AN IN-DEPTH ANALYSIS OF MIDWIVES' UNDERSTANDING AND PRACTICE OF RESPECTFUL MATERNITY CARE IN GHANA: A FOCUSED ETHNOGRAPHIC STUDY

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DECLARATION

I hereby declare that this research is my original work, and my PhD thesis has been written entirely by me. All sources of information that supported the writing of this thesis document has been duly acknowledged. This thesis has also not been previously submitted for any degree at this or any other university.

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ABSTRACT

Background: Research that explored women's experiences of maternity care in lower-middle income countries including Ghana over the past decade has, unfortunately, highlighted the mistreatment that women suffer during childbirth which may be partly responsible for the low uptake of skilled birth attendants in these settings. This has resulted in the focus on respectful maternity care (RMC). The emphasis on RMC has increased research attention to the conceptualisation of RMC and strategies for its promotion. The research evidence indicates that RMC has mostly been conceptualised as the 'absence' of abuse, the lack of RMC viewed as a behavioural problem of providers, and providers' concerns about systemic contraints partially interpreted as a justification for the mistreatement of women. This has influenced the use of human rights approach and the training of providers as predominant strategies for promoting RMC. Therefore, these strategies, though necessary, have had limited effect on promoting RMC because they do not address constraints that hinder the provision of RMC in these settings. The current conceptualisation of RMC also does not reflect contextual nuances and the needs of providers. Furthermore, there is limited attention to the identification of causal mechanisms and an investigation of how these mechanisms interplay to influence the agency of providers. This research, therefore, sought to elicit midwives' (who form the majority of provders in maternity care) beliefs and experiences to facilitate the conceptualistion of RMC in a manner that refelcts local nuances not captured within universal frameworks. Additionally, this research sought to identify causative mechanisms and establish how they interplayed to influence midwives' agency during the provision of RMC.

Aim of the study: to understand midwives' views and beliefs about RMC in the Ghanaian context and how RMC was enacted, influenced, and experienced in practice by addressing the following specific objectives:

- To understand what RMC meant to midwives working in a maternity unit

- To explore the factors that influenced the provision of RMC
- To explore the facilitators and barriers for the provision of RMC

Methodology and methods: a focused ethnographic approach with a critical realist philosophical underpinning. Data collection was carried out in three phases, in three different facilities, and using three different methods: (i) audio-taped focus group discussions with midwives (ii) participant observations at the labour wards, and (iii) audio-taped interviews with other stakeholders including directors of health facilities whose contribution to the care provided by midwives were identified by the researcher. Ethical approval was obtained from the Ghana Health Service Ethics Review Committee (Reference number GHS-ERC: 013/10/2018) and the University of Nottingham Faculty of Medicine and Health Sciences Ethics Committee (reference number: 154-1811). Informed consent was obtained from all participants prior to data collection. Recorded data was transcribed verbatim and coded. NVIVO software was used to facilitate the data analysis process. Thematic analysis of data was carried out using a realist-informed inductive and iterative process. The analysis was deepened by incorporating critical realist principles of abduction and retroduction to enable the identification of causative mechanisms influencing RMC.

Findings: three main themes emerged:

1. Reciprocal respect and mutual satisfaction: establishing a value-based midwife-woman relationship
2. Causal connection between structural deficiencies and inequalities on care and women's agency and autonomy
3. A fractured midwife-woman relationship

The core feature of RMC was the midwife-woman relationship with principles that are focused on reciprocal respect and mutual satisfaction for both women and midwives but underpinned by woman-centred care. Midwives utilised embodied values involving spirituality and notions of kinship attachment to develop a supportive relationship with

women and to ensure the presence of RMC. The values of reciprocity, mutuality, spirituality, and kinship attachment inherent in this concept facilitated the creation of a culturally sensitive and context specific concept of RMC. This is a novel finding from the study which extends the existing concept of RMC beyond the 'absence' of abuse. The initial approach utilised by midwives when the woman first reported in labour also emerged as highly significant in shaping the nature of the relationship. Ensuring the preservation of women's dignity, privacy, and confidentiality were also considered aspects of the RMC concept. Based on these findings, a conceptual framework for RMC was developed which established the connection between these elements. Observational data revealed that this idealised concept, however, did not always manifest in practice. The research found that resource constraints, lack of interprofessional collaboration, lack of concern for midwives' wellbeing, and midwives' fear of adverse outcomes and subsequent blame resulted in the lack of enactment of the idealised RMC concept. To enable the identification of deeper structures that had stronger causal connection with midwives' agency, the themes were further analysed using the critical realist principle of retroduction. This resulted in the postulation of five causative mechanisms and explanation was given on how these mechanisms interacted to influence midwives' agency, the midwife-woman relationship, and thus the provision of RMC which had been unrecognised. For instance, structural and gender-based violence and risk aversion arising from the fear of adverse outcomes and blame were causative mechanisms with deeper causal powers to influence midwives' paternalistic approaches care to ensure safe outcomes. The identification of these underlying mechanisms are key contributions of this study that extend the knowledge on factors influencing the provision of RMC. A conceptual model was developed to highlight the regularities and mechanisms that shaped the nature of agencies and influence the provision of RMC.

Conclusion: This study has presented novel contributions to the RMC discourse globally and in Ghana specifically and addressed some gaps within the global RMC concept. The study has highlighted that RMC is underpinned by a value-based midwife-woman-relationship which

though woman-centred, was reciprocal, focusing on women's unique experiences of care and midwives' experience of care provision. The identification of causative mechanisms through critical realism illuminated the real mechanisms that shaped the nature of RMC provision. The findings have demonstrated that the current discourse around RMC which positions care providers as perpetrators of mistreatment and women as victims needs to be broadened to include the systemic complexities that shape the agency of providers and the nature of care delivery. Ensuring RMC, therefore, requires a broader approach which addresses not just the safety of women, and the training and skill needs of midwives (both of which are common in the current literature) but also prioritises the creation of an enabling environment in terms of midwives' professional recognition, interprofessional collaboration, resources, and leadership.

Recommendations for future policy, practice, and research: The midwife-woman relationship has been the locus of interest in this study with regards to RMC. Strategies are, therefore, required to mitigate the challenges within this relationship. Development of a model of care that is context specific, recognises and acknowledges the realities of care yet inculcates the tenets of woman-centred care is required. This will facilitate the translation of the idealised value and relationship-based woman-centred approach to RMC into practice. The initial approach/interaction within the midwife-woman relationship when a woman reported to the facility in labour emerged as highly significant in this study. Hence, there is the need for further research to establish approaches that will enhance this initial encounter. Policies and guidelines which are woman-centred, context specific, and culturally sensitive and integrate both the views of women and midwives through robust research must be developed. A study that targets the wider health system stakeholders is also needed to gain an in-depth understanding of how the dynamics of power, management of risks, and the distribution of resources are contributing to creating the culture within the health care system and how care is provided. Further research into Interprofessionalism and shared decision-making in maternity care within the Ghanaian context will be necessary to test best practice

approaches to determine models for practice that will promote interprofessional collaboration and teamwork.

