addressed their anxiety and fears while 11% said that their fears and anxieties were not addressed.

83% of the respondents said that the doctors and nurses asked them how much pain they were in while 17% said that they were not asked how much pain they were in. Majority of the respondents at 80% reported that the doctors and nurses did everything they could to help control their pain while 20% reported that their pain was not controlled.

Majority of the respondents at 95% felt that the doctors, nurses or other staff at the facility paid attention while 5% felt that they did not pay attention. 89% of the respondents said that when they felt hungry/thirsty, they were allowed to eat and drink while 11% were not allowed to eat and drink when they felt hungry/thirsty (Table 38).

88.3% said that they were allowed to stay with someone whom they wanted to stay with during labour while 11.7% said that they were not allowed. Majority of the respondents at 69.4% said that they were allowed to have a birth companion stay with them during delivery while 30.6% said that they were not allowed to have a birth companion during delivery (Table 39).

Cumulatively the experience of supportive care was highly rated at 80.8%, moderate rating was at 18% while low rating was at 1.2% (Table 40)

Statement	Yes	No	Total
Did the doctors and nurses at the facility talk to you about how you were feeling?	337	23	360
	94%	6%	100%
Did the doctors, nurses, or other staff in the facility support your anxiety and fears?	320	40	360
	89%	11%	100%
Did the doctors and nurses ask how much pain you were in?	299	61	360
	83%	17%	100%
Do you feel the doctors or nurses did everything they could to help control your pain?	288	72	360
	80%	20%	100%
When you needed help did you feel the doctors, nurses or other staff at the facility paid attention?	341	19	360
	95%	5%	100%
Did the doctors and nurses pay attention to you during your stay at the facility?	341	19	360
	95%	5%	100%
When you felt hungry/thirsty, were you allowed to eat or drink?	321	39	360
	89%	11%	100%

Table 38: Supportive Care

Category	Frequency	Percent	Valid Percent	Cumulative Percent
High	318	88.3	88.3	88.3
Moderate	42	11.7	11.7	100.0
Total	**360**	**100.0**	**100.0**	

Table 39: Presence of a Birth Companion during Labour

Category	Frequency	Percent	Valid Percent	Cumulative Percent
High	291	80.8	80.8	80.8
Moderate	65	18	18	98.8
Low	4	1.2	1.2	100.0
Total	360	100.0		

Table 40: Cumulative Experience of Supportive Care

3.3.1.6. Facility Environment

Majority of the respondents at 60.5% said that there were no enough staff in the facility to care for them while 39.5% said that there were enough staff to care for them at the facility. 67% reported that the labour and postnatal wards at the facilities were crowded while 33% said that they were not crowded. 100% said that water was available in the facility. 100% said that electricity was available in the facility. In overall 98% said that they felt safe in the facility while 2% said that they did not feel safe (Table 41)

Cumulatively 97.5% had a positive experience on facility environment while 2.5% rated the facility environment moderately (Table 42)

Statement	Yes	No	Total
Was there enough health staff in the facility to care for you?	142	218	360
	39.5%	60.5%	100%
Considering the labour and postnatal wards, do you feel the health facility was crowded?	241	119	360
	67%	33%	100%
Was water available in the facility?	360	0	360
	100%	0%	100%
Was electricity available in the facility?	360	0	360
	100%	0%	100%
In overall, can you say that you felt safe in the health facility?	353	7	360
	98%	2%	100%

Table 41: Facility Environment

Category	Frequency	Percent	Valid Percent	Cumulative Percent
High	351	97.5	97.5	97.5
Moderate	9	2.5	2.5	100.0
Total	360	100.0	100.0	

Table 42: Cumulative Experience on Facility Environment

3.3.1.7. Overall Rating by the Respondents

Majority of the respondents at 63.8% were satisfied with the services offered at the facility followed by 86% who were very satisfied. 11.3% were neither satisfied nor dissatisfied, 3% were dissatisfied while 0.3% were very dissatisfied (Table 43).

40.3% of the respondents rated the level or quality of care as good, 40% rated the quality of care as fair, 17.8% rated the quality of care as very good while 1.9% rated the quality of care as excellent (Table 44)

73.3% said they would definitely deliver in the same facility again, 28.1% said that they would somewhat deliver in the same facility again while 1.7% said that they would not deliver in the same facility again (Table 45)

70.8% said that they would definitely recommend to another women to deliver in the facility, 23.6% said that they would somewhat recommend to another woman to deliver in the facility while 5.6% said that they would not recommend to another women to deliver in the facility (Table 46)

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Neither satisfied nor dissatisfied	40	11.3	11.3	11.3
Satisfied	230	63.8	63.8	75.1
very satisfied	80	23.8	23.8	98.9
Dissatisfied	3	0.8	0.8	99.7
very dissatisfied	1	0.3	0.3	100.0
Total	360	100.0	100.0	

Table 43: Rating of the Level of Satisfaction with the Services Offered at the Facility

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Fair	144	40.0	40.0	40.0
Good	145	40.3	40.3	80.3
Very good	64	17.8	17.8	98.1
Excellent	7	1.9	1.9	100.0
Total	360	100.0	100.0	

Table 44: Rating on the Level/Quality of Care Offered at the Facility

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Yes, Somewhat	90	25.0	25.0	25.0
Yes, Definitely	264	73.3	73.3	98.3
No	6	1.7	1.7	100.0
Total	360	100.0	100.0	

Table 45: Choice to Deliver in the Same Facility Again

Category	Frequency	Percent	Valid Percent	Cumulative Percent
Yes, Somewhat	85	23.6	23.6	23.6
Yes, Definitely	255	70.8	70.8	94.4
No	21	5.6	5.6	100.0
Total	360	100.0	100.0	

Table 46: Recommendation to another Woman to Deliver in the Facility

3.3.1.8. Prevalence of Disrespect and Abuse

75% rated highly the user experience of care, 24% rated moderately the user experience of care while 1% rated low the positive user experience of care. The prevalence of experiencing any form of disrespect and abuse at post intervention phase was at 25% (Table 4.47)

Category	Dignity and Respect	Autonomy, Privacy and Confidentiality	Communication	Supportive Care	Facility Environment	Cumulative Prevalence of D&A (%)- divided by 5
Highly	4.7	95	99	80.8	97.5	75
Moderate	93.3	5	1.0	18	2.5	24
Low	1.9	0	0	1.2	0	1.0

Table 47: Prevalence of Disrespect and Abuse at Post Intervention

3.3.2. Performance Standards Observation Checklist

Observation of midwives while conducting deliveries was done post intervention to assess the practice on respectful maternity care. The aspects looked at included protection from physical harm or ill treatment, protection of the woman's rights to informed consent and choice/preference, protection of privacy and confidentiality, treatment of woman with dignity and respect and not leaving the woman without care.

