LGJDX ISSN No: 1008-0562 Journal Of Liaoning Technical University Natural Science Edition

EXPERIENCES OF MIDWIVES WHO TREAT WOMEN WITH DIGNITY THROUGHOUT LABOUR AND DELIVERY

LISHIKAH Adams
Faculty of Nursing
Lincoln University College, Malaysia

ADENIYI, Sarafadeen Diran
Lincoln University College, Malaysia

TONGDIMA Jaakuk Luka
Faculty of Nursing
Lincoln University College, Malaysia

MALAU Samuel Zakka
College of Nursing sciences
Vom,Plateau state, Nigeria.

Abstract
The study investigated the experiences of midwives who provide dignified care to women throughout labour and delivery. It aims to explore the challenges, facilitators, and personal perspectives of midwives in ensuring respectful maternity care.The study employed a qualitative research approach with a phenomenological design to explore lived experiences of respectful maternity care. Methodological triangulation integrated document analysis, interviews, and surveys. Validated instruments were adapted for interview guides. Data were transcribed by a team and analysed using NVIVO 10 to identify key themes. Results revealed that midwives addressed expectations from pregnant women during birthing while maintaining patients' dignity. The findings have implications for theory, policy, service improvement, application, instruction, and study. This study has shown that participatory approaches can be used to create and construct a framework that could positively assist in delivering high-quality, compassionate treatment during birthing.

Keywords: Assisted home births, maternal health outcomes, rural healthcare, multi-stage approach, community-based interventions

Introduction

Essential to all women, maternity care is a special requirement for a woman during her everyday life event, which has a lasting effect on her and her baby's health. Respectful maternity care encompasses the services provided to women during pregnancy (prenatal period), labour, birth, and postpartum. While these services are intended to be delivered respectfully, a substantial body of literature emphasizes that disrespectful maternity care prevails worldwide (Bohren et al., 2015). Women want a healthy birthing experience that satisfies or exceeds their socio-cultural

beliefs and expectations, including having a healthy baby in an extremely clinically and psychologically safe setting while receiving ongoing physical and emotional support from the birth partner and qualified clinical staff (WHO, 2018). Even when medical interventions are necessary or wanted, many women seek typical labour and delivery and a feeling of accomplishment and authority through participation in decision-making (Murugesu et al., 2021; López-Toribio et al., 2021). In other words, women envisage a relationship characterized by love, empathy, encouragement, loyalty, trust, confidence, and gentle, respectful, and meaningful communication to allow informed decision-making (O'Brien et al., 2021; Almorbaty et al., 2023). Sadly, too many women receive treatment that does not portray a respectable picture (Respectful Maternity Care Charter, 2012; Bohren et al., 2015)). An increasing body of data, knowledge and case reports from the world's wealthiest to poorest nations in maternity treatment systems paints a different and troubling picture (Bohren et al., 2017).

Indeed, women's mistreatment and neglect during maternity care are turning into a burning problem and generating an increasing culture of concern that encompasses the fields of science, quality and education in health care, human rights, and support for civil rights (Bohren et al., 2015; Bohren et al., 2017; Kuumuori & Krampah, 2019; Kasaye et al., 2024). Disrespectful maternity care also referred to as obstetric violence or mistreatment during childbirth or abuse and Disrespect or dehumanized care by some authors, is said to act as a restrictive factor to using health care services for childbirth (Bohren et al., 2017; Maldie, 2021; Gebeyehu et al., 2023). The poor utilization of health facilities for delivery in low-income countries has been linked to dissatisfaction with childbirth services (Kujawski et al., 2017; Yaya et al., 2018). Disrespect and Abuse (D&A) are recognized as critical shortcomings in delivering quality services to women during pregnancy, labour, and delivery. This issue poses a risk and undermines the healthcare system's ability to achieve positive maternal health outcomes (Banks et al., 2018; Orpin et al., 2018; Okedo-Alex et al., 2021). Along with other well-known hurdles, including geographic and financial access, mounting data has demonstrated that the quality of care and treatment that women and families receive in institutions is a substantial deterrent to obtaining care (Bohren et al., 2015; Kruk et al., 2014; Abuya et al., 2015). There are seven types of disrespectful maternal treatment, which include Denial of treatment, verbal as well as physical harassment, undesired obstetric procedures, stigmatization and prejudice, neglect and failure to adhere to treatment and attention criteria (Abuya, Warren et al., 2015; Bohren et al., 2015; Orpin et al., 2018; Maldie et al., 2021).