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"Not to us, O LORD, not to us but to your name be the glory, because of your love and faithfulness." Psalm 115: 1

I would like to thank the participants and the facilities involved in this study for giving me entry to their social world and enabling me to use their voices and experiences to develop this project. This study began with a desire to change the status quo in midwifery practice, improve women's experience of midwifery care, and enhance the provision of maternity care in Ghana. I (we) as midwife(s) share the common desire of empowering ourselves and transforming our practice even in the face of the untold challenges that beset us and the system in which we function. I am grateful that the stories of midwives will become one of the foundations on which the future will be built.

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CONFERENCE AND SEMINAR PRESENTATIONS FROM THIS STUDY

Towards a midwifery model of care: The midwife-woman relationship- A focused ethnographic study of midwives' views and beliefs about respectful maternity care in Ghana. Presentation at the Faculty of Medicine, Universitas Brawijaya, Indonesia in 2021

Respect is relational: A fractured midwife-woman relationship A focused ethnographic study of midwives' views and beliefs about respectful maternity care in Ghana. Virtual International Day of the Midwife, 2021

Respect is system shaped: A conceptual model of the influences on respectful maternity care in Ghana. Poster presentation at the University of Nottingham School of Health Sciences research festival, 2021

Respectful Maternity Care: Dual contexts and perspectives. Joint presentation with the University of Amsterdam at the University of Nottingham Maternal Health and Wellbeing Research Group Seminar in 2021

Respect is reciprocal – initiating and maintaining a midwife-woman relationship: views and beliefs of midwives about respectful maternity care in Ghana. Poster presentation at the Glow conference 2020.

Respectful maternity care among midwives in a maternity unit: A focused ethnography. Presentation at the Life beyond PhD conference in 2018.

LIST OF ABBREVIATIONS

ANC	Antenatal Care
CS	Caesarean Section
COPE	Client-Oriented Provider-Efficient services
CR	Critical Realism
D&A	Disrespect and Abuse
DDNS	Deputy Director of Nursing Services
FE	Focused Ethnography
FGD	Focus Group Discussion
FIGO	International Federation of Gynaecology and Obstetrics
GDP	Gross Domestic Product
GHS	Ghana Health Service
ICM	International Confederation of Midwives
IPC	Interprofessional Collaboration
LWM	Labour Ward Manager
MMR	Maternal Mortality Rates
MDGs	Millennium Development Goals
MOH	Ministry Of Health
NHIS	National Health Insurance Scheme
NMC	Nursing And Midwifery Council
PCC	Person-Centred Care
PCMC	Person-Centred Maternity Care
PO	Participant Observation
PTSD	Post-Traumatic Stress Disorder
QCO	Quality Control Officer
RMC	Respectful Maternity Care
SBA	Skilled Birth Attendance/Attendant

SDG	Sustainable development Goals
SSI	Semi-Structured Interview
TBA	Traditional Birth Attendant
UK	United Kingdom
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Education Fund
VCAT	Values Clarification and Attitude Transformation
WRA	White Ribbon Alliance
WHO	World Health Organisation

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CHAPTER ONE: INTRODUCTION

1.1 Background of the study

This PhD thesis reports on a study conducted in Ghana that aimed to understand midwives' views and beliefs about Respectful Maternity Care (RMC) and how RMC was enacted, influenced, and experienced in practice. As a midwife with experience in clinical practice, and education in Ghana, my interest in RMC emanated from the encounters of mistreatment of women and the poor treatment of midwives within the care system. As I progressed through my career and held leadership positions, I developed a strong interest in the development of strategies to mitigate these problems. This study, therefore, sought to gain insight to facilitate the development of robust strategies.

Poor quality maternal healthcare has been reflected in high maternal mortality rates (MMR). Though there was a halving of mortality rates globally between 1990 and 2015 with the implementation of strategies to meet the Millennium Development Goals (MDGs), this progress was sporadic (Kruk, Kujawski, Moyer et al., 2016; United Nations, 2000). Increased access to Skilled Birth Attendants (SBAs) (Midwives, doctors, and nurses) (UNFPA/ICM/WHO, 2014) received urgent attention when it was highlighted as a key indicator for the attainment of the MDG 5 (World Health Organization, 2004). Countries including Ghana, have, thus made remarkable progress in scaling up of access to SBAs (World Health Organisation, 2021b). Despite this improvement, quality maternal healthcare in many lower-middle income countries, in particular, is still not a guarantee for many (Reis, Deller, Carr et al., 2012). The behaviours of SBAs have unfortunately become one of the barriers to the utilisation of maternal healthcare (Moyer, Rominski, Nakua et al., 2016).

Research over the past decade have highlighted high levels of disrespect and abuse (D&A) that women may encounter during facility-based birth with the identification of various categories of D&A or mistreatment (Bohren, Vogel, Hunter et al., 2015; Bowser and Hill, 2010;

Jolivet, 2012). This represents a violation of the trust that exists between women and their healthcare providers and can be a source of discouragement for women seeking maternal healthcare (World Health Organization, 2014). D&A does not only deter women from accessing SBAs but also has lasting effects on them. For example, in a quantitative systematic review, Shorey, Yang, and Ang (2018) found positive associations between negative childbirth experience and the decision to delay subsequent births and increased maternal requests for caesarean section (CS). In an earlier systematic review of quantitative studies and case studies by Olde, van der Hart, Kleber et al. (2006), the authors reported negative staff interaction with women as a risk factor for post-traumatic stress disorder.

D&A devalues women and is indicative of a crisis in quality and a breakdown of accountability of the healthcare system (Freedman and Kruk, 2014). In their recommendations for intrapartum care, the WHO cited the promotion of RMC as the first recommendation for a positve childbirth experience (World Health Organisation, 2018). There is, therefore, the need to intensify efforts to eliminate all forms of D&A and to promote RMC especially within healthcare systems like Ghana (where the study was conducted). Strategies that are adopted to promote RMC must be informed by concrete context specific evidence obtained from both women and midwives. Thus, necesitating the adoption of an inductive approach to the exploration of the perspectives of midwives in Ghana, who form the majority of care providers. To achieve this, it is expedient to first explore the system that shapes the nature of care provision. This chapter will, therefore, explore the healthcare system in Ghana with a focus on maternal healthcare and the challenges and strategies that have been implemented to mitigate these challenges. Women's experience of maternity care will also be discussed.