3.3.2.1. Protection of Woman from Physical Harm or ill Treatment

All the midwives observed at 100% did not use physical force or harsh behavior on the women including slapping or hitting. Majority of the midwives at 90% did not physically restrain women while 10% physically restrained women. 84% of the midwives exhibited a caring attitude and touched the women in a culturally appropriate way while 16% did not exhibit a caring attitude and touched the women in a culturally inappropriate way.

All the midwives observed did not separate women from their babies unless medically necessary. 95% of the midwives did not deny the women food or fluid during labour unless necessary while 4% denied the women food or fluid while in labour when it was not necessary. 92% of the midwives provided comfort/pain relief to the women during labour as necessary while 8% did not provide comfort/pain relief as necessary (Table 48).

Cumulatively 99% of the midwives highly protected the women from physical harm or ill treatment while 1% moderately protected the women from physical harm or ill treatment (Figure 2).

Statement	Yes	No	Total
Does not use physical force or harsh behavior on the woman including slapping or hitting	80	0	80
	100%	0%	100%
Does not physically restrain woman	72	8	80
	90%	10%	100%
Exhibits a caring attitude and touches the woman in a culturally appropriate way	67	13	80
	84%	16%	100%
Woman is not separated from her baby unless medically necessary	80	0	80
	100%	0%	100%
Woman in labour is not denied food or fluid unless necessary	76	4	80
	95%	5%	100%
Comfort/pain relief is provided as necessary	74	6	80
	92%	8%	100%

Table 48: Protection from Physical Harm or Ill Treatment

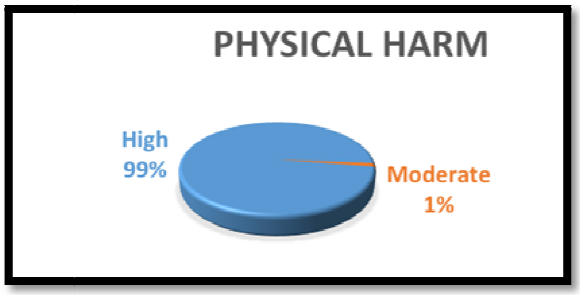

Figure 2: Cumulative Rating on Protection from Physical Harm or Ill Treatment

3.3.2.2. Protection of the Woman's Right to Informed Consent and Choice/Preference

91% of the midwives introduced themselves to the women and their companions while 9% did not introduce themselves to the women and their birth companions. 84% of the midwives encouraged the companions to remain with the women whenever possible while 16% did not encourage the companions to remain with the women whenever possible.

76% of the midwives encouraged the women and their companions to ask questions and responded to the questions with promptness, politeness and truthfulness while 24% did not encourage the women and their companions to ask questions and did not respond with promptness, politeness and truthfulness. 86% of the midwives responded to women's questions with promptness, politeness and faithfulness while 14% did not respond to women's questions with promptness, politeness and faithfulness.

91% of the midwives explained to the women what was being done and what to expect all through labour and delivery while 9% did not explain to the women what was being done and what to expect all throughout labour and delivery. 86% of the midwives gave the women periodic updates on the status and progress of labour while 14% did not give the women periodic updates on the status and progress of labour.

86% of the midwives allowed the women to move around during labour while 14% did not allow the women to move around during labour. Majority of the midwives at 64% allowed women to assume the position of their choice during delivery while 36% did not allow women to assume the position of their choice during delivery. 91% of the midwives obtained consent or permission from the women before any procedure while 9% did not obtain consent or permission from the women before any procedure (Table 49).

Cumulatively 87.5% of the midwives highly protected the women's rights to informed consent and choice or preference while 12.5% moderately protected the women's rights to informed consent and choice or preference (Figure 4.2).

Statement	Yes	No	Total
Health provider introduces him/herself to the woman and her companion	73	7	80
	91%	9%	100%
The companion is encouraged to remain with the woman whenever possible	67	13	80
	84%	16%	100%
The woman and her companion are encouraged to ask questions. are responded to with promptness, politeness and truthfulness	61	19	80
	76%	24%	100%
Questions are responded to with promptness, politeness and faithfulness	69	11	80
	86%	14%	100%
The woman is explained to what is being done and what to expect all through labour and birth	73	7	80
	91%	9%	100%
Periodic updates on status and progress of labour are given	69	11	80
	86%	14%	100%
The woman is allowed to move around during labour	69	11	80
	86%	14%	100%
The woman is allowed to assume position of choice during labour	51	29	80
	64%	36%	100%
Consent or permission is obtained before any procedure	73	7	80
	91%	9%	100%

Table 49: Protection of the Woman's Right to Informed Consent and Choice/Preference

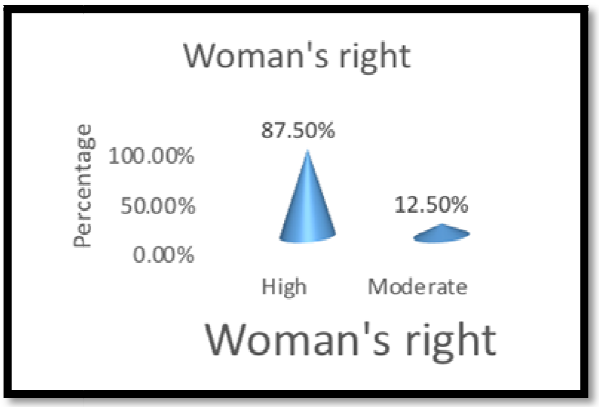

Figure 3: Cumulative Rating on Protection of Women's Rights to Informed Consent and Choice/Preference

3.3.2.3. Protection of Privacy and Confidentiality

81% of the midwives kept the patients' files in locked cabinets with limited access while 19% of the midwives did not keep the patients' files in locked cabinets with limited access. 94% of the midwives used curtains or other barriers to protect women during examinations and birthing process while 6% did not use curtains or other barriers to protect women during examinations or birthing process. 80% of the midwives used drapes or covering appropriately to protect women's privacy while 20% did not use drapes or covering appropriately to protect women's privacy (Table 50).
Cumulatively, 88.8% of the midwives protected the women's privacy and confidentiality while 11.3% did not protect the women's privacy and confidentiality (Figure 4).