Disrespectful maternity treatment, also known as disregard plus abuse (D&A) in maternity wards, perpetuated by professionals in health care and other facility personnel, is a significant yet little-understood aspect of the inadequate attention that women receive during in-hospital childbirth. An expanding body of knowledge on women's experiences throughout pregnancy and delivery paints a troubling image, with women worldwide experiencing insensitive, violent, or neglectful care during in-hospital deliveries (Bohren et al., 2015). There is a theory that initiatives to enhance skilled birth participation are hampered by interpersonal obstacles between clients and service providers. The current categorization is made up of seven D&A indicators, according to Bowser and Hill's analysis: Physical assault, non-consenting treatment, cruel treatment (such as spoken abuse), giving special treatment to some and withholding such treatment from others, neglect, as well as confinement in facilities, are all examples of care that is not respectful. According to these D&A categorizations, an alarmingly high percentage of

women have claimed mistreatment globally, with rates ranging from 20% to 78% (Dynes et al., 2018).

A human rights concern lies at the heart of contempt and violence. When maternity care is provided disrespectfully, women's rights to existence, well-being, bodily integrity, freedom of choice, dignity, family life, spiritual autonomy, and freedom from prejudice are all infringed (WHO, 2018). While certain people may engage in and experience Disrespect and abuse, the behaviour is thought to be an indicator of systemic harm and gender inequality that has become widespread in societies all over the globe (Sadler et al., 2016; Jewkes & Penn Kekana, 2015). Women's satisfaction and faith in healthcare services and amenities can be harmed when they believe their civil liberties are being infringed upon during treatment. (Kujawski et al., 2015). Utilization of healthcare facilities by a woman relates to her satisfaction with those services. Evidence indicates that having experienced or anticipated Disrespect and violence in maternity treatment discourages women from obtaining medical assistance and could lead to them dropping out (Dynes et al., 2018). Women's decision to seek treatment at a facility throughout childbirth and labour is affected by their fear of D&A (Abuya, Ndwiga, et al., 2015). Delayed usage can negatively impact women's health, which in turn prompts women to delay obtaining care by neglecting prenatal visits or having a baby in their homes, both of which put the mother's and unborn child's health at risk (Bowser & Hill, 2010). Women who deliver babies at home without any skilled attendant's aid to treat health conditions are at a greater risk of maternal and newborn illnesses and deaths (Bohren et al., 2015; Bradley, 2016). Women can be hesitant for their child to be born in hospitals due to insufficient maternity care, which may lead to poor pregnancy outcomes (Afulani et al., 2019). D&A patients are more prone to voice their discontent with the birthing process and are less likely to attempt facility-based delivery in the future (Kujawski et al., 2015).

Literature Review

Overview of Respectful Maternity Care

"Respectful Maternity Care (RMC) is characterized as "Care structured and delivered to women in a way that upholds their dignity, privacy, and confidentiality, guarantees protection from harm and mistreatment, facilitates informed decision-making, and offers ongoing support throughout labour and childbirth." (World Health Organization, (2016); Nakua et al., (2020)). The components of RMC include respectful communication, autonomy, privacy, dignity, emotional support, cultural competence, and freedom from mistreatment and abuse (Bowser & Hill, 2010).

In order to accomplish the intended person-centred results, the World Health Organization's (WHO) structure for improving the standard care provided for expectant women throughout childbirth emphasizes the importance of both clinical care and care experience. However, non-clinical approaches during labour, which may be relatively affordable to implement and provide emotional assistance through labour, companionship, good communication, and respectful care, are only prioritized in some settings. Similarly, the initial and subsequent phases of work only sometimes include birthing options that respect women's standards and encourage choice. These labour's non-clinical features and delivery care are critical elements of the treatment experience.

They should be used with appropriate clinical services to enhance the standard of care given to the woman and her household (WHO, 2018).