1.1.1. Healthcare system in Ghana

The healthcare system in Ghana is controlled by the Ministry of Health (MOH) in partnership with other agencies accountable for the promotion and delivery of healthcare in Ghana. The health workforce within this system is grossly inadequate. According to current available data,

there were 3,236 doctors and 82,462 nursing and midwifery personnel in 2019 representing 1.06 and 27.11 per 10,000 population respectively (World Health Organisation, 2021a). Whilst the number of doctors has steadily increased over the years, the nursing and midwifery workforce saw a drastic decrease from 135,513 presenting 45.52 per 10,000 in 2018 to 82,462 in 2019 representing 27.11 per 10,000. This can be linked to migration to other destinations (Teye, Setrana, and Acheampong, 2015). Alhassan and Nketiah-Amponsah (2016) have also emphasised that these professionals are poorly motivated due to inadequate resources leading to poor quality of care and patient safety. Current available data from the MOH indicate that these personnel operate within 5,865 healthcare institutions in Ghana, comprising of Community-based Health Planning and Services zones, clinics, district hospitals, health centres, hospitals, midwife-led maternity homes, Polyclinics, and Psychiatric hospitals (Ministry of Health, 2015) (See table 1). This table, however, does not consider the Christian Health Association of Ghana and quasi government facilities such as university hospitals, military and police hospitals which also contribute to the number of facilities in Ghana.

Ghana is a country in Sub-Sharan Africa with a comparatively low expenditure on health. According to figures from the World Bank, the total expenditure on health as a percentage of Ghana's Gross Domestic Product in 2018 was 3.54%, which is below the average of 4.09% and 5.9% for lower middle-income countries and Sub-Saharan Africa respectively (World Bank, 2021). This represents a decrease from 4.62% in 2015 and 5.4% in 2013 (World Bank, 2021). Despite this downward trend in government's investments in the health sector, various reforms have led to improved access to health and health outcomes.

Table 1: Number of health facilities in Ghana in 2015

Region	CHPS	Clinic	District Hospital	Health Centre	Hospital	Midwife / Maternity	Mines	Polyclinic	Psychiatric Hospital
Ashanti	906	116	25	141	94	71	0	0	0
Brong Ahafo	423	107	18	83	13	41	0	4	0
Central	219	67	12	64	15	35	0	2	1
Eastern	477	112	14	84	16	25	0	2	0
Greater Accra	176	277	6	20	70	86	0	12	2
Northern	185	57	15	83	12	9	0	4	0
Upper East	233	48	6	44	1	2	0	0	0
Upper West	176	15	3	68	6	5	0	5	0
Volta	273	39	17	146	11	16	0	2	0
Western	267	144	18	59	20	36	3	1	0
National	3335	982	134	792	258	326	3	32	3

These include the introduction in 2003 of the National Health Insurance Scheme (NHIS) by an act of parliament (ACT 650 and amended to ACT 852) and fully implemented in 2004 (National Health Insurance Authority, 2009). The aim of introducing the NHIS was to remove the financial barriers to accessing health and improving the universal health coverage (Atinga, Abekah-Nkrumah, and Domfeh, 2011). Though the scheme has contributed to improved health coverage (Mensah, Oppong, and Schmidt, 2010), this is not commensurate with the quality of services provided due to lack of adequate resources for the sector (Fenny, Kusi, Arhinful et al., 2016) and some level of wastage of scarce resources (Alhassan, Nketiah-Amponsah, Akazili et al., 2015). According to Alhassan, Nketiah-Amponsah, and Arhinful (2016), the capacity of the NHIS to continuously contribute to the universal health coverage, is hampered by escalating cost, political interference, inadequate technical capacity, inadequate monitoring mechanisms, large exemption groups, and poor quality of care within NHIS certified health facilities. These have resulted in the lack trust and utilisation of the scheme. To attain the Sustainable Development Goal (SDG) 3 of ensuring healthy lives and promoting well-being for all at all ages (United Nations, 2015), Ghana's health system needs to be strengthened particular through the improvement of its financing system and its health

workforce. One of the indicators of health in need of strengthening is maternal health and a discussion of this sector in Ghana is presented below.

1.1.2. Maternal healthcare in Ghana

Maternal healthcare has consistently remained a priority in Ghana and the government has regularly developed strategies to improve this sector. One of these strategies is the promotion of SBA, in accordance with international recommendations. In Ghana, which had a population estimated at 31.7 million (United Nations Population Fund, 2021), SBA is provided by midwives, doctors, nurses, and community health nurses with midwives forming the largest group of providers (Prosser, Sonneveldt, Hamilton et al., 2006). There are an estimated 12,673 midwives in Ghana (World Health Organisation, 2021a) with 56% being relatively young (<35years) (World Health Organisation, 2021b). This represents a significant increase up from 4,929 in 2010, when an estimated 79% were in older age ranges (between the ages of 41 and 60 years) (Ghana Health Workers Observatory, 2011; Prosser et al., 2006). This has been attributed to an increase in the number of educational institutions and a resultant increase in the number of midwives educated (Ghana Health Service, 2017).

This improvement has yielded benefits as evidenced by the significant improvement in some maternal health outcome indicators over the last decade. Current available data indicates that 98% of women received antenatal care (ANC) from a skilled provider (70% from midwives/nurses, 24% from doctors, 6% from community health nurses), 89% attended the recommended four or more ANC visits and there were 79% institutional deliveries (91% were in urban and 69% in rural areas) (Ghana Statistical Service, Ministry of Health, and The DHS Program, 2018). These achievements have, nonetheless, failed to propel Ghana towards where it wants to be. Like other lower-middle income countries, achieving MMR at target levels continues to be a challenge in Ghana as evidenced by the inability to reach the MDG 5 of reducing MMR by three quarters (Dalaba, Akweongo, Savadogo et al., 2013).

The MMR in Ghana is 308 per 100,000 live births (World Bank, 2019). Maternal mortality was declared a national emergency in Ghana in 2008 (Ministry of Health, 2008), however, constraints within the healthcare system have made reducing this rate a challenge. For instance, despite the significant increase in SBAs (Ghana Statistical Service et al., 2018) and the innovative free maternal healthcare scheme introduced in 2005 (Dzakpasu, Soremekun, Manu et al., 2012), there continue to be variations in the uptake of SBAs. For example, in some regions, skilled attendance during ANC was as high as 97.7% whilst institutional deliveries was only 59.2% (Ghana Statistical Service et al., 2018). This represents a considerable gap between skilled attendance during pregnancy and SBA. Lack of transportation and accessible roads continue to be causative factors for this low uptake (Ghana Statistical Service et al., 2018). However, there is little evidence regarding why despite these challenges women do seek out ANC, but not SBA. According to the Ghana Statistical Service et al. (2018) the frequently mentioned reason was the lack of awareness of the onset of labour and challenges with transportation, with more women in the rural areas reporting transportation challenges.

Proper utilisation of the services of SBAs has significant implications on universal access to maternal healthcare for the improvement of maternal health outcomes. Research conducted in 12 public health facilities in Ghana identified that the underutilisation of existing services especially SBAs did not only lead to poor maternal health outcomes but also led to high unit cost for the government (Dalaba et al., 2013), who is investing money into services that are not being utilised. This information is useful for the distribution of scarce resources and the financing of the NHIS. Evidence also indicates that the under-utilisation of SBAs can be attributed to women's experiences of facility-based birth. There have been widespread reports of D&A that women encounter when seeking care during labour and it is hypothesised that this D&A may be deterring women from the continued uptake of these services (Bohren et al., 2015; Bowser and Hill, 2010). This is further expanded on in the section below.

