

Respectful Maternity Care: Concept Paper**Ethel Tsomondo¹****Itai Chihava¹****Christine Mary Kasu²****Gladys Mugadza²**

1, 2, 3, 4 (University of Zimbabwe College of Health Sciences, Nursing Science Department)

***Ethel Dorothy Itayi Tsomondo (corresponding Author)**

Email: dollyitayi@gmail.com

Mobile phone + 263 776420824

Zimbabwe, Harare

Abstract

There are varying perceptions regarding the meaning of respectful maternity care (RMC) among service providers and the women cared for despite being an area of concern for decades.

Objective

The objective of the concept paper was to determine what respectful maternity care means for the purpose of measuring it.

Methodology

Walker and Avant (2011) concept analysis model was used to guide this paper.

The following search engines, Google Scholar, Pubmed and Medline were utilised to select 15 articles relevant to the concept of interest.

Results:

The meaning of RMC is not very clear to both clients and care givers, policies are not being translated to action fully for effective RMC

Conclusion

The curricula of care providers' education to emphasise on affective domain skills and further research and action on findings to improve RMC.

Keywords: Walker and Avant, respectful, maternity care, disrespect, abuse

1. Introduction and Background

Freely accessible services of the skilled birth attendants during pregnancy, labour, birth and after birth is every woman and baby's fundamental right. The way women are treated from the physical care to the way the healthcare providers interact with them has far reaching implications on future institutional deliveries. In Ethiopia Shefraw et al., (2016) indicated that negative experiences with health service providers will be remembered for a long time with emotional pain. Globally the aim is to have all babies delivered in institutions by skilled birth attendants (SBA) to reduce maternal and neonatal mortality and morbidity to meet the Sustainable Development Goals (SDGs). Over the last four decades various organisations took note that globally women seeking for services antenatally, during labour and after delivery were not being given the expected humane treatment in maternity institutions. Jhpeigo through Maternal and Child Health Integrated Program (MCHIP), Maternal and Child Survival Program (MCSP), World Health Organisation (WHO) and other programs has supported the implementation of Respectful Maternity Care as part of quality improvement efforts within maternal health services since 2008 (Jhpeigo, Ndwiga,2017).

According to United States Agency for International Development (USAID) and MCHIP (2013) the historical background of the concept of respectful maternity care started spanning from 1975 in Brazil known as Birth of the Humanising Childbirth. In 1985 World Health Organisation (WHO)/Pan American Health Organisation (PAHO) held a conference on appropriate technology for birth. In the United States of America in 1996 there was the Mother – Friendly Childbirth Initiative. The first international conference on Humanising Childbirth was held in Fortaleza in Brazil in 2000. Bowser and Hill (2010) under USAID- Traction Project produced a report on the landscape analysis on exploring evidence for disrespect and abuse in facility based childbirth.

Seven categories of abuse and disrespect in childbirth were developed using a theoretical framework.

The charter which coined women rights during maternity care as Respectful Maternity Care came into being through the collaborative efforts of White Ribbon Alliance (WRA) and other organisations in 2011.

1.2 Problem Statement

Literature neither seems to be clearly defining RMC, which appears to be contextual since there are variations in its perceptions among caregivers and recipients of care. Despite efforts to implement RMC globally for good mother and newborn outcomes a disrespect and abuse have been reported on globally. In addition respect is difficult to measure because of social norms and cultural implications depending on the setting within which care is provided. There was acknowledgement that the provision and experience of care were critical elements that may affect service utilisation and health outcomes for the mother and newborn (Currie and Bingham, 2016).

1.3 Justification of the study

An in-depth knowledge and more clarity on what respectful maternity care really is would assist both the health care giver and the women to have a mutual understanding of RMC. The review helps to highlight the importance of the need for care givers to honour the women rights in a culture sensitive manner. Women would have a better awareness of their rights under care in maternity units.

1.4 Objective

The reviewers sought to determine what respectful maternity care means and to measure the knowledge of both the health care givers and the clients cared for.

1.5 Methodology

Walker and Avant (2011) concept analysis model was used to guide this paper. The concept analysis steps included concept selection, purpose of the analysis, significance and use of the concept, determination of defining attributes, identification of the model case, additional cases, identification of antecedents and consequences, and definition of empirical reference.