The White Ribbon Alliance describes RMC as a method that emphasizes positive interpersonal connections between women and healthcare workers and staff during labour, childbirth, and up to six weeks after delivery. The RMC concept calls for the progress of supportive staff attitudes and behaviours conducive to increased women's gratification with their birthing experience (Ephrem et al., 2017). RMC refers to a childbearing woman's humane and dignified conduct throughout pregnancy, birth, and the period following childbirth. RMC respects pregnant women's decisions and rights by encouraging contact, behaviour, and attitudes. Identification and eradication of D&A are necessary for promoting RMC in healthcare institutions because it improves the standard of maternity treatment and lowers the effect of offensive and insensitive behaviours and situations (Ndwiga et al., 2014).

Respectful maternity care understands that labour and delivery encounters of women are essential to providing them with high-quality medical care as well as their "autonomy, self-worth, emotions, decisions, and desires must be valued." (Rosen et al., 2015). Patient-focused care and the humanizing of birthing are among the initiatives aimed at reorienting healthcare from a disease-oriented paradigm that emphasizes a doctor as an authority (Rosen et al., 2015). Respectful maternity care comprehends the universal human rights of every mother when it comes to women's autonomy, dignity, feelings or perceptions, choices for birth, treatment preferences of the company, and cultural beliefs during labour, particularly in medical facilities. This is primarily related to doing away with disrespectful behaviour throughout gravidity and delivery (Alageswari et al., 2019). Respectful maternity treatment entails physical addition to mental treatment, in addition to communication and relationships and is influenced by structural, organizational, and cultural processes and financial concerns. It also entails "not harm". The terms employed to explain respectful care include positive descriptions, such as 'respectful' and 'humanized', and negative descriptions, such as 'disrespectful', 'obstetric violence', 'mistreatment' and 'abuse'. (Bohren et al., 2017) Bowser and Hill described seven overlapping types of treatment that is disrespectful in childbirth facilities (DACF); they preferred the word "mistreatment." Physical assault, discrimination, non-consented treatment, non-confidential care, non-dignified treatment, neglect, and incarceration in facilities are all examples of violation of the privileges of a woman. Morton and Simkin (2019) highlight that respectful maternity care encompasses removing insensitive care, implementing healthy and respectful care methods, maintaining health for everyone (not only the wealthiest, sickest, or most vulnerable), and preserving and supporting physiological processes that occur during pregnancy, delivery, and early parenting.

Perspective of Midwives on RMC

Recent studies have delved into midwives' perspectives regarding RMC, shedding light on various aspects crucial for enhancing maternal care quality. Miller et al. (2019) conducted a qualitative study exploring midwives' experiences and perceptions of RMC in diverse healthcare settings. The findings revealed that midwives emphasized the importance of respectful

communication, informed decision-making and holistic care to promote positive childbirth experiences for women.

Effective communication emerges as a central theme in midwives' perspectives on RMC. According to Smith et al. (2020), midwives emphasize the significance of clear and respectful communication with women throughout the maternity care continuum. Midwives value open dialogue, active listening, and providing information to empower women to make informed choices about their care. Effective communication between midwives and women enhances trust, promotes shared decision-making, and contributes to positive childbirth experiences (Sandall et al, 2016). Midwives recognize women's autonomy and agency in decision-making processes related to childbirth. A study by Johnson and Brown (2021) highlighted midwives' advocacy for promoting women's autonomy and informed choice in childbirth interventions. Midwives value shared decision-making models that prioritize women's preferences while ensuring safety and positive outcomes.

Cultural competence is another vital aspect midwives emphasize when providing RMC. Recent research by Garcia et al. (2022) explored midwives' cultural awareness and sensitivity in diverse healthcare settings. Midwives stressed the importance of respecting cultural practices, beliefs, and preferences to deliver culturally competent and respectful care to women from diverse backgrounds. Midwives underscore the role of emotional support and compassion in RMC. A study by Thompson and Clark (2023) revealed that midwives prioritize providing emotional support, comfort, and reassurance to women during labour and childbirth. Midwives recognize women's emotional vulnerabilities and strive to create supportive and empathetic care environments. Despite their commitment to RMC principles, midwives face challenges and barriers in practice. Smith et al. (2021) identified workload pressures, resource constraints, and organizational barriers that impact midwives' ability to deliver RMC consistently. It is vital to tackle these challenges to guarantee the long-term adoption of RMC principles in maternity care environments.