1.1.3. Women's experiences of the maternity care system

Poor provider attitude has been discussed in professional and public spheres in Ghana for many years, but relatively little appears to have changed (Dzomeku, Mensah, Nakua et al., 2020a). In spite of early awareness of D&A through research (D'Ambruoso, Abbey, and Hussein, 2005), liitle response has been elicited from governement and professional bodies in addressing the issue. Evidence from the past decade has highlighted the widespread D&A during facility-based birth especially in low-middle income countries including Ghana. In the explorations of the experiences of women during childbirth in public healthcare institutions in Ghana, researchers assert that women report both positive and negative childbirth experiences (Afaya, Dzomeku, Baku et al., 2020; Afaya, Yakong, Afaya et al., 2017; Dzomeku, van Wyk, and Lori, 2017; Mensah, Mogale, and Richter, 2014) with greater attention given to women's negative experiences (Adatara, Strumpher, and Ricks, 2019; Ameyaw, Amoah, Njue et al., 2021; Maya, Adu-Bonsaffoh, Dako-Gyeke et al., 2018). Maya et al. (2018) explored the perspectives of women on mistreatment as part of a World Health Organization (WHO) study and highlighted that the mistreatment women experienced often occurred during the second stage of labour and resulted from their inability to push, reporting without the needed items for birth, or the lack of adherence to instructions.

The mistreatment of women during facility-based childbirth is a global phenomenon earmarked as a deterrent to the utilisation of SBA (Ganle, Parker, Fitzpatrick et al., 2014; Wassihun and Zeleke, 2018). Based on an earlier comprehensive review of the evidence, Bowser and Hill (2010) identified seven categories of D&A in childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. In a mixed methods systematic review by Bohren et al. (2015) including 65 studies from 34 countries, seven domains of mistreatment were identified which included: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints. Though these

typologies may have some differences, the underlining factors are the lack of professionalism and the disregard of basic human rights. National and international recognition of women's experiences during facility-based birth have, therefore, gained momentum and culminated in the ongoing implementation of strategies to mitigate this problem and promote RMC.

1.1.4. Respectful maternity care

In order to build momentum towards RMC and the achievement of the SDGs, many international bodies like the WHO, International Confederation of Midwives (ICM), International Federation for Obstetricians and Gynaecologists (FIGO), and the White Ribbon Alliance (WRA) are increasingly recognising and promoting RMC as a critical strategy for the improvement of the quality and utilisation of maternal healthcare (Molina, Patel, Scott et al., 2016). In the WHO's recommendations on intrapartum care for a positive childbirth, RMC was the first recommendation made for the optimisation of the childbirth experience. The guideline defined RMC as "care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth" (World Health Organisation, 2018, p.3). RMC is also an individualised approach to care that is based on the principles of ethics and respect for human right. It promotes practices that are based on women's choices and the needs of women and their newborns (Reis et al., 2012). This concept will be further explored with its constituent components in addition to the strategies that have been adopted to promote and measure it in the scoping review in the next chapter.

1.2. Structure of the thesis

The thesis is presented in nine chapters. The first chapter is the introduction which presents the background of the research. This section explored the health system in Ghana, the challenges in the system, and the strategies implemented to mitigate them. Specific interest was given to the maternal health system and women's experiences of this system were described while focusing on the problem of D&A. Finally, the focus of this study, RMC, was briefly described as a preamble. The first-person singular is used throughout the thesis as is appropriate in qualitative research and to maintain reflexivity throughout thesis.

Chapter two focuses on the review of relevant literature on RMC, constructed as a scoping review following the Joanna Briggs Institute guide for scoping reviews. This section present findings from the review by exploring the conceptualisation of RMC, interventions implemented to promote RMC, and tools developed to measure RMC. The gaps within the literature which necessitated the conduct of this study are highlighted during the presentation of findings. This chapter concludes with the justification for the current study and the aims and objectives of the study.

Chapter three presents the methodology and methods adopted in the conduct of the study. A description of focused ethnography and critical realism as the philosophical underpinning is carried out followed by the methods adopted for the conduct of the study. The adaptations made within the thematic analysis approach to facilitate the incorporation of critical realist principles for the identification of causative mechanisms is also highlighted. The chapter concludes with a discussion on how quality was maintained in the study and my reflexive account of the research process.

Chapter four begins the description of the findings of the study. Presentation of the core concept of RMC which is the midwife-mother relationship as first theme is carried out. This chapter describes the nature of reciprocal respect and mutual satisfaction within the value-based midwife-woman relationship and the components inherent in the establishment of this

relationship. A conceptual framework for RMC is developed, which summarises the components of RMC.

Chapter five explores the second theme of the research findings. This section discusses the complexities within the health system which have culminated in the loss of women's autonomy and agency whilst identifying the causative mechanisms that interact to produce this outcome. The chapter highlights the lack of human and material resources, issues relating to professionalism and interprofessional relationships, midwifery subordination, the absence of supportive leadership, and midwives' fear of adverse outcomes and blame.

Chapter six presents the final theme which provides an account of the fracturing of the midwife-woman relationship. The factors identified included the rejection of midwives' professional identity, the normalisation of the culture of reciprocal abuse, language barrier, and the financial cost of maternity care to women. Causative mechanisms are also identified in this chapter.

Chapter seven provides further explanation of the causative mechanisms that were postulated using the process of retroduction in the findings chapters. A conceptual model of all the factors influencing the provision of RMC is developed with domains that characterise the various factors and a summary provided.

Chapter eight is a discussion of the findings and an explanation of the causative mechanisms identified which is carried out in relation to the wider literature. This chapter has two sections. The first presents a description of the relational nature of respect with an in-depth analysis of the complexities within the midwife-woman relationship. The second section deliberates on the systemic factors influencing the provision of maternity care. These included stress, risk aversion, structural and horizontal violence as well the hierarchy of power and these are explored in-depth.

Chapter nine, the final chapter of this thesis, presents the conclusions drawn from this study. The study findings are summarised by highlighting the key contributions to the RMC

discourse as well as the provision of maternity care in Ghana. Recommendations are made for the improvement of different aspects of the maternity care system. Finally, the strengths and limitations of the study are presented.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In the previous chapter, an introduction to the healthcare system in Ghana was presented with a highlight of the challenges and the need for RMC. This chapter will review the existing literature on RMC and identify gaps for further research. The literature review adopted a scoping review methodology using the Joanna Briggs Institute (JBI) guide for scoping reviews (Peters, Godfrey, McInerney et al., 2015). The aim of this review was to identify and critique the nature and scope of existing literature on RMC irrespective of methodology, country, or context to demonstrate gaps in the evidence base and to justify the need for the proposed study. A scoping review can be used to identify how research is conducted in a particular field, clarify concepts, and identify key factors and gaps in knowledge relating to a particular field (Peters, Godfrey, McInerney et al., 2020). Unlike systematic reviews which address very precise questions (Joanna Briggs Institute, 2014), the scoping review approach is used to map existing evidence, to clarify key concepts, and to determine what specific questions can be posed and valuably addressed through further research (Peters et al., 2015). It was utilised to facilitate the mapping of existing evidence on RMC, identify the key concepts within it, and the contributory factors to the current nature of RMC. This enabled the identification of gaps within the available evidence which informed the conduct of further research.