The following search engines, Google Scholar, Pubmed and Medline were utilised for literature search and 30 articles ranging from 2008 to 2017 were identified. The researchers settled 15 articles which were relevant to the concept of interest. The inclusion criteria for articles utilised was based on health articles on respectful maternity care and related studies and reports.

1.6 Data Sources

The following search engines were utilised as data sources Google Scholar, Pubmed/NCBI, and Medline. The search words used were respectful maternity care.

1.7 Study Selection

Literature review was done to determine whether respectful maternity care had been clearly defined or measured since the concept of respects is difficult to measure, including determining

the variations in perspectives of respectful maternity care among caregivers and recipients of care.

Respectful maternity care was classified into themes with the same characteristics.

Literature review of 30 articles was conducted for the period 1998 to 2017, from 15th September to 20th October, 2017. The final sample selection was (n =15) comprising articles from nursing, midwifery and health related disciplines with the rest of the articles excluded.

1.8 Figure 1: Results

No.	Author	Year	Sample size	Population
1.	Freedman et al	2014		WHO Report on projects Kenya and Tanzania
2	White Ribbon Alliance	2011		Charter on RMC
3	Lokugamage & Pathberiya	2017		Review of human rights childbirth- legal case
4	Morgan	2015		Articles
5	Warren et al	2013	6 1 25& 381/district	Health facilities in , Large maternity hospital health providers, facility and national level managers, policy makers, perinatal mothers & community members
6	Ndwiga et al.	2017	142	Care providers in 13 facilities
7	Shefraw et al.	2017	240 117	Women Care providers
8	Shefraw et al.	2016	509	Post partum women
9	Changole et al.	2010	1562	Post partum women
10	Asefa and Bekele	2015	80	Post partum women
11	Rosen et al.	2015	2164	Labour and delivery observations
12	Balde et al.	2017	5, 5 131	Women, Doctors Midwives
13	Floyd et al	2014	11	Post partum women
14	Khosla et al.	2016		Review of reports
15	Bowser and Hill	2010		Report

1.9. Concept Analysis

Concept analysis is a process that aims to come up with defining characteristics or attributes of a concept to facilitate an operational definition. The concept should be very clear and not vague. The researcher can choose or come up with a measuring instrument which is a precise reflection of defining characteristics of the concept. The concept analysis can be utilised to develop a theory and for the purpose of research measurement (Walker & Avant, 2005). The concept is differentiated from other concepts and the irrelevant characteristics are eliminated.

Respectful maternity care has been talked about much with a lot of literature ending up discussing disrespect and abuse at length under RMC. Literature has also revealed there maybe varying perceptions of what respect is or what women's rights really are and cultural aspects play a part.

The concept paper will use Walker and Avant concept analysis model (2011). Walker and Avant concept analysis steps are as follows: 1. Choosing a concept, 2. Specification of the aims of the analysis, 3. identification of concept utilisation, 4. Determination of defining attributes of the concept, 5. Development of a model case, 6. defining a borderline case with similarities and differences from the concept, 8. Defining antecedents and consequences and defining empirical reference.

2.0 Identifying uses of the concept

Firstly the results of the study can be used assist health care providers have a better understanding of what RMC is not only from the caregiver perspective but from the mother and newborn's perspective inclusive of the family. Secondly the results would highlight the importance of a measuring tool as guidance for RMC. Fourthly, the influence of governments or institutional policies either on promotion or contrary to RMC implementation efforts and the need for a

measuring tool within each context of practise. Lastly results would identify gaps for further research in provision of respectful maternity care in health institutions.

2.1 Definition of respectful maternity care

The Oxford dictionary (2015) defines respectful as a feeling or showing deference and the synonyms were deferential, reverent, admiring, humble, reverential, dutiful and subservient.

Collins dictionary defined respectful as showing respect for someone and the synonyms are being polite, civil, mannerly and humble. Thesaurus dictionary defined respect as full of, showing, or giving respect with the synonyms Courteous, polite, decorous, civil, and deferential. The common words featuring are respect, polite, civil, humble, deference reverence.