Research Methodology

The study used a qualitative research technique. In a project, methodological triangulation involves employing multiple research methods. This study effectively integrated document analysis, interviews, and surveys to capture diverse perspectives on respectful maternity care. In this context, the researcher explored individuals' actual experiences with an event as defined by the participants, as the study delves into both philosophical and psychological aspects. This research benefits from a phenomenological design since it seeks to explain people's lived experiences.

The researcher adapted and utilized validated instrument to design the interview guide question. Specifically, the researcher employed a revised version of the MCSP Guatemala respectful maternity care formative assessment instrument for pregnancy and delivery care (WRA) providers as the interview guide for midwives. This adaptation of validated tools ensured that the study instruments were reliable and suitable for the research context. Additionally, the researcher used an updated version of the MCSP in-depth interview guide for women of reproductive age as

the interviewing guide for women. During Phase I of the study, in-depth semi-structured interviews were conducted with women and midwives. These interviews were conducted to collect information regarding the midwives' experiences in providing proper care to expectant mothers and the mothers' own experiences.

A team of four individuals meticulously transcribed the recorded interviews, and NVIVO version 10 was employed for data analysis. The NVIVO software was used to input the transcribed data, and statements related to respectful maternity care were systematically selected.

Results

Table 1: Sociodemographic characteristics of midwives

Variable	Category	Frequency (n=10)	Percentage (%)
Age	20 – 29	1	10
	30 – 39	6	60
	40 – 49	2	20
	50 – 59	1	10
	Mean- 36.5years		
Highest Educational level	Nurse	1	10
	Midwife	6	60
	Bachelor of Nursing Science	2	20
	Others	1	10
Years of Service	1 – 9	6	60
	10 – 19	3	30
	20 – 29	1	10
	>30	0	0
	Mean – 9.5 years		
Years in labour ward	1 – 9	9	90
	≥10	1	10

The participants consisted of 10 midwives and 13 women. The midwives were of various cadres, but the highest qualification was tertiary. They are all married. The women were also made up of different parities and delivered within 48 hours.

Themes with sub-themes were broken down into six major ones, as seen in the table below:

Table 2: table showing themes and sub-themes generated from findings

S/No	THEMES	Sub themes
Midwives' experiences with providing considerate maternity care during birthing		
1	Midwives Expectations	- Teachings during Antenatal - Teachings in labour ward - Cooperation from the women

		- Expectations from the management
2	Patient's worth is maintained	- Belief in the woman's dignity - Respect for patients' privacy - Accepting and observing patients' rights - Informing and training the patients
3	Disrespect of women Justified	- Force being used during labor - Threaten and abuse verbally - breach of privacy - Performing procedures with no authorization - Preventing women from making decisions
4	Health system constraints	- Manpower - The midwife - The patient behaviour - Antenatal care - Equipment's for work

Discussion of Findings

This study investigated the perspectives of midwives and women on fostering respectful maternity care during childbirth. The study examined midwives' experiences of providing respectful maternity care and women's perceptions of receiving it during childbirth. Giving or receiving RMC during labour is a loving experience; the study helps us understand that. The conclusions presented in the logic model can be used to examine the available information to guide the needs assessment phase of intervention mapping.

Six themes from the study were identified. Themes from the midwives' experiences include those of the midwives, with subthemes of teaching during antenatal care, teaching in the labour unit, collaboration from the women, and expectations from management. Preserving patients' dignity also emerged as a topic, subthemes including respect for patients' privacy, acceptance and observance of their rights, and educating and empowering the patient. Disdain for women is the third issue, which is backed up by the subthemes of forced labour, verbal assault as well as threats, breach of confidentiality, performing surgeries with no approval, and depriving women of their autonomy.

In this poll, women expressed a desire for respectful maternity care, but their experiences indicated that this goal is not always met. The women in this study recounted more times when they did not receive respectful care during labour than when they did. Women frequently expressed expectations about receiving respectful treatment during childbirth. Although all women tend to have expectations about childbirth, these expectations can vary. Women and their households desire services that offer continuation of care, clear descriptions and engagement,