Statement	Yes	No	Total
Confirmation by the observer that the patient files are stored in locked cabinets with limited access	65	15	80
	81%	19%	100%
Curtains or other visual barriers are used to protect woman during examinations and birthing processes	75	5	80
	94%	6%	100%
Drapes or covering are used appropriately to protect woman's privacy	64	16	80
	80%	20%	100%

Table 50: Protection of Privacy and Confidentiality

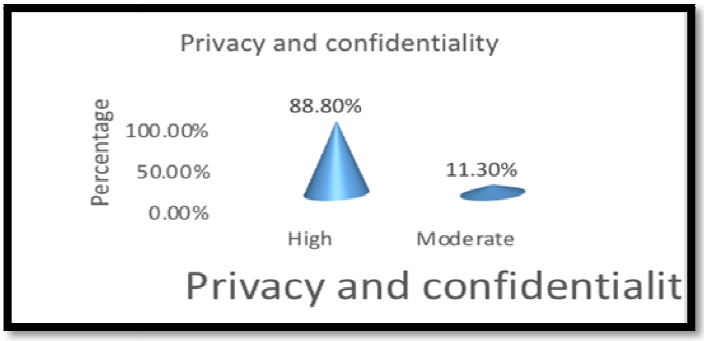

Figure 4: Cumulative Rating on Protection of Privacy and Confidentiality

3.3.2.4. Treatment of Women with Dignity and Respect

Majority of the midwives at 89% spoke politely to the women and birth companions while 11% did not speak to the women and birth companions politely. 69% of the midwives allowed the women and the birth companions to observe cultural practices as much as possible while 31% did not allow the women and birth companions to observe cultural practices as much as possible. 95% of the midwives did not insult, intimidate, threaten or coarse women or their birth companions while 5% insulted, intimidated, threatened or coursed women and their birth companions (Table 51)
Cumulatively 95% of the midwives highly practiced dignity and respect towards the women and their birth companions while 5% did not practice dignity and respect towards the women and their birth companions (Figure 5)

Statement	Yes	No	Total
The woman and companion are spoken to politely.	71	9	80
	89%	11%	100%
The woman and the companion are allowed to observe cultural practices as much as possible.	55	25	80
	69%	31%	100%
The woman or her companion are not insulted, intimidated, threatened or coursed.	76	4	80
	95%	5%	100%

Table 51: Treatment of the Woman with Dignity and Respect

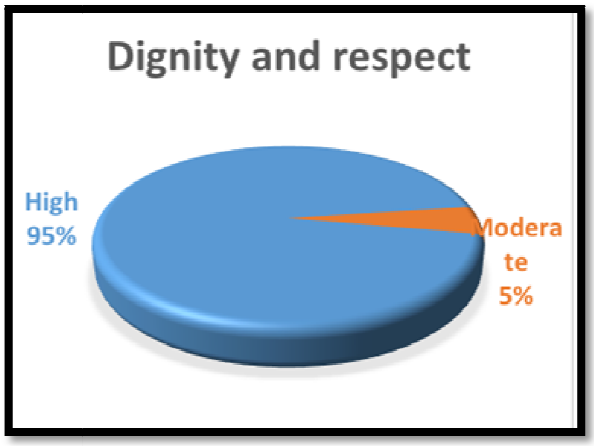

Figure 5: Cumulative Rating on Treatment of Women with Dignity and Respect

3.3.2.5 Woman Is Not Left Without Care/Unattended

92% of the midwives encouraged the women to call if needed while 8% did not encourage to call them if needed. 79% of the midwives responded quickly to women's calls while 21% did not respond quickly to women's calls. 81% never left the women alone or unattended while 19% left the women alone or unattended (Table 52)

Cumulatively 85% of the midwives rated highly on not leaving the women without care while 15% rated moderately on not leaving the women without care (Figure 6)

Statement	Yes	No	Total
The woman is encouraged to call if needed.	74	6	80
	92%	8%	100%
The mid wife comes quickly when woman calls.	63	17	80
	79%	21%	100%
The woman is never left alone or unattended.	65	15	80
	81%	19%	100%

Table 52: Women are on no Occasion Left without Care/Unattended

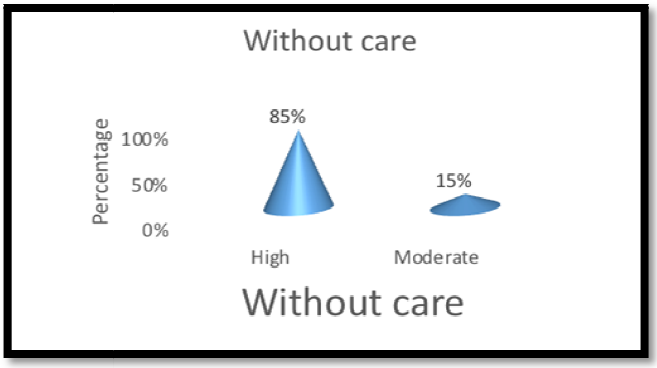

Figure 6:Cumulative Rating on Not Leaving Women without Care/Unattended

3.3.3. Summary Tables on Pre and Post Intervention Outcomes

The tables below are a summary of the pre and post intervention outcomes on the women's experience of care through exit interview (Table 53), performance standards observation of midwives while conducting delivery (Table 54) and the prevalence of disrespect and abuse (Table 55).

RMC Category	Cumulative Rating (N=360)	Pre f (%)	Post f (%)
Dignity & Respect	High	18 (4.8)	17 (4.7)
	Moderate	325 (90.8)	336 (93.3)
	Low	17 (4.4)	7 (1.9)
Autonomy, privacy & confidentiality	High	13 (3.4)	343 (95.3)
	Moderate	330 (87.5)	17 (4.7)
	Low	17 (9.1)	0
Communication	High	341 (95.3)	358 (99.4)
	Moderate	19 (4.7)	2 (0.6)
	Low	0	0
Supportive care	Yes	301 (83.6)	318 (88.3)
	No	59 (16.4)	42 (11.7)
Presence of a birth companion	Yes	165 (46.8)	250 (69.4)
	No	195 (54.2)	110 (30.6)
Facility environment	High	343 (95.5)	351 (97.5)
	Moderate	17 (4.5)	9 (2.5)
	Low	0	0

Table 53: Pre and Post Evaluation Outcomes on Women's Experience of Care

RMC Category	Cumulative Rating (N=80)	Pre f (%)	Post f (%)
Protection from physical harm and ill treatment	High	76 (95)	76 (95)
	Moderate	3 (3.8)	4 (5)
	Low	1 (1.3)	0
Protection of women's right to informed consent	High	66 (82.5)	71 (87.5)
	Moderate	13 (16.3)	10 (12.5)
	Low	1 (1.3)	0
Protection of privacy and confidentiality	High	70 (87.5)	71 (88.8)
	Moderate	10 (12.5)	9 (11.2)
	Low	0	0
Treatment of women with dignity and respect	High	68 (85)	76 (95)
	Moderate	12 (15)	4 (5)
	Low	0	0
Women not left unattended	High	67 (83.8)	68 (85)
	Moderate	13 (16.2)	12 (15)
	Low	0	0

Table 54: Pre and Post Evaluation Outcomes on Performance Standards Observation

Category	Pre	Valid Percent
Highly	57.8	75.0
Moderate	36.6	24.0
Low	5.6	1.0
Total	100	100

Table 55: Pre and Post Prevalence of Disrespect and Abuse

3.3.4. Relationship between Pre and Post Evaluation Outcomes on Women's Experience of Care (Respectful Maternity Care)

McNemar test, a test on a 2x2 contingency table that checks the marginal homogeneity to two dichotomous variables or paired data from the same participants was used to determine there were differences between pre intervention and post intervention outcomes on women's experience of care (respectful maternity care) for improved quality of maternal and newborn care.