Thesaurus (2013) on respect cites admiration, high opinion, deference, reverence and esteem, Oxford dictionary (2015) cites deep admiration for one's capabilities and polite greetings. The maternity patient and family do not come to seek admiration from service providers but high quality services. A polite greeting, being courteous and humble come closer in defining respect in the context of the subject of interest. The issue of respect also depends on one's location with cultural implications playing a part on what is a respectful greeting versus professionalism for the care giver. As an example a therapeutic touch to promote good interpersonal relations may be a breach of respect and social distance to the client.

Maternity care according to Thesaurus is the heed, being concerned, bothered worry about motherhood this definition tallies with every woman seeking maternal health services' expectation of safe motherhood.

The right to health according to the International law required accessibility, availability, acceptability of health services of a high standard and the RMC charter encompassing women's basic human rights.

2.2. Health Professional Perspective

WRA as defined RMC as an approach with emphasis on good interpersonal relations of women with health service providers and staff during labour, delivery and the post partum period. The definitions found in literature were either the seven articles of women's rights to respectful maternity care by WRA (2011) or enshrined within the articles.

The articles of the charter for RMC were given as every woman having a right to: 1. To be free from harm and ill treatment. 2. Information, informed consent and refusal, respected for her choices and preferences including the choice of a birth companion. 3. Privacy and confidentiality. 4. Be treated with dignity and respect. 5. Equality, freedom from discrimination and equitable care. 6. Health care and to the highest attainable level of health liberty, autonomy and self determination. 7. Freedom from coercion (WRA, 2011, Browser and Hill, 2010). The concept of RMC acknowledges that women's experiences of childbirth are critical elements of the quality of health care and that their autonomy, feelings, dignity, choices, and preferences should be respected (Rosen et al., 2015). There were variations in the definitions of respectful maternity care with a tendency to define disrespect and abuse rather than respectful maternity care making it necessary to review. In addition with respect there is need to take cognisance of the patients' culture under their care.

Three of World Health Organisation's (WHO, 2014) eight domains on the quality maternal and newborn care are appropriate to RMC. The three are effective and responsive communication, care

provided with respect and dignity and emotional support. The domains indicate that communication is two-way care is discussed, the person is respected and cared for in a dignified manner with the necessary emotional support since childbirth issues are a source of anxiety socially.

If care is to be considered respectful care the care is non-patronising. There should be partnership in planning and implementation care with the patient retaining her autonomy. The patient's voice is heard thus empowered to make choices and decisions about having a companion during labour and delivery, the mode of delivery and birth position. Beliefs culture and traditions should be respected within safety limits for example there may be gender issues clashing with culture if the midwife is male. Among the reasons for low institutional deliveries was fear of being attended to by male midwives, fear of exposing body to strangers (Asefa & Bekele, 2015). The whole process of having a baby should be without indecent exposure and conducted in a dignified manner with continuous support and monitoring. Activities of care and resource allocation should be just without bias inclusive of use of medications and procedures should neither be used in excess and too early nor late interventions.

As a result it becomes necessary to do a concept analysis to aid health workers in understanding and rendering respectful maternity care that is socially and culturally acceptable.

2.3 Defining attributes

Attributes and critical characteristics are deduced from meaning of RMC above. Defining attributes are the characteristics that keep on appearing (Walker and Avant, 2005). In this case it is the characteristics deemed necessary for RMC to occur.

Maternity care provided should be accessible to every woman and of the highest achievable quality free from harm. This attribute tallies with Articles I & VI of RMC charter (WRA, 2011, Currie & Bingham, 2016).

Common understanding, good rapport, collective responsibility and collaboration between the patient and health care providers in the planning and implementation of the care to achieve a common goal of safe motherhood. The woman is an active participant not just a recipient (Khosla et al., 2016).

The woman and her companion are given truthful information. This gives the woman the power to make decisions, the independence to make informed choices including birth companion preferences based on information provided. This attribute tallies with Article II RMC charter (WRA, 2011, Khosla et al., 2016).

Communication should be a two- way process and the woman's voice is heard. Respect should be mutual in the relationship, non judgemental and based on integrity and the treatment should be respectful with dignity. This attribute tallies with Article IV RMC charter (WRA, 2011, Currie & Bingham, 2016)).