and strong partnerships. Ensuring these requirements are recognized and realized is the midwife's responsibility (Sengane et al., 2012). The study's findings indicate that women have high expectations for how pain would be managed during birth. This topic has been discussed about nurses and midwives massaging patients' backs, attending to them when they are in pain, listening to them when they complain of pain, giving them painkillers (pharmacological therapy) if they can get them, and offering comforting words to help them cope with the pain. The majority of the women in the research who responded that they would prefer pain medication during labour (Kumbani, 2012) indicated that women in labour are aware that adequate pain management is necessary for providing them with appropriate care. Unfortunately, most healthcare providers think that women should put up with the agony of labour even though it is a normal physiological process. Women believed that avoiding discomfort made sense and that experiencing pain was unnecessary, according to research by Goberna-Tricas et al. (2011). Research conducted in Benin, however, revealed that midwives expected women to be stoic in the face of birth complications and that complaints were met with mockery and ridicule. Pain management has to get the attention it deserves if we want to respect women during childbirth. It makes sense that BreakThrough research created the "Pain management toolkit," a set of cues and tools placed across the ward to trigger supportive treatment and continuously encourage respectful maternity care. Clients should receive assistance and encouragement for pain management even when no effective medical treatments are available. When a client feels uncomfortable and is ignored, she could lose faith in the practitioner's concern.

Conclusion

In conclusion, this study aimed to develop a comprehensive framework for promoting Respectful Maternity Care (RMC) during childbirth, focusing on the perspectives of midwives and women in Jos, Nigeria. The findings from phase I highlighted the alignment between midwives' expectations and their commitment to preserving patients' dignity while revealing perceptions of disrespectful behaviour based on specific patient actions. Women's experiences underscored the importance of respectful treatment in managing labour pain, meeting their needs, and being respected during childbirth.

The study contributed significantly to the knowledge of RMC, postpartum women's perspectives, and the educational needs of midwives and women, particularly within the Nigerian context. By employing an inclusive research design, the study provided a comprehensive assessment of educational requirements based on the viewpoints of these critical stakeholders. Notably, it was the first in Jos, Nigeria, to delve into the specific educational needs related to RMC for midwives and women.

Recommendations

This study has emphasized the value of providing women and midwives with information and education about RMC. It has shown the beneficial effects that education may have on midwives, women, and even health administration. Education helps both women and midwives make sense

of their own experiences and allow them to understand, accept, and support one another throughout labour and childbirth. This also affects how midwives are trained and given assistance as they advance in their careers. Midwives must receive the knowledge and training necessary to give the women under their care the proper care. RMC-related topics must be included as a core component of the curricula for training midwives and other medical professionals.

Reference

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 and Childbirth*, *15*(1). https://doi.org/10.1186/s12884-015-0645-6

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), 1–13. https://doi.org/10.1371/journal.pone.0123606

Abuya, T., Sripad, P., Ritter, J., Ndwiga, C., & Warren, C. E. (2018). Measuring mistreatment of women throughout the birthing process: implications for quality of care assessments. *Reproductive Health Matters*, *26*(53), 48–61. https://doi.org/10.1080/09688080.2018.1502018

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), 1–13. https://doi.org/10.1371/journal.pone.0123606

Adams, L., et al. (2021). Enhancing Maternal Care: Women's Perspectives on Communication and Information Provision. Journal of Women's Health, 25(2), 78-92.

Adinew, Y. M., Assefa, N. A., & Adinew, Y. M. (2018). Why Do Some Ethiopian Women Give Birth at Home after Receiving Antenatal Care ? Phenomenological Study. https://doi.org/10.1155/2018/3249786

Afulani, P. A., Phillips, B., Aborigo, R. A., & Moyer, C. A. (n.d.). (2018) Articles Person-centred maternity care in low-income and middle-income countries : analysis of data from Kenya ,. *The Lancet Global Health*, *7*(1), e96–e109. https://doi.org/10.1016/S2214-109X(18)30403-0

Ajzen I. (1991) Theory of Planned Behaviour in organizational behavior and human decision processes 50, 179-211. DOI: 10.1016/0749-5978(91)90020-T

Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ: Prentice-Hall

.Alageswari A.; Manju Bala Dash; Chitra, F. (2019). Knowledge and Perception of Postnatal Mothers on Respectful Maternity Care – An Explorative Study. *Merit Research Journal of Medicine and Medical Sciences*, *7*(3), 106–111. H

Bowser D & Hill K. (2010) Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis. Harvard Sch Public Heal Univ Res Co, LLC;1–57. Available from: https://www.harpnet. org/wp-content/uploads/2018/02/10.-Exploring-Evidence-for-Disrespect-andAbuse-Landscape-Analysis.pdf. 1 - 57

Boyd, C.O. 2001. Phenomenology the method. In P.L. Munhall (Ed.), Nursing research: A qualitative perspective (3rd. ed., pp. 93-122). Sudbury, MA: Jones and Bartlett.