The components measured included dignity and respect; privacy and confidentiality; communication; autonomy/consented care; social support; supportive care; trust; stigma and discrimination; and predictability and transparency of payments. P-value of ≤ 0.05 showed association between pre and post evaluation outcomes on women's experience of care.

3.3.4.1. Dignity and Respect

Cross tabulation pre and post intervention showed an increase in women who experienced dignity and respect. 23 did not experience dignity and respect at the pre intervention phase of whom 10 experienced dignity and respect at the post intervention phase (Table 56).

McNemar's test statistics showed a P value <0.02 implying that the proportion of those who experienced dignity and respect was statistically significantly different after the intervention compared to before.

Cross Tabulation Table				
		Post Dignity and respect		Total
		NO	YES	
Pre-Dignity and respect	NO	23	10	33
	YES	2	325	327
Total		**25**	**335**	**360**

Tests Statistics[a]		
	Value	Exact Sig. (2-sided)
McNemar Test		.002[a**]
N of Valid Cases	360	
a. Binomial distribution used.		

*Table 56: Pre-Dignity and Respect * Post Dignity and Respect Cross Tabulation*

3.3.4.2. Privacy and Confidentiality

Cross tabulation pre and post intervention showed an increase in women who experienced confidentiality. 75 did not experience confidentiality at the pre intervention phase of whom 38 experienced confidentiality at the post intervention phase (Table 57).

Cross tabulation table				
		Post Privacy and Confidentiality		Total
		NO	YES	
Pre-Dignity and respect	NO	75	38	113
	YES	18	229	247
Total		93	267	360

Tests statistics[a]	
	Pre-Privacy and confidentiality & Post Privacy and confidentiality
N	360
Chi-Square[b]	212.113
Asymp. Sig.	.000***
a. McNemar Test	

*Table 57: Pre-Privacy and Confidentiality * Post Privacy and Confidentiality Cross Tabulation*

3.3.4.3.Communication

Cross tabulation pre and post intervention showed an increase in women who experienced positive communication. 15 did not experience positive communication at the pre intervention phase of whom 2 experienced positive communication at the post intervention phase (Table 58).

McNemar's test statistics showed a P value <0.000 implying that the proportion of those who experienced positive communication was statistically significantly different following the intervention compared to before hence rejecting the null hypothesis.

Cross tabulation table				
		Post Privacy and Confidentiality		Total
		NO	YES	
Pre-Privacy and Confidentiality	NO	75	38	113
	YES	18	229	247
Total		93	267	360

Tests statistics[a]		
	Value	Exact Sig. (2-sided)
McNemar Test		.000**
N of Valid Cases	360	
a. Binomial distribution used.		

*Table 58: Pre-Privacy and Confidentiality * Post-Privacy and Confidentiality Cross Tabulation*

3.3.4.4. Autonomy/Consented Care

Cross tabulation pre and post intervention showed an increase in women who experienced autonomy/consented care. 18 did not experience autonomy/consented care at the pre intervention phase of whom 7 experienced autonomy/consented care at the post intervention phase. There was no change among those who experienced autonomy/consented care at the pre intervention phase (Table 59).McNemar's test statistics showed a P value <0.063 implying that the proportion of those who experienced negatively on autonomy/consented care did not change over the

course of intervention hence the intervention was not statistically significantly different hence failing to reject the null hypothesis.

Cross Tabulation Table				
		Post Autonomy / consented care		Total
		NO	YES	
Pre-Autonomy / consented care	NO	18	7	25
	YES	3	332	335
Total		21	349	360
Tests Statistics[a]				
		Pre-Autonomy / consented care & Post Autonomy / consented care		
N		360		
Exact Sig. (2-tailed)		.063[b]		
a. McNemar Test b. Binomial distribution used.				

*Table 59: Pre-Autonomy / Consented Care * Post Autonomy / Consented Care Cross Tabulation*

3.3.4.5. Social Support

Cross tabulation pre and post intervention showed an increase in women who experienced social support. 30 did not experience social support at the pre intervention phase of whom 24 experienced social support at the post intervention phase (Table 60).

McNemar's test statistics showed a P value <0.000 implying that the proportion of those who experienced social support was statistically significantly different after the intervention compared to before hence rejecting the null hypothesis.

Cross Tabulation Table				
		Post Social Support		Total
		NO	YES	
Pre-Social Support	NO	30	24	54
	YES	1	305	306
Total		31	329	360
Tests Statistics[a]				
		Pre-Social Support & Post Social Support		
N		360		
Exact Sig. (2-tailed)		.000[b***]		
c. McNemar Test *d. Binomial distribution used.*				

*Table 60: Pre-Social Support * Post Social Support Cross tabulation*

3.3.4.6.Supportive Care

Cross tabulation pre and post intervention showed an increase in women who experienced supportive care. 19 did not experience supportive care at the pre intervention phase of whom 3 experienced supportive care at the post intervention phase. There was no change among those who experienced supportive care at the pre intervention phase (Table 61).

McNemar's test statistics showed a P value <0.250 implying that the proportion of those who did not experience supportive care did not change over the course of intervention hence the intervention was not statistically significantly different hence failing to reject the null hypothesis.

Cross Tabulation Table				
		Pre-Supportive care		Total
		NO	YES	
Pre-Supportive care	NO	19	3	22
	YES	4	334	338
Total		**23**	**337**	**360**
Tests Statistics[a]				
		Pre-Social Support & Post Social Support		
N		360		
Exact Sig. (2-tailed)		.250[b]		
a. McNemar Test *b. Binomial distribution used.*				

*Table 61:Pre-Supportive Care * Post Supportive Care Cross Tabulation*

3.3.4.7. Trust

Cross tabulation pre and post intervention showed an increase in women who experienced trust. 18 did not experience trust at the pre intervention phase of whom 10 experienced trust at the post intervention phase (Table 62).
McNemar's test statistics showed a P value <0.008 implying that the proportion of those who experienced trust was statistically significantly different after the intervention compared to before hence rejecting the null hypothesis.

Cross Tabulation Table				
		Post-Trust		Total
		NO	YES	
Pre-Trust	NO	18	10	28
	YES	2	330	332
Total		**20**	**340**	**360**
Tests Statistics[a]				
		Pre-Social Support & Post Social Support		
N		360		
Exact Sig. (2-tailed)		.008[b**]		
a. McNemar Test *b. Binomial distribution used.*				

*Table 62: Pre-Trust * Post Trust Cross tabulation*

3.3.4.8. Stigma and Discrimination

Cross tabulation pre and post intervention showed an increase in the number of women who did not experience stigma and discrimination. 16 experienced stigma and discrimination at the pre intervention phase of whom 14 did not experience stigma and discrimination at the post intervention phase (Table 63).
McNemar's test statistics showed a P value <0.000 implying that the proportion of those who did not experience stigma and discrimination was statistically significantly different after the intervention compared to before hence rejecting the null hypothesis.