Freedom or liberty from being coerced into uncalled for procedures or medicalisation of care. This attribute tallies with Article VII of RMC charter (WRA, 2011).

Resource allocation during care should be without bias or discrimination and the organisational system's care activities should be accommodative taking into account diversity in cultural and religious beliefs and respect culture sensitive issues within safety limits. This attribute tallies with Article V RMC charter (WRA, 2011, Khosla et al., 2016).

The care provided should promote privacy and confidentiality. This attribute tallies with Article III of RMC charter (WRA, 2011, Currie & Bingham, 2016, Khosla et al., 2016).

2.4 Identifying Antecedents and Consequences

2.4.1 Antecedents

Antecedents are the requisites for the concept to occur. The antecedents for RMC to occur are outlined below:

A woman who reports to a health institution with pregnancy, in labour, for delivery or post partum.

There should be respectful, courteousness, open communication, good rapport between caregivers and clients and a mutual relationship and understanding.

A systematic organisation in an institution of delivery, well resourced with human and material resources, competent, committed staff

Highest achievable quality care should be made accessible to all, supervised, monitored and evaluated and problem-solving for clients.

Confidence, ethics, integrity on the part of health care givers and participatory decision making with the patient.

Information sharing between the care givers and women to foster promotion of independence, self-determination and informed choices and the preference of a companion

Recognising and honouring cultural diversity (accommodative environment) by health care givers.

2.4.2 Consequences

Consequences are the events occurring as a result of the concept. Consequences and attributes are similar.

There is increased facility and skilled birth attendants utilisation if respectful maternity care is offered. Violation of women's rights is a contributory factor to decreased or non to utilisation of health facilities (AMDD, 2009).

Prevention of delays in decision making and seeking care

Mutual respect and egalitarian relationship (Rosen et al., 2015)

Equality with principle of power and responsibility sharing

Partnership and collaboration in decision making about the birthing process.

Well informed to enhance independence, self- esteem, self- reliance and self – determination, good communication about the type of care and emotional support

Sustainable competent comprehensive evidence based personalised care with empathy, respect, compassion in a safe, accessible and affordable institution for the birthing process (Balde et al., 2017, Rosen et al., 2016).

2.5 Constructing a model case

A model case is a case scenario with the crucial attributes of the concept under study respectful maternity care.

A 29 year old woman Mrs Imba reported in labour at admissions of a maternity hospital accompanied by her mother, sister in law and her husband. She is a Para 1 Gravida 2. She was a booked case with 4 antenatal visits hence had some on the birthing process. Mrs Imba is admitted by Midwife X who introduced herself and was courteous and very pleasant. The nurse informed Mrs Imba that she was her main care nurse but introduced her to two other nurses who would assist as necessary. Mrs Imba is admitted into a very clean room with audio-visual privacy, a comfortable bed with clean linen.

The midwife X asked Mrs Imba which language she was comfortable with and how she wanted to be addressed first name or surname. Mrs Imba opted for surname and Shona language. In addition she was asked whether she wanted a birth companion during the whole birthing process or not and if anyone else was to be given information about her. Mrs Imba opted for her mother as a birth companion and consented to her husband being given information. Midwife X assured her of confidentiality, continuous monitoring and support.

On examination Mrs Imba was found to have a stone in a cloth around her waist. On enquiry the nurse was informed it was cultural to protect her and the baby. The nurse explained in a non judgemental manner that it was alright for her to have it but for functional purposes in hospital requested that it be removed from the waist and Mrs Imba consented and bagged the stone and cloth. After being examined by she was informed that her baby was alright. A doctor also came to assess her and confirmed labour was expected to progress well.

They discussed pharmacological and non pharmacological pain management options, birthing positions, feeding options and benefits. Mrs Imba opted for non pharmacological pain management; she also preferred to walk around instead of lying in bed continuously. Mrs Imba

requested to drink fluids and was allowed. The labour progressed well and she delivered a healthy live baby girl in a squatting position as per choice. Soon after delivery skin to skin contact with the baby was promoted as well as early initiation of breastfeeding. The nurse ensured Mrs Imba was breast feeding correctly. After delivery she was made comfortable, both mother and the baby were monitored to ensure they were in good condition and safe.