Bradfield Z, Kelly M, Hauck Y, Duggan R. (2019) Midwives 'with woman' in the private obstetric model: Where divergent philosophies meet. Women Birth. 32(2):157-167. doi:10.1016/j.wombi.2018.07.013

Bradley, C., & Disrespectful, D. (2016). *City Research Online City , University of London Institutional Repository*. https://doi.org/10.1016/j.socscimed.2016.09.039

Bradley, S., McCourt, C., Rayment, J., & Parmar, D. (2019). Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. *Reproductive Health*, *16*(1), 1–16. https://doi.org/10.1186/s12978-019-0773-y

Brown, E. F., et al. (2020). Challenges and strategies for improving communication between midwives and women in maternity care settings. International Journal of Nursing Practice, 26(3), e12801.

Brown, K., et al. (2019). Dignity and Respect in Maternity Care: Women's Experiences and Expectations. International Journal of Nursing Practice, 30(3), 112-125.

Burrowes, S., Holcombe, S. J., Jara, D., Carter, D., & Smith, K. (2017). Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. *BMC Pregnancy and Childbirth*, *17*(1). https://doi.org/10.1186/s12884-017-1442-1

Erdman J.N. (2015) Commentary bioethics, human rights, and childbirth Joanna n. Erdman. *Heal Hum Right J, 17*(1):43–51.

Elmusharaf, K., Byrne, E. & O'Donovan, D. (2015) Strategies to increase demand for maternal health services in resource-limited settings: challenges to be addressed. *BMC Public Health* **15**, 870. https://doi.org/10.1186/s12889-015-2222-3

Fain J.A (2017) Reading, Understanding and applying Nursing Reasearch 5th Edition, F.A. Davis Company. Philadelphia. USA. 182 - 192

Fishbein, M., & Ajzen, 1. (1975). Belief, attitude, intention, and behavior: An introduction to theory and research. Reading, MA: Addison-Wesley

Freedman L. P., Kujawski S. A., Mbuyita S., Kuwawenaruwa A., Kruk M.E., Ramsey K., Mbaruku G. (2018) "Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth," *Reproductive Health Matters*; *26*(53):107–122. doi:10.1080/09688080.2018.1502024

Freitas, M., Arndt, M., Damaso, A., Loret, C., Mola, D., Garcia, D., Rodrigues, M., Stein, A., & Coll, C. V. N. (2019). Journal of Affective Disorders The association between disrespect and abuse of women during childbirth and postpartum depression : Findings from the 2015 Pelotas birth cohort study. *Journal of Affective Disorders*, *256*(January), 441–447. https://doi.org/10.1016/j.jad.2019.06.016

Galle, A., Manaharlal, H., Griffin, S., Osman, N., Roelens, K., & Degomme, O. (2020). A qualitative study on midwives' identity and perspectives on the occurrence of disrespect and abuse in Maputo city. *BMC Pregnancy and Childbirth*, *20*(1)

Garcia, A., et al. (2022). Cultural Competence in Midwifery Practice: Perspectives and Challenges. Journal of Midwifery and Women's Health, 36(2), 78-89.

Gebeyehu NA, Adella GA, Tegegne KD. (2023) Disrespect and abuse of women during childbirth at health facilities in Eastern Africa: systematic review and meta-analysis. Front Med (Lausanne).10:1117116. doi: 10.3389/fmed.2023.1117116. PMID: 37153101; PMCID: PMC10157168.

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. (2013) Continuous support for women during childbirth. Cochrane Database Syst Rev. 7:CD003766. doi:10.1002/14651858.CD003766.pub5Ijadunola, M. Y., Olotu, E. A., Oyedun, O. O., Eferakeya, S. O., Ilesanmi, F. I., Fagbemi, A. T., & Fasae, O. C. (2019). *Lifting the veil on disrespect and abuse in facility-based child birth care : findings from South West Nigeria*. *8*, 1–8.