Cross Tabulation Table				
		Post stigma and discrimination		Total
		NO	YES	
Pre stigma and discrimination	NO	16	14	30
	YES	1	329	330
Total		**17**	**343**	**360**
Tests Statistics[a]				
		Pre-Social Support & Post Social Support		
N		360		
Exact Sig. (2-tailed)		.000[b**]		
a. McNemar Test b. Binomial distribution used.				

*Table 63: Pre-Stigma and Discrimination * Post Stigma and Discrimination Cross Tabulation*

3.3.4.9. Predictability and Transparency of Payments

Cross tabulation pre and post intervention showed that the women who negatively experienced predictability and transparency of payments reduced from 16 to 4 pre to post intervention phases respectively (Table 64).
McNemar's test statistics showed a P value <0.000 implying that the proportion of those who did not negatively experience predictability and transparency of payments was statistically significantly different after the intervention compared to before hence rejecting the null hypothesis.

Cross Tabulation Table				
		Post predictability and transparency of payments		Total
		NO	YES	
Pre predictability and transparency of payments	NO	4	16	20
	YES	1	339	340
Total		5	355	360

Tests Statistics[a]	
	Pre-Predictability and transparency of payments & Post predictability and transparency of payments
N	360
Exact Sig. (2-tailed)	.000[b**]

a. McNemar Test
b. Binomial distribution used.

*Table 64: Pre-Predictability and Transparency of Payments * Post Predictability and Transparency of Payments Cross Tabulation*

4. Summary of the Findings

4.1. Socio Demographic Characteristics of the Study Population

A number of socio-demographic characteristics of the postnatal mothers were found to significantly influence respectful maternity care/experience of care. They included age, marital status and education level.

Women aged 15-19 years experienced disrespect and abuse more compared to older women who were less likely to experience disrespect abuse. This was also established in a survey in Tshwane Health District, South Africa which found out that age was significantly associated with disrespectful care with younger women being more prone (Oosthuzein*et al.,* 2017). Married women were more likely to experience disrespect and abuse compared to women who were single or divorced/separated. This finding concur with those of Abuya*et al.,* 2015 which found out that married women were more likely to experience disrespect and abuse including being neglected.

Women who had primary or less level of education were more likely to experience disrespect and abuse compared to women with a higher level of education who were less likely to experience disrespect and abuse. This is consistent with a study carried out in Guatemala which found out that disrespectful and abusive maternity care was a common and pervasive problem among marginalized and less educated women (Austad*et al.,* 2017).

4.2. Treatment of Mothers during Childbirth (Experience of Care/Respectful Maternity Care)

There is Poor provider-patient relationship during childbirth in the health facilities and most women experience physical abuse and discrimination (Rhiannon George-Carey, 2018). Some providers do not introduce themselves to the women (Siraj*et al.,* 2019). The results of this study indicate that there were incidents where women experienced disrespect and abuse whereby they were talked to in unfriendly manner and did not introduce themselves to the women which also come out evidently from many women during FGD.

Afulani*et al.,* 2017 recommended four factors influencing women's perceptions of quality care: responsiveness, supportive care, dignified care and effective communication. The study revealed that most women experienced responsive care, however there were incidences whereby some women experienced care that was not responsive.

Rebecca Bartlett, 2015 reported incidences of terrible abuses in health facilities in the Philippines that reflected a lack of value to the lives of women and newborns. Women who reported to have experienced disrespect and abuse were less likely to plan delivery in a facility in the future (Kruk *et al.,* 2014, Abuya*et al.,* 2015). In support of the findings, this study has also shown that some women reported to have had poor experience whereby they received unfriendly and insensitive treatment from some of the health care providers who went to the extent of being sarcastic to the women. These women reported that they would not wish to deliver in the same facility in future. Provision and experience of care- how women are treated- are both critical components of quality that can influence service utilization and health outcomes (WHO, 2018).

Most women receive non-confidential care whereby their information is divulged to people not involved in their care and are not covered and beds screened during examination (Rhiannon George-Carey, 2018). 81.7% of the women were not accorded privacy by use of curtains/visual barriers (Siraj*et al.,* 2019). In agreement to the findings, this study revealed that women's privacy and confidentiality was inadequate due to a congested bed occupancy that forced them to share beds alongside their newborns and there were no screens or curtains. Contrary to the findings, this study found that women's information was not divulged to people not involved in their care.

In this study, it was evident that the doctors, nurses and other staff did not involve women in decision making about their care. Some women reported that permission or consent was not obtained from them by the doctors, nurses or other staff at the facility before doing procedures and examinations on them. Some women also reported that they could not voice their dissatisfactions since they felt debased by some healthcare providers and hence they could not be listened to. Andrea L.S *et al.,* 2015 suggested that factors considered to promote autonomy such as promotion of coercion-free personal relationships, facilitating access to information, and fostering active participation of women were negligible and

hence more effort was required to fully achieve this goal. Women should participate in decisions about their care (Chalmers B, 1992).

The study revealed that majority of the women were denied food or fluid during labour unless necessary, they were also not allowed to assume a position of their choice during delivery and were not explained to why some procedures were being carried out on them hence denying them their right to autonomy. In support to these findings Balde*et al.,* 2017 concluded that the prevailing model of intrapartum care in many parts of the world, which enables the healthcare provider to control the birthing process, may expose apparently healthy pregnant women to unnecessary medical interventions that interfere with the physiological process of childbirth.

Communication in health helps in advancing the health and well-being of women and their newborns. Poor rapport and communication between women and providers and failure to meet professional standards in most healthcare facilities (WHO, 2015). This study revealed that despite there being good communication and supportive care from some healthcare providers, some women reported that communication was inadequate with some experiencing negative attitude from the healthcare providers as well as not being told about they kind of medication or care they were receiving.
Presence of a birth companion enhances positive user experience as well as labour and delivery outcomes. Barriers to humanizing birth care include the institutional rules and strategies that restrict the presence of a birth companion (Behruzi*et al.,* 2010). Women should be allowed accompaniment and labour support as an avenue to improve experience of care for both patients and providers and also decrease opposition to hospital level obstetric care (Austad*et al.,* 2017). The companion's presence during labour constitutes a major form of care (Oliveira *et al.,* 2014). This study revealed that majority of the women were not allowed to have a birth companion during labour and delivery.

A study in Kenya by Rhiannon George-Carey, 2018 found out that many facilities lacked basic equipment and infrastructure including electricity and water as well as skilled birth attendants and emergency care capacity. These findings concur with the findings of the present study whereby the health facilities lacked adequate supplies, space and beds to accommodate the patient population as well as skilled birth attendants. Unlike George-Carey's findings, in the present study, the health facilities had adequate electricity and water. The lack of basic equipment and supplies, space, beds as well as human resource needs a lot of advocacy so that the problem is addressed.