She was given a demonstration on cord care, baby hygiene and information on personal hygiene, baby care and vaccines and review appointments before discharge. On exit interview Mrs Imba indicated that she was very pleased with the care and would use the hospital again for future maternity care.

2.6 Borderline case

A borderline case contains some of the crucial attributes but not all of them (Walker and Avant, 2011). Ruva a 25 year old married woman reports in advanced stage of labour accompanied by her sister in law. She had 4 antenatal care visits. She had all the information about what to expect in labour how to feed and look after the baby. On admission she was admitted by two nurses C and D who introduced themselves and they were very pleasant. Nurse C informed that she was going to be the main caregiver. She was admitted into a partitioned cubicle with visual but not audio privacy. On examination she was found to have a high temperature and had been draining liquor for more than 12 hours. Ruva was informed that she needed to get her relative to purchase an antibiotic which was unavailable at the hospital but the relative had no money. The whole birthing process was discussed, Ruva preferred the squatting birth position but the midwife informed her that she was only skilled in conducting deliveries on the bed with Ruva on her back. On delivery of the baby there was poor maternal effort. The doctor was summoned. The doctor proceeded to

do a vacuum extraction without discussing and getting consent from Ruva. She progressed to deliver a live baby boy.

2.7 Related case

A related case is related to the concept but does not contain the crucial attributes (Walker and Avant, 2011). Ms Huni is a single 18 year old woman who is Para 0 Gravida 1 admitted in active labour at 1600 hours. Ms Huni never sought antenatal care. Hence she had neither clue about the whole birthing process nor baby feeding or care. She was accompanied by her partner who was told to go back home after paper work was completed because the institution did not have room for companions.

Ms Huni was admitted by Midwife Z into a two-bedded room shared by another patient hence no option of a birth companion. There was no audio visual privacy. The room was not very clean. There were only two nurses on duty with 6 patients in labour. The midwife who did not introduce herself to the patient had already developed a negative attitude. She enquired rudely why Ms Huni had not attended antenatal care. On being told of financial constraints and an unplanned pregnancy the midwife rudely asked the patient why she had not used protection.

On examination Ms Huni was in active labour, fetal heart was within normal ranges but she was restless and screaming because of pain. Midwife Z instructed Ms Huni to lie on the left side all the time and stay in bed if she wanted a live baby and that the nurses were too busy to spend time with her. She would push with every contraction. Midwife Z did not bother to discuss pain management she just gave Ms Huni Pethidine injection. Ms Huni settled for just about 2 hours and she started screaming for the nurses to come and was pushing with every contraction.

Midwife Z only came to review her after about 4 hours; examination was difficult because she was uncooperative. This frustrated the overworked nurse who started using abusive language about having an unplanned pregnancy. The cervix was 8 cm dilated presenting part was 2/5 above the brim, moderately strong contractions 2 in 10 minutes, the fetal heart was grade within normal range.

On delivery Ms Huni was out of her wits and in pain, she had no idea what was happening. As a result when asked to push or stop pushing she was not compliant. Midwife Z became more frustrated and told Ms Huni they did not want a stillborn on their records and pinched and slapped the patient. Sensing no progress Midwife Z did an episiotomy without local anaesthetic or warning the patient. A live healthy baby girl was delivered, shown to the mother, wrapped up and put in a crib- no skin to skin contact. The episiotomy was sutured without anaesthesia. Breastfeeding was not initiated in the first hour. Ms Huni did not get enough support on how and when to breastfeed or breast care, cord care baby and personal hygiene. She was detained for two days before discharge for non settlement of the hospital fees and ended up on a floor bed to accommodate a new patient.