2.2. Method of scoping review

The scoping review presented here was conducted in two stages. In order to help formulate the research question (prior to the initiation of fieldwork), a review was first conducted between June 2018, and September 2018. It was then updated between August 2021 and October 2021 after completion of the fieldwork, for the purpose of ensuring the final thesis

presented an up-to-date picture. The review presented below combines the searches undertaken in 2018 and 2021.

Scoping reviews provide an overview of existing evidence irrespective of its quality and the aim of this review was to provide a narrative description of available literature to facilitate the identification of gaps for further research. Therefore, no assessment of methodological quality was conducted for the included papers. However, to improve the quality of reporting and methodological conduct, the JBI Manual for Evidence Synthesis (scoping reviews) (Peters et al., 2020) and the PRISMA extension for scoping reviews (PRISMA-ScR) (Tricco, Lillie, Zarin et al., 2018) were referred to. The scoping review framework from Peters et al. (2020) was the primary guideline for reporting this review. This approach is congruent with the PRISMA-ScR checklist, and both have influenced how this review is reported.

This review is entitled: Exploring respectful maternity care during facility-based birth: A scoping review. The review addressed the following broad question: how has RMC been conceptualised, promoted, and measured? The following sub- questions facilitated the mapping of the evidence:

- How has RMC been conceptualised?
- What are the strategies that have been utilised to facilitate and promote RMC?
- What tools have been developed and used to measure RMC during facility-based births?

2.2.1. Eligibility criteria

The “PCC” (Population, Concept, and Context) mnemonic is a recommended guide for constructing a title for a scoping review and the inclusion criteria must correspond with this. The eligibility criteria for included studies is presented in table 2.

Table 2: Eligibility criteria

Criteria	*Inclusion*	*Exclusion*
Type of participants	All types of participants were included	No category of participants was excluded
Concept	Studies that focused on RMC including studies that had focused on how RMC is conceptualised, measured and the interventions implemented to promote RMC	Studies that had focused on D&A including its typologies, the implementation of interventions aimed at eliminating D&A, and tools to measure D&A without a focus on RMC were excluded
Context	All contexts were included Facility-based births	No context was excluded Births that occurred outside of health facilities
Types of sources of evidence	All types of studies were included if published in English. Commentaries on interventions with no published empirical studies. All types of reviews focused on RMC	Commentaries on interventions were excluded if an empirical study on the same intervention has been published. Policy documents were excluded. Reviews focused on D&A

2.2.2 Search strategy

The search strategy aimed at identifying both published and unpublished studies. This updated search was conducted between 23rd August and 3rd September 2021. A three-step approach was utilised as outlined in the table 3 and the key words which facilitated the search are presented in table 4.

Table 3: Search strategy

Steps	Description
First step	A limited search of MEDLINE and google scholar using the keywords 'respectful maternity care'. The titles and abstract of identified articles were analysed for keywords and index terms that described the articles
Second step	A comprehensive search of several databases was carried out using identified keywords (table 4) and MeSH headings. The databases searched were ASSIA, CINAHL, MEDLINE, PsycINFO, and Web of Science. Search terms were combined with Boolean operators OR, AND and NOT. Grey literature was also searched including WHO website, White Ribbon Alliance and google scholar. All retrieved articles were exported to Endnote referencing software where the titles and abstract of the articles were assessed for inclusion
Third step	A hand search of reference lists of identified relevant papers, was carried out, for additional studies that may have been missed during the systematic search

Table 4: Key words/terms

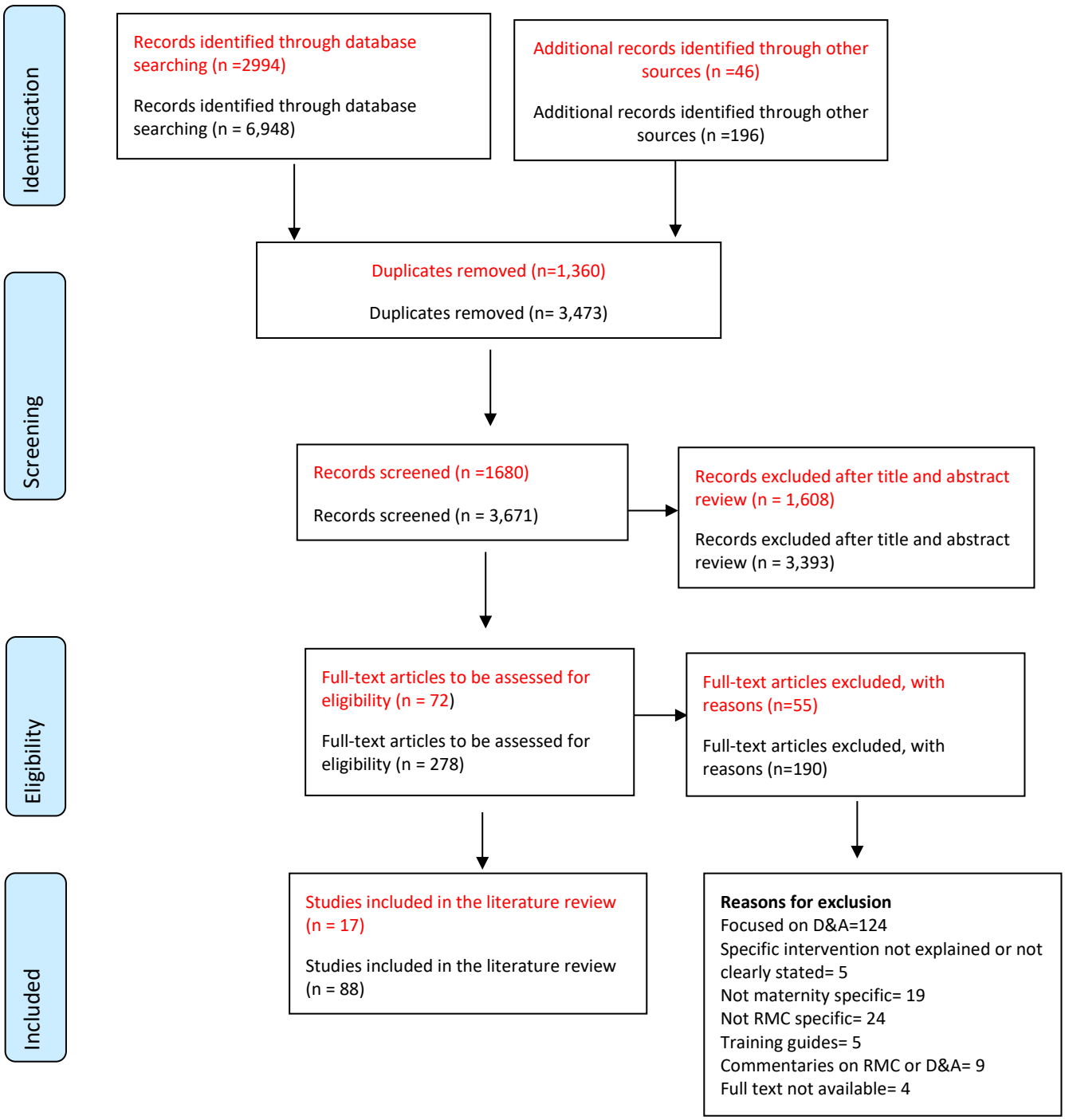
Key Concepts	*Synonyms/related terms/alternative terms for keywords*
Respect	Respect*, digni*, humani*, human right, compassion*
Maternity care	Childbirth, maternal health care, maternal health service, deliver*, maternal care, maternity services
Facility based birth	Facility based birth, hospital birth, hospital-based birth, hospital-based deliver*, intrapartum care, maternity care, institutional birth*
Conceptualisation	View*, belie*, opinion*, understand*, perspective*, perception*, experience*