This study revealed that 57.8% experienced dignity and respect, this gives us the prevalence of disrespect and abuse to be 42.2% as per the exit interview and 2 in 5 experienced feeling humiliated during labour in Bungoma County. This finding surpasses the prevalence in Kenya by Rhiannon George-Carey, 2018 which stated that 20% of women reported to have experienced some form of disrespect and abuse, and 1 in 5 experienced feeling humiliated during labour (Rhiannon George-Carey, 2018). This high prevalence of disrespect and abuse during facility-based delivery shows a health system in crisis hence calls for more concerted efforts in addressing the issue.
Bowser *et al.,* 2010 stated that it is naturally envisioned that the relationship between women and the healthcare providers should be characterized by caring, empathy, support, trust, confidence and empowerment as well as gentle, respectful and effective communication to enable informed decision making but unfortunately, too many women experience care that does not match this image. The statement is evident in the findings of this study in the essence that a number of women experienced some form of disrespect and abuse with a prevalence of 42.2% hence the need for action.

4.3. Factors Contributing to Disrespect and Abuse during Childbirth

Human resource in healthcare that are highly equipped with quality are much better able to provide outstanding services for their patients. It was evident in this study that there was staff shortage as well as healthcare provider demotivation due to lack of promotions, and inadequate support supervision from the managers which could be attributed to negative user experience. The findings are in agreement with Hasting, M.B, 2015 who found out that limited resources; stressful working conditions; and institutional factors such as poor health worker supervision, substandard infrastructure, and lack of accountability as some of the factors leading to disrespect and abuse. The usefulness of the midwife has conventionally been associated with maintaining standards of care hence the need for ensuring adequate deployment to avoid human resource shortage (Abott*et al.,* 2010).

WHO, 2015 stated that poor rapport between women and providers as well as lack of cooperation and trust towards healthcare providers led to disrespect and abuse. This current study disclosed that poor understanding and negative attitude between the healthcare providers and mothers led to disrespect and abuse. The findings were also confirmed by most of the midwives in in-depth interview who reported that physical harm or ill treatment occurs sometimes due to clients' negative attitude and lack of understanding of the service being provided especially if the client declines to be assisted and does not cooperate even after being informed on the service being provided. Communication barrier or not giving adequate information to the clients also caused lack of cooperation.

In FGD, most women disclosed that they labored at home for more than 12 hours before deciding to go to the health facility, majority of them ended up being done caesarean section due to complications. Their lack of seeking prompt healthcare was attributed to fear of receiving inadequate treatment, lack of reliable transport and low compliancy to referral advice. The findings compare well with those carried out in the Philippines that found out that disrespect and abuse contributed to delays #1 and #3 (Rebeccah Bartlett, 2015). Lack of reliable transport, costs involved and perceived quality of care at the hospitals led to delays in seeking healthcare (Pembe*et al.,* 2008). If a woman does not feel safe and respected when she first visits a maternity center, she is less likely to seek delivery services in good time hence increasing her risk of both pregnancy-related morbidity and mortality.

Women rate quality in terms of adequate medical equipment; health staff; room; water; information; clean environment, privacy and the presence of family members. They consider the presence and availability of trained medical

personnel and supplies in the form of medicines (Rajedra*et al.,* 2014). This study established that the health facilities had water, the environment was clean and patient privacy was adhered to but there was inadequate medical equipment; shortage of human resource, inadequate information and birth companions were not allowed to stay with the women during labour and delivery which contradicts with the definition of appropriate technology that can enhance positive experience of care which entails those that have both good functionality (efficacy, effectiveness and safety) and good fit with the environment where they will be used (Tsu V.D & Free M.J, 2002).

Too much workload made healthcare providers to take the shortest time possible per client in order to serve all of them hence leading to substandard care that may be equated to disrespect and abuse as revealed by most midwives in in-depth interview. This finding corresponds with that of the Kenya National Commission on Human Rights which found out that Kenya's public health facilities have long been plagued by reports of abuse, mistreatment, and negligence of patients in the hands of staff which could be attributed to poor supervision and understaffing (Bourbonnais, 2013).

The study showed as recounted by many of the midwives in in-depth interview that some cultural factors such as use of traditional herbs by some women during labour while in the hospital made them to be treated with disrespect and abuse since cultural practices were not allowed in the hospital. The finding corresponds with those of Afolabi*et al.,* 2009 who found out that culturally inappropriate care, disrespectful and inhuman services and lack of emotional support can deter women form accessing obstetric care. There is need for the healthcare providers to be respectful to women's cultural beliefs and practices as long as they are not detrimental.

Hogan *et al.,* 2010 revealed that majority of maternal and newborn deaths and negative user experience in SSA were associated with birth complications related to lack of trained supervision at delivery. These findings correlate with those of this study which revealed that that there was inadequate training on the key thematic areas in maternal and newborn care including respectful maternity care and most of the staff trained in the thematic areas were deployed to other departments.

Mistreatment can occur at the level of interaction between the woman and provider, as well as through systemic failures at the health facility and health system levels (Bohren*et al.,* 2015). Drivers to disrespect and abuse can be at the policy, facility, and community levels (Ndwiga, 2017). In agreement, this study found out that communication barrier between the women and provider or not giving adequate information, shortage of healthcare providers, inadequate training and support supervision, and women sharing beds alongside their newborns which curtailed their privacy and exposed them to nosocomial infections were some of the factors leading to disrespect and abuse.

Mirkuzie*et al.,* 2014 reported that lack of national commitment and financial support; poor decision making power among women; absence of access to, availability and quality care during pregnancy and delivery; poorly functioning health systems with weak referral systems especially during obstetric and neonatal emergencies; and weak national human resource development and management, comprising the continuing brain drain of skilled personnel. These findings correspond with those of this study in that some women labored at home for more than 24 hours before reaching the hospital due to fear of the healthcare care providers and undergoing caesarean section of which they ended being done due to obstetric complications that could have come up due to delays. There was shortage of staff due to transfers and resignations. In contrary, the current study found out that transport was not a barrier to accessing a health facility in Bungoma County as suggested by Gabrysch*et al.,* 2009).

The study showed that barriers to positive user experience included limited beds that could cater for the high bed occupancy hence making women to share beds, not allowing birth companions to stay with the woman during labour and delivery, not allowing women to assume positions of their choice during delivery and disregarding women's cultural practices. These findings agree with those of Mselle*et al.,* 2018 who found out that barriers included physical space issues, engrained traditions within the hospitals that limited family involvement, not providing a woman the choice for the position during birth and disregard for belief, traditions and culture of mothers.

Bingham & Main, 2010 reported that knowledge, attitude and practice as well as missing strong leadership from the top are important barriers to implementing change in maternity units. In agreement, this study established that too much workload with few healthcare providers who were demotivated led to provider negative attitude as well as inadequate support supervision from top leadership which was also evidenced by lack of reports on support supervisions done as stated by most of the midwives in in-depth interview.

The predominant model of childbirth care is characterized by the abusive or inappropriate use if interventions and restriction of the parturient rights (restriction of the presence of birth companions) in all stages of labour (Hassan *et al.,* 2013). The report concurs with the findings of this study which revealed that majority of the women were not allowed to have a birth companion during labour and delivery which needs to be resolved.