2.8 Contrary Case

A thirty year old woman Ivy reported for admission escorted by her husband. She was admitted for induction of labour for post dates. Ivy is Para 0 Gravida 1. Ivy was told by the doctor to come for admission on the day with prescribed medication (Cytotec) for induction of labour. Ivy was admitted into a hot and stuffy cubicle for four patients with neither visual nor audio privacy. The bed was uncomfortable with just sheets and no blankets. The husband was told to go and come back during visiting times. Ivy was not consulted as to whether she wanted a birth companion or

not. On admission Nurse V just took her papers and read what was written without talking to her. Nurse V without introducing self just instructed Ivy to hand over the Cytotec and lie on her back. The nurse proceeded to examine the patient and listened to the fetal heart after which she documented her findings with no feedback to Ivy. Nurse V instructed Ivy to lie on her left side till she comes back. On return the nurse just pulled the top sheet off the patient and asked her to lie in lithotomy position and she inserted the Cytotec vaginally. When the nurse was done she asked the patient to lie on the left side and to inform the nurse when labour pains start.

Ivy went into labour after about two hours. She was feeling hot and thirsty and started pacing up and down the room shouting for the nurse to come. Nurse V came after an hour and asked what the drama was all about, the patient asked for water and she was told it was not time for having drinks but labour and to quickly get back on to the bed. The nurse listened to fetal heart monitored the contractions, did a vaginal examination with no screens for privacy and patient's dignity in full view of the patient on the next bed, documented and left without another word. Ivy screamed that there was something coming out but no one came. She proceeded to deliver a live baby girl on her own. The baby did not cry at birth. Nurse V came and found the baby on the bed and took the baby for resuscitation. Nurse V shouted at Ivy for not calling for the nurse and implied that it was her fault she delivered on her own. The baby cried after resuscitation. Ivy had a second degree tear which was bleeding profusely. The nurse informed the doctor after examination Ivy was put on a stretcher and was told to sign a form for her to be sutured in theatre out of fear she just complied and was wheeled to theatre without further explanation. No one told her about what was going to happen to her baby in her absence.

Post operatively Ivy was told she needed to pay \$120.00 for one unit of blood since she had lost blood. When Ivy's husband came he was bombarded with information about the money he was

supposed to pay but no explanation about what had transpired with regards to his wife and baby. The health education Ivy received before discharge was through group talk not individualised education and was barely sufficient for her to cope with new status of motherhood with regards to breastfeeding, breast care, baby care, cord care and perineal hygiene. Ivy was discharged after being detained for extra three days for failing to pay part of the hospital bill.

2.9 Empirical referents

Empirical referents are indicators or classes of the phenomena used to demonstrate the occurrence of the concept or measure the concept (Walker and Avant, 2011).

Infrastructure to support privacy and confidentiality during patient care

Adequate human and material resources at health facilities

Respectful and polite health staff in health facilities

Documentation signed by the patient to the effect that there was information sharing, autonomy, informed choices and preferences about aspects of care like procedures or birth positions

Exit interviews for patients to evaluate services offered care

Monthly care audit meetings to improve on shortcomings

3.0 Discussion

Respect and politeness are difficult concepts to define. Most of the articles selected did not define RMC while others did so with emphasis on abuse and disrespect (Morgan, 2015, Freedman, Ramsey, Abuya, Bellows, Ndwiga, Warren, Kujawski, Moyo, Kruk & Mbaruku, 2014, Sheferaw et al. 2017, Floyd et al.2014, Bartlett, 2015).

Fifteen articles were dropped for several reasons: Eleven articles were quite detailed on abuse and disrespect as indicators of poor quality of care without clearly indicating antecedents and attributes for RMC (Bradley, 2016, Sacks, 2017, Jewkes et al. 1998, Nystedt & Hildingsson, 2017, Sando et al. 2016, Bartlett, 2015, Miller & Lalonde, 2015, Abuya et al.2015). On the other hand the articles clarified the consequences of lack of RMC and the drivers of abuse and disrespect in maternity wards and suggested strategies.

Two articles focused on women's satisfaction with the maternity care rendered to them. The health workers scored well in skills, information sharing and participation in decision making, cleanliness of the facilities scoring the lowest. The studies however highlighted the importance of multispectral approach in educating clients and health workers about clients' rights and improvement of physical environment and the need for research for improvement of patient satisfaction and future utilisation of facilities (Paudel et al., 2015 & Jolivet, 2012).