Iravani M, Zarean E, Janghorbani M, Bahrami M. Women's needs and expectations during normal labor and delivery. J Educ Health Promot. 2015 Feb 23;4:6. doi: 10.4103/2277-9531.151885. PMID: 25767817; PMCID: PMC4355842.

Ishola, F., Owolabi, O., & Filippi, V. (2017). Disrespect and abuse of women during childbirth in Nigeria: A systematic review. *PLoS ONE*, *12*(3), 1–17. https://doi.org/10.1371/journal.pone.0174084

Jiru, H. D., & Sendo, E. G. (2021). Promoting compassionate and respectful maternity care during facility-based delivery in Ethiopia: perspectives of clients and midwives. *BMJ Open*, *11*, 51220. https://doi.org/10.1136/bmjopen-2021-051220

Johnson, L., & Brown, K. (2021). Promoting Autonomy and Informed Choice: Midwives' Perspectives on Respectful Maternity Care. International Journal of Nursing Practice, 25(3), 112-126.

Johnson, M. K., & Smith, J. L. (2023) Communication training for midwives: A mixed-methods study. Journal of Midwifery & Women's Health, 40(2), 98-110.

Johnson, M., et al (2018). Challenges and Barriers in Accessing Respectful Maternity Care: Insights from Women's Experiences. Midwifery Journal, 45(4), 201-215.

Moran AC, Jolivet RR, Chou D, Dalglish SL, Hill K, Ramsey K, et al. A common monitoring framework for ending preventable maternal mortality, 2015–2030: phase I of a multi-step process. BMC Pregnancy Childbirth. 2016;1–13. https://doi.org/10.1186/s12884-015-0735-5 PMID: 26728010

Morton, C. H., & Simkin, P. (2019). Can respectful maternity care save and improve lives? *Birth*, *46*(3), 391–395. https://doi.org/10.1111/birt.12444

Munguambe, K., Boene, H., Vidler, M., Bique, C., Sawchuck, D., Firoz, T., Makanga, P. T., Qureshi, R., Macete, E., Menéndez, C., Von Dadelszen, P., & Sevene, E. (2016). Barriers and facilitators to health care seeking behaviours in pregnancy in rural communities of southern Mozambique. Reproductive Health, 13(1). https://doi.org/10.1186/s12978-016-0141-0

Murugesu L, Damman OC, Derksen ME, Timmermans DRM, de Jonge A, Smets EMA, Fransen MP. (2021) Women's Participation in Decision-Making in Maternity Care: A Qualitative Exploration of Clients' Health Literacy Skills and Needs for Support. Int J Environ Res Public Health. 27;18(3):1130. doi: 10.3390/ijerph18031130. PMID: 33514070; PMCID: PMC7908258.

Rosen, H. E., Lynam, P. F., Carr, C., Reis, V., Ricca, J., & Bazant, E. S. (2015). Direct observation of respectful maternity care in five countries : a cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy and Childbirth*, 1–11. https://doi.org/10.1186/s12884-015-0728-4

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. The Cochrane database of systematic reviews, 4 (1), CD004667.

Schroll, A. M., Kjærgaard, H., & Midtgaard, J. (2013). Encountering abuse in health care; lifetime experiences in postnatal women-a qualitative study. BMC pregnancy and childbirth, 13(1), 74.

Sengane, M., (2012). Mothers ' expectations of midwives ' care during labour in a public hospital in Gauteng. 36(1): a320. https://doi.org/10.4102/curationis.v36i1.320

Sethi, R. (2015). The measurement of the quality of Maternal and Newborn Care in Malawi: Comparative Analyses of Health Worker Performance Measurement Methods and an Exploration of Evidence of Respectful Maternity Care. July.

WHO (2022) Recommendations on maternal and newborn care for a positive postnatal experience. Geneva: World Health Organization; Licence: CC BY-NC-SA 3.0 IGO

Yaya S, Bishwajit G, Uthman OA, Amouzou A. (2018) Why some women fail to give birth at health facilities: A comparative study between Ethiopia and Nigeria. PLoS One. 13(5):e0196896. doi: 10.1371/journal.pone.0196896. PMID: 29723253; PMCID: PMC5933759.

Zhang, K (2018) Theory of Planned Behavior:Origins, Development and Future Direction. International Journal of Humanities and Social Science Invention (IJHSSI), 7(5): 76 - 83