4.4. Strategies for Addressing Issues Affecting Respectful Maternity Care for Promoting Quality of Maternal and Newborn Care

To ensure women understand their rights, duties and responsibilities, targeted information, education and communication should be provided (Hailu*et al.,* 2013). The recommendations concur with the findings of this study as suggested by most of the key informants in in-depth interview who said that adequate education should be provided to women during ANC visits so as to allay myths and misconceptions and also seek medical care in good time so as to avoid obstetric complications.

Most of the key informants in in-depth interview suggested that leadership and supervision by the CHMTs, SCHMTs and health managers ought to be scaled up for purposes of accountability and quality checks. This recommendation agrees with that of the World Health Organization that says that strengthening monitoring and evaluation can go a long way in improving maternal and newborn health outcomes (WHO, 2013).

It was suggested in this study by most of the key informants that supervisors should not be harsh and problem searching since it demotivates staff and aggravates disrespect and abuse towards mothers due to too much pressure. Instead, they should be supportive and give positive feedback that is not punitive. These suggestions concur with those of Ndwiga, 2017 who recommended that a supportive environment that includes adequate equipment and supplies, work areas that support privacy and confidentiality can help mitigate disrespect and abuse.

When providing care to women, obstetric nurses should develop actions geared towards individualized, welcoming and efficient care in an environment enabling integral care practices (Andrea *et al.,* 2015). This was also suggested in this study by most of the key informants who stated that healthcare providers should be welcoming; adhere to privacy and confidentiality; listen to clients' needs and concerns; empathetic and involve women in decision making.

Oosthuizen*et al.,* 2017 suggested that the health system should employ respectful obstetric care practices, recognizing the plight of vulnerable women and accommodating them in respectful routine care practices matched with support for midwives and improved clinical governance in maternity facilities. This was also suggested by most of the midwives and key informants in this study stating that healthcare providers ought to be sensitized on respectful maternity care; women should be sensitized on patients' rights and on dignity and respect; encouraging presence of birth companions and more midwives should be deployed which can help in lowering burnout and hence enhancing women's positive experience of care.

Factors that influence women's perception of quality of care include responsiveness, supportive care, dignified care and effective communication (Afulani*et al.,* 2017). This agrees with the strategies suggested in this study by most of the key informants and midwives who said communication should be strengthened by orienting or sensitizing staff on how to have a common understanding with their clients hence enhancing dignified, responsive and supportive care.

Most of the key informants in this study suggested that all structures i.e. community, health facilities, CHMT/SCHMT, the national level, GOK structures, professional associations should provide peer review in ensuring that all the healthcare professionals are held to account. Legal address mechanisms should be provided to ensure that victims of disrespect and abuse get justice. The findings were also suggested by Ndwiga, 2017 who said that respectful maternity care requires that all levels of healthcare work concurrently, because no single effort or intervention can on its own to reduce disrespect and abuse.

It was proposed by most of the key informants in this study that in order to curb disrespect and abuse the following should be done by the health facilities: exit interviews for mothers, suggestion boxes for compliments and complaints, availing hospital phone number to the public and installing CCTV cameras. This is supported by WHO, 2013 who suggested that strengthening monitoring and evaluation can go a long way in improving maternal and newborn health outcomes.

Another resolution suggested in this study for curbing possible drivers to disrespect and abuse included adhering to the code of regulations, staff motivation by promotion, adhering to working hours schedules, provision of adequate resources through budgeting and resource mobilization, and incorporating respectful maternity care practices in the routine Quality of Maternal and Newborn Care practices. WHO recommends a nurse patient ratio in the labour ward as 1:4 (Sandall*et al.,* 2011). This study found out that the nurse patient ratio was 1:35 which can hinder provision of adequate care.

Autonomy during childbirth includes promotion of a coercion-free personal relationships, facilitating access to information and fostering the active participation of women (Andrea *et al.,* 2015). The findings correlate with those of this study which additionally suggested that women should also be given adequate education during ANC visits so as to allay myths and misconceptions, ensure they seek medical care in good time and not laboring at home for too long only to go to hospital when they experience complications.

The American College of Nurse-Midwives (ACNM) maintains that every individual has the right to safe, satisfying healthcare that accommodates human and cultural variations (ACNM, 2004). Most of the key informants and midwives in this study suggested that for women to feel respected and well treated, they should be warmly welcomed, offered privacy and confidentiality, be listened to and be given feedback on findings after examination.

Borhen*et al.,* 2014 in a study on the burden of maternal and perinatal deaths in low and middle income countries was high and recommended that improving the quality of care around the time of birth is the most impactful strategy for reducing still births, maternal and newborn deaths. This corresponds with the findings of this study that showed a reduction in the number of caesarean sections, maternal and neonatal deaths and timely referrals after sensitization which led to improvement in the quality of care.

Bartlett, 2015 documented that impressive programs are being implemented in high-burden countries to increase women's access to the utilization of services (the demand side of the equation) hence improving health system's capacity to offer quality care that meets (the supply side) is the next moral and public health imperative. This study retorted to the recommendation by carrying out a baseline evaluation to assess the quality of user experience during childbirth to identify the gaps then followed by sensitization of midwives on respectful maternity care and later did a post intervention evaluation which showed tremendous increase in positive user experience.

Quality of care means ensuring that women's voices and opinions are prioritized when developing interventions to improve quality in maternity care provision, the results were richest across the domains of effective communication, respect and dignity, emotional support, competent and motivated human resources, and essential physical resources (Bohren*et al.,* 2017). Similarly, this study findings recommended employment of more human resource for health, continuous quality standard checks by healthcare managers, sensitization of healthcare providers on respective maternity care that may help allay negative attitudes, autonomy, dignity and respect.

4.5. Post Intervention Evaluation Outcomes on Respectful Maternity Care

WHO, 2018 found out that women are probably more likely to report experiencing respectful care with RMC interventions than without RMC interventions (WHO, 2018). Another study in Kenya found out that RMC interventions reduced the incidence of disrespect from 20% to 7% (Ndwiga 2017). The findings concur with the findings of this study which found out that women reported a more positive experience on respectful care after RMC intervention as compared to before RMC intervention. The prevalence rate on disrespect and abuse reduced from 42.2% to 25%.

Afulani*et al.,* described the process of developing a tool on patient-centered maternity care (PCMC) which is recognized as critical to improving reproductive health outcomes, yet little research exists to operationalize it. This study operationalized the tool through exit interviews and performance observation through before and after intervention and it was validated that interventions had a positive outcome.

As a motivation by variations in reported prevalence of disrespect and abuse (D&A) of women during childbirth in health facilities, a systematic literature review was carried out to analyze the methodological approaches employed to estimate prevalence of disrespect and abuse. It was found that there was lack of standardized definitions, instruments, and study methods used to date (Sando*et al.,* 2017). This study sought to address the issue by using tools that yielded prevalence estimates with high validity and generalizability through a quasi-experimental pre and post comparison study design.