2.2.3 Result of search

The result of the search is presented in the Prisma flow diagram in figure 1. The results from the initial search are presented in red and the updated version in black. The initial and updated searches yielded 3,040 and 7,144 records from databases and other sources like

grey literature and google scholar respectively. The data obtained were exported to Endnote software and duplicates removed with software and then later manually when identified. The process of analysis led to the inclusion of 17 studies in the initial review and 88 studies in the updated version. These comprised of empirical studies, systematic reviews, and commentaries. A summary of the included articles is presented in appendix 1.

Figure 1: Prisma 2009 Flow Diagram



(Moher, Liberati, Tetzlaff et al., 2009)

2.2.4. Data synthesis and analysis of the evidence

Titles, abstracts, and full texts were screened in a stepwise manner to exclude papers that did not meet the inclusion criteria. Discrepancies were discussed with supervisors and a consensus reached. Data was grouped according to the type of study. Commentaries on interventions were grouped separately, and the data on the intervention extracted and reported on. Extracted data included aims and objectives, study design, research setting, methodology and methods, study population, and findings. Data was extracted according to their relevance to the review questions and objectives. Tables were used to summarise the extracted data (see appendix 1). The tables are categorised into empirical studies that conceptualised RMC, reviews that conceptualised RMC, interventions to promote RMC, systematic reviews, and commentaries on interventions to promote RMC, empirical studies on tools to measure RMC, and systematic reviews on tools to measure RMC. Findings were analysed according to their relevance to the review questions. A narrative description of the analysis is then presented in themes.

2.3. Characteristics of included papers

The initial scoping review included 14 primary studies (Ackers, Webster, Mugahi et al., 2018; Erlandsson, Sayami, and Sapkota, 2014; Geddes, Humphrey, and Wallace, 2017; Hall and Mitchell, 2017; Ndwiga, Warren, Ritter et al., 2017; Ouédraogo, Kiemtoré, Zamané et al., 2014; Rosen, Lynam, Carr et al., 2015; Sheferaw, Bazant, Gibson et al., 2017; Sheferaw, Mengesha, and Wase, 2016; Shimoda, Horiuchi, Leshabari et al., 2018; Vedam, Stoll, Martin et al., 2017; Vedam, Stoll, Rubashkin et al., 2017; Warren, Ndwiga, Sripad et al., 2017; Wilson-Mitchell, Robinson, and Sharpe, 2018), 3 reviews (Downe, Lawrie, Finlayson et al., 2018; Ratcliffe, 2013; Shakibazadeh, Namadian, Bohren et al., 2018), and 1 commentary (Austad, Chary, Martinez et al., 2017). None of the primary studies included in this scoping review had been included in any of the reviews identified. The primary studies included six qualitative studies (Ackers et al., 2018; Erlandsson et al., 2014; Rosen et al.,

2015; Sheferaw et al., 2017; Shimoda et al., 2018; Vedam et al., 2017), one quantitative study (Vedam et al., 2017), two mixed method studies (Ndwiga et al., 2017; Sheferaw et al., 2016), and five reported interventions including the commentary (Austad et al., 2017; Geddes et al., 2017; Hall and Mitchell, 2017; Warren et al., 2017; Wilson-Mitchell et al., 2018). Only three of the primary studies were conducted in high-income countries: one in the United Kingdom (UK) (Hall and Mitchell, 2017) and two in Canada (Vedam et al., 2017, Vedam et al., 2017). Two were conducted in South America (Austad et al., 2017; Erlandsson et al., 2014) and nine in Africa (Ackers et al., 2018; Geddes et al., 2017; Ndwiga et al., 2017; Rosen et al., 2015; Sheferaw et al., 2017; Sheferaw et al., 2016; Shimoda et al., 2018; Warren et al., 2017; Wilson-Mitchell et al., 2018). This low-income country focus may have resulted from the high number of studies that had reported D&A in these countries and the focus on ensuring RMC within these countries. However, none of these studies had been conducted in Ghana.

Though RMC had predominantly focused on care during childbirth, all the studies focused on professionals within maternal healthcare in general and not those in a specific clinical setting. Two studies focused specifically on midwives (Shimoda et al., 2018; Wilson-Mitchell, Marowitz, and Lori, 2018), one specifically on midwifery students (Hall and Mitchell, 2017) and nine involved a combination of stakeholders such as women, providers, managers at different levels (national, local), and policy makers (Ackers et al., 2018; Erlandsson et al., 2014; Geddes et al., 2017; Ndwiga et al., 2017; Ouedraogo et al., 2014; Rosen et al., 2015; Sheferaw et al., 2017; Sheferaw et al., 2016; Warren et al., 2017). Two of the studies also focused only on women's experiences (Vedam et al., 2017; Vedam et al., 2017).

This initial scoping review highlighted a dearth of reports of the opinions of frontline health professionals in maternity care, especially midwives from Ghana. Furthermore, in-spite of the report of D&A in Ghana (Dzomeku et al., 2017; Moyer et al., 2014) and though alarmingly D&A appeared to be justified even by student midwives (Rominski, Lori, Nakua et al., 2017), there was no focus on RMC within the Ghanaian context. This current PhD

research was, therefore, conducted to elicit the views and beliefs of midwives and other stakeholders like ward managers on RMC and to investigate the facilitators and barriers for the provision of RMC. However, since the conduct of the fieldwork, there has been an increased focus on RMC and midwives' perspectives specifically in several countries including Ghana which can be noted in the updated version of the review. Nonetheless, the continued presence of gaps within the evidence obtained made the findings of this study vital in addressing these. More details on the justification for the study will be presented in section 2.8 of this chapter. The characteristics of the studies included in the updated review is presented in table 5 below.