Five articles sought to measure the level of disrespect and abuse, develop measuring tools for respectful maternity care and compassionate care and low utilisation of maternity services respectively. There was an analysis of the existence of maternal care under a continuum of practice without adequate resources, evidence- based standards and the unavailability of care and analysis of bioethics in the maternal health rights respectively. (Burnell, 2013, Miller et al., 2016, Finlayson & Downe, 2013, Erdman, 2015, Koblinsky et al., 2016).

As far as respect is concerned the context and culture play a role As an example professionally people look at each other in the face yet in some African cultures Zimbabwe included looking at an older adult or male figure in the face is disrespectful. In concurrence Asefa &Bekele,(2015) confirmed that women feared exposing their bodies to males and strangers. Morgan (2015) argued

that an acceptable definition of woman- centred care is nonexistent. Woman- centred care has the following attributes non authoritarian relationship, informed choice and woman centred care.

The definition of RMC is not as clear as that of disrespect and abuse including the effect of working environment, working relations, emotional well being of staff as contributory factors (Freedman et al., 2014, Ndwiga et al., 2017). Their findings are in agreement with the attributes above and emphasise the need for provider self regulation, supervision and being responsive to midwife and patient needs.

The definition on RMC is not clear in Shefraw et al., (2016) but they came up with a four- pronged measurement tool focussing on friendly care, abuse-free, timely care, discrimination-free care. When it comes to attributes of reception and greeting in Shefraw et al., (2017) on the checklist that is not enough, the facial expression or voice of intonation on reception and greeting of clients may not depict respectful care.

Lokugamage and Pathberiya (2017) focus on the FREDA principle as the core issues namely fairness, respect, equality, dignity and autonomy which are some of the antecedents for RMC. The study cited a legal case on violation of human rights where health care used to tell patients what to do with no choice and the patient's voice was not heard. Antecedents

Warren et al., (2013) sought to assess measure and design intervention for reduction of abuse and disrespect. Their finding indicated that most facilities in Kenya were unable to minimum requirements for safe deliveries, had staff limitations and patients were not empowered, They also highlighted that despite this being a global problem with various reports written there seems to be a "veil of silence" on women abuse.

Attributes like privacy, dignity and acceptance of culture can be challenged when the caregiver is male with no other option at facility of care and therapeutic touch that a woman in labour needs can be misunderstood.

Shefraw et al.,2017 's definition of RMC cited White Ribbon Alliance's definition as an approach highlighting the importance of the positive interpersonal relations between women and health care providers and staff during the perinatal period.

On attributes the observation checklist by Shefraw et al., 2016 focused the positives which were on interpersonal communications between women and health care givers, politeness, encouraging walking and position changing in labour, allowing women choice of birth position and light meals. The negatives were physical and verbal abuse, lack of privacy and abandonment. Issues of informed consent on procedures and pain management options are not clear. In addition it is not clear whether infrastructure and material resources were addressed as these are crucial in RMC. The type of infrastructure and material resources available may not support attributes like privacy and inadequate resources don't can be frustrating to overworked caregivers affecting their attitudes and temperaments.

3.1 Summary

Respectful maternity care is crucial in achieving the Sustainable Development Goals in order to reduce maternal mortality to 70/100 000 by 2030. This is only possible with increased utilisation of skilled birth attendants and institutional deliveries in the absence of disrespect and abuse. The care provided should be patient- centred, accessible, affordable in well resourced delivery institutions, with skilled, pleasant and are well motivated staff.

3.2 Conclusion

Policy makers need to put policies in place to support respectful maternity care in terms of infrastructure, resources and supportive supervision and accountability. The curriculum of midwives, nurses and all medical staff should emphasize the affective domain, psychomotor skills not just the cognitive skills to effect RMC taking cognisance of respect, dignity, compassion, empathy, patients rights to choice and autonomy. Healthy systems should plan for and have adequate human and material resources, a conducive working environment for both workers and patients.