Mixed methods designs are recommended as the optimal strategy to evaluate mistreatment and the inclusion of direct observations that may help bridge the gap between observed measures and participants' self-reported experiences of mistreatment (Savage & Castro, 2017). This study employed the recommendation and measured the perceived and observed frequencies of mistreatment in level 5 health facilities in Bungoma County, examined the macro and micro level factors that drive mistreatment and later evaluated the interventional outcomes in terms of improvement of user experience which gave optimal results.

Abuya*et al.,* 2015 stated that little was known about interventions aimed at lowering the frequency of disrespectful and abusive behaviors. This study aimed at filling the gap through a pre and post interventional study that involved training providers on respectful maternity care and also involved policy makers through key informant interviews. The results showed a decrease in disrespect and abuse.

Implementation of evidence-based practices in modifying normal delivery care improves service delivery (Cortes *et al.,* 2018). This study also used evidence based before-and-after hospital based intervention on respectful maternity care and the results revealed an improvement in user experience.

Sensitization of healthcare providers that involved assessment, feedback, training and action shows a significant reduction in unnecessary or harmful practices (Iyengar*et al.,* 2014). This study also employed the same strategy whereby midwives were sensitized on respectful maternity care at baseline and the outcome at post intervention showed a significant increase in the number of women whose rights were protected, given information for informed decision making, offered privacy and confidentiality, and those who were allowed to be with a birth companion during labour and delivery.

Evaluation efforts need to reflect the fact that meaningful change will tend to be long-term and that treatment of mothers during childbirth activities will occur over a long period of time and thus evaluation will take place over time (Gagliard*et al.,* 2011). This study carried a baseline evaluation then sensitization of midwives on respectful maternity care after which there was a four months period in between for monitoring to ensure that implementation was taking place then later carried out a post intervention evaluation that saw a meaningful change in user experience of care.

Despite investments in infrastructure, equipment and supplies, monitoring tools and manpower, suboptimal gains in indicators point towards potential challenge in quality of care and the successful implementation of the quality improvement process leads to improved pregnancy outcomes (Das *et al.,* 2018). The outcome of this interventional study also realized positive user experience and pregnancy outcomes.

Quality of Maternal and Newborn Care interventions have a substantial increase in communication between nurse-midwives and mothers and in the rate of delivering the essential childbirth practices (Nababan*et al.,* 2017). This study also saw an improvement in the components of respectful maternity care after intervention.

In support of the findings, Respectful Maternity Care which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth is one of the actions that may enhance women's experience of care and also improve women's and newborns' chances of survival during pregnancy and childbirth in low-income countries. Yet in many regions the proportion of women who experience disrespect and abuse during childbirth is quite high. The major reason for advocating for respectful maternity care is to ensure positive user experience which may lead to increased uptake of skilled birth attendance, reduced maternal and newborn morbidities and mortalities hence leading to leading to Improved Quality of Maternal and Newborn Care.

5. Conclusion

On assessment of the socio-demographic characteristics, it was found that younger women were more likely to experience disrespect and abuse compared to older women. Married women were more likely to experience disrespect and abuse. Women who had primary or less level of education were more likely to experience disrespect and abuse

On overall the study found out that majority of the women experienced dignity and respect from the doctors, nurses and other healthcare providers. Majority of the healthcare providers were responsive to the women's needs offered supportive and dignified care as well as effective communication. Despite the positive user experience by most of the

respondents, some women reported to have had poor experience that was unfriendly and insensitive. Women who experienced poor treatment reported not to deliver in the facility in future or recommend another woman to deliver in the facility. Inadequate privacy and confidentiality, autonomy in decision making and not allowing the presence of a birth companion during labour and delivery were found to be major aspects of disrespect and abuse. The prevalence of disrespect and abuse was at 42.2% at baseline and 25% at post intervention.

It was found out that the major factor leading to disrespect and abuse or negative user experience was staff shortage as well as healthcare providers demotivation due to lack of promotions and inadequate support supervision from managers. Poor understanding and negative attitude between healthcare providers and women led to disrespect and abuse. Communication barrier or not giving adequate information to the clients cause incorporation which eventually led to disrespect and abuse. Women laboring at home for more than 12 hours then coming to hospital with obstetric emergencies aggravated disrespect and abuse. Lack of adequate medical equipment and supplies, health staff, small rooms and lean bed capacity to accommodate the patient population and not allowing the presence of family members contributed to disrespect and abuse. Not honoring women's cultural practices also led to disrespect and abuse.

Strategies identified in addressing issues affecting respectful maternity care in promoting quality of maternal and newborn care included provision of adequate education to mothers during ANC visits so as to ally myths and misconceptions and also seek medical care in good time so as to avoid obstetric complications. Another strategy was for the health managers to scale up supervision for purposes of accountability and quality checks and that they should not be harsh and problem searching. Healthcare providers should be welcoming, adhere to privacy and confidentiality and listen to clients' needs and concerns. Adhering to code of regulations by staff/healthcare providers. Another strategy was staff motivation through promotion and provision of adequate resources. Respect of positive cultural practices and incorporating respectful maternity care practices in the routine quality checks.

The study found out that women reported a more positive experience on respectful care after RMC interventions as compared to before RMC interventions. The prevalence of disrespect and abuse reduced from 42.2% to 25%. The patient-centered tools used in the study helped to bridge the gap between the patient self-reported experience of care and the observed practices on respectful maternity care.

Provision of respectful maternity care during childbirth is a women's right and any form of disrespectful and abusive treatment not only violates the rights of women to respectful care, but also threatens their rights to life, health, bodily integrity and freedom from discrimination.

5.1. Recommendations

The Ministry of Health should develop a policy guideline on Respectful Maternity Care and include RMC into routine care and there should be continuous sensitization as well as monitoring and evaluation so as to ensure positive impact. Research and implementation efforts must continue to ensure that all new mothers receive dignified positive birth experience they deserve no matter the circumstances.

The Ministry of Health should ensure adequate deployment of human resources for health who are motivated. Equipment and supplies should be made adequate as well as adequate space and bed capacity that can accommodate the patient population.

The ministry of culture, gender and social services should address socio-cultural factors that lead to disrespect and abuse including women empowerment and delay in seeking medical care in good time.

Mixed methods study designs should be used as the optimal strategy to evaluate mistreatment. Inclusion of direct observations may help bridge the gap between observed measures and participants' self-reported experiences of mistreatment. Evaluation efforts need to reflect the fact that meaningful change will tend to be long-term and that treatment of mothers during childbirth activities will occur over a long period of time and thus evaluation will also take place over time.

5.2. Further Research

The role of birth companions during labour and delivery should be explored. Clarity and consensus is required in order to ensure robust oversight and accountability processes are established.

Research on the 3 delays models should be carried out in order to establish the exact issues that impact on women when deciding to seek appropriate medical help for an obstetric emergency; reaching an appropriate obstetric facility; and receiving adequate care when a facility is reached

There is need for a longitudinal study to establish changes in the prevalence of disrespect and abuse over time.

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