Table 5: Characteristics of included studies

Characteristic of study	Number	Reference
Methodology		
Quantitaive primary studies	44	(Adane, Bante, and Wassihun, 2021; Afulani, Buback, McNally et al., 2020; Afulani, Diamond-Smith, Golub et al., 2017; Afulani, Diamond-Smith, Phillips et al., 2018; Afulani, Feeser, Sudhinaraset et al., 2019; Afulani, Sayi, and Montagu, 2018; Arsenault, English, Gathara et al., 2020; Bante, Teji, Seyoum et al., 2020; Bulto, Demissie, and Tulu, 2020; Butler, Fullerton, and Aman, 2020; Christe and Padmanaban, 2021; Currie, Natiq, Anwari et al., 2021; Declercq, Sakala, and Belanoff, 2020; Deki and Choden, 2018; Deki and Wangmo, 2020; Dynes, Twentyman, Kelly et al., 2018; Dzomeku, Boamah Mensah, Nakua et al., 2020; Esmkhani, Namadian, Nooroozy et al., 2021; Feijen-de Jong, van der Pijl, Vedam et al., 2020; Hajizadeh, Asghari Jafarabadi, Vaezi et al., 2020; Hajizadeh, Vaezi, Meedya et al., 2020; Jenkinson, Kearney, Kynn et al., 2021; John, Duke, and Esienumoh, 2020; Manu, Zaka, Bianchessi et al., 2021; Montoya, Fritz, Labora et al., 2020; Moridi, Pazandeh, Hajian et al., 2020a; Mousa and Turingan, 2018; Ogbuabor and Nwankwor, 2021; Pathak and Ghimire, 2020; Raval, Puwar, Vaghela et al., 2021; Rosen et al., 2015; Rubashkin, Baji, Szebik et al., 2021; Rubashkin, Szebik, Baji et al., 2017; Sheferaw et al., 2017; Shimoda et al., 2018; Singh, Gogoi, Caleb-Varkey et al., 2021; Taavoni, Goldani, Rostami Gooran et al., 2018; Vedam, Stoll, Martin, et al., 2017; Vedam, Stoll, McRae et al., 2019; Vedam, Stoll, Rubashkin, et al., 2017; Wubetu, Sharew, and Mohammed, 2020; Yosef, Kebede, and Worku, 2020),
Qualitative primary studies	14	(Ackers et al., 2018; Andru, Olwit, Osingada et al., 2020; Bradley, 2018; De Kok, Uny, Immamura et al., 2020; Dzomeku, Boamah Mensah, et al., 2020; Erlandsson et al., 2014; Ige and Cele, 2021; Jolly, Aminu, Mgawadere et al., 2019; Miltenburg, Lambermon, Hamelink et al., 2016; Moridi, Pazandeh, Hajian et al., 2020b; Scott, Gharai, Sharma et al., 2020; Stein, 2019; Uwamahoro, Sengoma, Ndagijimana et al., 2021; Wilson-Mitchell, Marowitz, et al., 2018)
Mixed methods studies	3	(Ayoubi, Pazandeh, Simbar et al., 2020; Moyer, McNally, Aborigo et al., 2021; Sheferaw et al., 2016)
Reviews	10	(Afulani et al., 2020; Bradley, McCourt, Rayment et al., 2019; Dhakal, Gamble, Creedy et al., 2021; Downe et al., 2018; Mgawadere and Shuaibu, 2021; Namusonge and Ngachra, 2021; Ratcliffe, 2013; Rubashkin, Warnock, and Diamond-Smith, 2018; Shakibazadeh et al., 2018; Wilson-Mitchell, Eustace, Robinson et al., 2018)
Interventions including 1 commentary	23	(Ackers et al., 2018; Afulani, Aborigo, Walker et al., 2019; Asefa, Morgan, Bohren et al., 2020; Asefa, Morgan, Gebremedhin et al., 2020; Austad et al., 2017; Downe et al., 2018; Dzomeku, Mensah, Nakua et al., 2021; Geddes et al., 2017; Green, Perez, Walker et al., 2021; Hall and Mitchell, 2017; Kujawski, Freedman, Ramsey et al., 2017; Namusonge and Ngachra, 2021; Ndwiga et al., 2017; O'Connor, McGowan, and Jolivet, 2019; Ouédraogo et al., 2014; Ratcliffe, 2013; Ratcliffe, Sando, Lyatuu et al., 2016; Reis et al., 2012; Rubashkin et al., 2021; Smith, Schachter, Banay et al., 2020; Warren et al., 2017; Webber, Chirangi, and Magatti, 2018; Wilson-Mitchell, Robinson, et al., 2018)