References

1. AMMD (2009). *Respectful Maternity Care*. Columbia University, Mailman School of Public Health.
2. Abuya, T., Ndwiga, C., Ritter, J., Kanya, L., Bellows, B., Binkin, N., Warren, C. E.(2015).The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya, *BMC Pregnancy Childbirth*, 15, 224.
3. Abuya, T., Warren, C. E., Miller, N., Njuki, R., Ndwiga,C., Maranga, A., Mbehero, F., Njeru, A. & Bellows, B. (2015). Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. *PLoS One*, 10(4).
4. Asefa, A. & Bekele, D. (2015). Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centres in Addis Ababa, Ethiopia *Reproductive Health*, 22(33)
5. Bartlett, R. (2015). *Respectful Maternity Care is Everyone's Responsibility*.
6. Collins English Dictionary Copyright © HarperCollins Publishers.
7. Currie, S. &Bingham, C. (2016).*All Women Deserve Respectful Maternity Care*. The Development Set.
8. Erdman, J.E.(2015). Bioethics, Human Rights, and Childbirth *Health and Human Rights*, 17(1).
9. Floyd, L., Coulter, N., Asamoah, S. & Agyare- Asante, R. (2014). Women's views and experience of their maternity care at a referral hospital in Ghana. *African Journal of Midwifery and Women's Health*, 8 (4).

10. Jolivet, R. (2012). *Take Action: Respectful Maternity Care is a Universal Right*. White Ribbon Alliance for Safe Motherhood.
11. Koblinsky, M., Moyer, C.A., Calvert, C., Campbell, O.M.R., Feigl, A.B., Graham, W.J., Hodgins, S., Matthews, Z., McDougall, L., Moran, A.C., Nandakumar, A.K. and Langer, A. (2016). Quality maternity care for every woman, everywhere: call to action. *The Lancet*, 388(10057), 2307 – 2320.
12. Maternal Health Task Force. *The Role of Maternal Health Task Force*.
13. Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., Diaz, V., Geller, S., Hanson, C., Langer, A., Manuelli, V., Millar, K., Morhason-Bello, I., Castro, C.P., Pileggi, V.N., Robinson, N., Skaer M., Souza, J.P., Vogel J.P. & Althabe, F. (2016). Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide *Lancet*, 388 (10056), 2176-2192. 6736(16)31472-6.
14. Molina, R.L., Patel, S.J., Scott, J., Schantz-Dunn, J. & Nour, N.M. (2016). Striving for Respectful Maternity Care Everywhere. *Maternal and Child Health Journal*
15. 20, (9), 1769–1773.
16. Morgan, L. (2015). Conceptualising Woman- Centred Care in Midwifery. *Canadian Journal of Midwifery Research and Practice, Volume 14* (1)
17. Mugweni, E., Ehlers, V.J. & Roos, J.H. (2008). Factors contributing to low institutional deliveries in the Marondera district of Zimbabwe. *Curationis*, 31(2), 5-13.
18. Oxford Dictionary of English. (2015). (3rd Ed.). Oxford University Press.
19. Paudel, Y, R, Mehata, S., Paudel, D., Darang, M., Aryal, K.K., Poudel, P., King, S. & Barnett, S. (2015). Women's Satisfaction of Maternity Care in Nepal and Its Correlation

with Intended Future Utilisation. *International Journal of Reproductive Medicine*, 2015, Article ID 783050, 9 pages.

20. Philip Lief Group. (2013). *Roget's 21st Century Thesaurus*. (3rd Edition). Copyright.
21. Rosen, H.E., Lynam, P.F., Carr, C., Reis, V., Ricca, J., Bazant, E.S. & Bartlett, L.A.(2015).Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa.*BMC Pregnancy Childbirth*15,306.
22. Sheferaw, E. D., Bazant, E., Gibson, H., Fenta, H.B., Tsigereda, B. B., Worku, M.M., Kebebu, A.E., Woldie, S.A., Kim, Y.M., van den Akker, T. & Stekelenburg, J. (2017). Respectful maternity care in Ethiopian public health facilities. *Reproductive Health*, 14(60).
23. Sheferaw, E. D., Mengesha, T.Z. & Wase, S.B. (2016). Development of a tool to measure women's perception of respectful maternity care in public health facilities. *BMC Pregnancy and Childbirth*,16(67)
24. White Ribbon Alliance Guide for RMC
25. WHO. (2014).*The prevention and elimination of disrespect and abuse during facility-based childbirth*. United Nations General Assembly.
26. WH0. (2016).*Standards for improving Quality of Maternal and Newborn Care in Health Facilities*.