Geographical location		
High-income countries	12	(Declercq et al., 2020; Feijen-de Jong et al., 2020; Green et al., 2021; Hall and Mitchell, 2017; Jenkinson et al., 2021; Rubashkin et al., 2021; Rubashkin et al., 2017; Rubashkin et al., 2018; Stein, 2019; Vedam, Stoll, Martin, et al., 2017; Vedam et al., 2019; Vedam, Stoll, Rubashkin, et al., 2017)
Upper-middle-income countries	3	(Austad et al., 2017; Montoya et al., 2020; Wilson-Mitchell, Marowitz, et al., 2018)
Lower-middle-income countries	37	(Afulani, Aborigo, et al., 2019; Afulani et al., 2017; Afulani, Diamond-Smith, et al., 2018; Afulani, Feeser, et al., 2019; Ayoubi et al., 2020; Christe and Padmanaban, 2021; Deki and Choden, 2018; Deki and Wangmo, 2020; Dynes et al., 2018; Dzomeku, Boamah Mensah, et al., 2020; Dzomeku, Mensah, et al., 2021; Dzomeku, Mensah, Nakua et al., 2020b; Erlandsson et al., 2014; Esmkhani et al., 2021; Hajizadeh, Asghari Jafarabadi, et al., 2020; Hajizadeh, Vaezi, et al., 2020; Ige and Cele, 2021; John et al., 2020; Kujawski et al., 2017; Miltenburg et al., 2016; Moridi et al., 2020a, 2020b; Mousa and Turingan, 2018; Moyer et al., 2021; Ndwiga et al., 2017; Ogbuabor and Nwankwor, 2021; Pathak and Ghimire, 2020; Ratcliffe, 2013; Ratcliffe, Sando, Lyatuu, et al., 2016; Raval et al., 2021; Scott et al., 2020; Shimoda et al., 2018; Singh et al., 2021; Smith, Schachter, et al., 2020; Taavoni et al., 2018; Warren et al., 2017; Webber et al., 2018)
Low-income countries	19	(Ackers et al., 2018; Andru et al., 2020; Asefa, Morgan, Bohren, et al., 2020; Asefa, Morgan, Gebremedhin, et al., 2020; Bante et al., 2020; Bradley, 2018; Bulto et al., 2020; Currie et al., 2021; De Kok et al., 2020; Geddes et al., 2017; Jolly et al., 2019; Mengistu, Alemu, Kassa et al., 2021; Ouédraogo et al., 2014; Sheferaw, Bakker, Taddele et al., 2021; Sheferaw et al., 2017; Sheferaw et al., 2016; Uwamahoro et al., 2021; Wubetu et al., 2020; Yosef et al., 2020)
Multiple locations	7	(Afulani, Feeser, et al., 2019; Arsenault et al., 2020; Butler et al., 2020; Manu et al., 2021; O'Connor et al., 2019; Reis et al., 2012; Rosen et al., 2015)
Study population		
Midwives only	16	(Andru, 2019; Bradley, 2018; Butler et al., 2020; Deki and Choden, 2018; Dzomeku, Mensah, et al., 2021; Dzomeku, Mensah, et al., 2020b; Geddes et al., 2017; Ige and Cele, 2021; Moridi et al., 2020a, 2020b; Shimoda et al., 2018; Stein, 2019; Uwamahoro et al., 2021; Webber et al., 2018; Wilson-Mitchell, Marowitz, et al., 2018; Wilson-Mitchell, Robinson, et al., 2018)
Midwifery students only	1	(Hall and Mitchell, 2017)
Women only	34	(Adane et al., 2021; Afulani et al., 2017; Afulani, Diamond-Smith, et al., 2018; Afulani, Feeser, et al., 2019; Arsenault et al., 2020; Ayoubi et al., 2020; Bante et al., 2020; Bulto et al., 2020; Christe and Padmanaban, 2021; Declercq et al., 2020; Deki and Wangmo, 2020; Dzomeku, Boamah Mensah, et al., 2020; Esmkhani et al., 2021; Feijen-de Jong et al., 2020; Green et al., 2021; Hajizadeh, Asghari Jafarabadi, et al., 2020; Hajizadeh, Vaezi, et al., 2020; Jenkinson et al., 2021; Kujawski et al., 2017; Miltenburg et al., 2016; Mousa and Turingan, 2018; Ogbuabor and Nwankwor, 2021; Pathak and Ghimire, 2020; Ratcliffe, Sando, Lyatuu, et al., 2016; Raval et al., 2021; Rubashkin et al., 2021; Rubashkin et al., 2017; Scott et al., 2020; Sheferaw et al., 2016; Vedam, Declercq, Monroe et al., 2017; Vedam, Stoll, Martin, et al., 2017; Vedam et al., 2019; Wubetu et al., 2020; Yosef et al., 2020)

Providers only (including doctors, nurses, midwives, and anaesthetists)	11	(Afulani, Aborigo, et al., 2019; Asefa, Morgan, Bohren, et al., 2020; Currie et al., 2021; Dynes et al., 2018; Erlandsson et al., 2014; Manu et al., 2021; Montoya et al., 2020; Moyer et al., 2021; Ouédraogo et al., 2014; Rosen et al., 2015; Sheferaw et al., 2017)
Combination of women and midwives, SBAs, or providers	8	(Ackers et al., 2018; Asefa, Morgan, Gebremedhin, et al., 2020; De Kok et al., 2020; John et al., 2020; Jolly et al., 2019; Singh et al., 2021; Smith, Schachter, et al., 2020; Taavoni et al., 2018)
Combination of stakeholders such as women, providers, managers at different levels (national, local) and policy makers	6	(Mengistu et al., 2021; Ndwiga et al., 2017; O'Connor et al., 2019; Reis et al., 2012; Warren et al., 2017)

It can be noted from the table above that majority of the studies were conducted in low-income and lower-middle-income countries in Africa and Asia similar to the initial review. However, contrary to the initial review, 16 of the studies included in this updated version had focused on the perspectives of midwives only and 11 a combination of all SBAs indicating an increased attention to the perspectives of care providers. A detailed descriptive narrative of the findings in the updated version of the review is presented in the proceeding sections. The narration of the findings will highlight areas where significant differences were noted between the initial review and the updated version.

2.4. Findings

Both the initial and updated scoping reviews found that existing research related to RMC fell into three main categories: conceptualisation of RMC, interventions to promote RMC, and measuring RMC as categorised in the tables in appendix 1. The review findings have, therefore, been grouped into these. As part of the conceptualisation of RMC, the narrative description will also focus on the views of providers and women, women's experience of RMC, and the determinants of that experience. The evidence in relation to the purpose of the review is summarised in the following sections, in addition to noting gaps and making conclusions to inform the conduct of the current study.

2.5. Conceptualisation of respectful maternity care

This scoping review identified one qualitative evidence synthesis conducted to support the development of the WHO guideline for intrapartum care (Shakibazadeh et al., 2018), a qualitaive systematic review and meta-synthesis (Bradley et al., 2019), and one literature review (Wilson-Mitchell, Eustace, et al., 2018) that had conceptualised RMC, two of which were identified in the updated review (Bradley et al., 2019; Wilson-Mitchell, Eustace, et al., 2018). The evidence synthesis which had its primary focus on the conceptualisation of RMC included 67 studies from 32 countries: six in Sub-Saharan Africa, seven in Asia, one in

Oceania, eight in Europe, five in the Middle East and North Africa, two in North America, and three in Latin America (Shakibazadeh et al., 2018). It had a wider scope of inclusion criteria, than just the RMC concept. The authors included studies which focused on women's satisfaction with maternity care, women's choice for birth, D&A, and humanisation of childbirth, leading to the high number of studies included. Though the synthesis did not provide a working definition for RMC, it demonstrated that RMC as a concept was broader than merely the reduction or elimination of D&A. This was evidenced in 12 themes inherent in the provision of RMC that were developed. They were: Being free from harm and mistreatment, maintenance of privacy and confidentiality, preserving women's dignity, provision of information and seeking informed consent, ensuring continuous access to family and community support, enhancing quality of physical environment and resources, providing equitable maternity care, engaging with effective communication, respecting women's choices that strengthen their capabilities to give birth, availability of competent and motivated human resources, provision of efficient and effective care, and continuity of care

Some of the studies included in this evidence synthesis were focused on D&A and the humanisation of childbirth (Behruzi, Hatem, Fraser et al., 2010; Bhattacharyya, Issac, Rajbangshi et al., 2015) and not necessarily the provision of RMC. Hence, there appears to be conflation at times between respectful care, absence of D&A, and humanisation of childbirth and there is the need to explore the similarities and differences between these concepts. This is, however, not carried out in this scoping review.

Bradley et al. (2019) and Wilson-Mitchell, Eustace, et al. (2018) also synthesised evidence on the conceptualisation of RMC though this was not the central focus of their reviews. According to Bradley et al. (2019), the conceptualisation of RMC included trust and communication, treating the woman as an individual, empathy, and involving women in their care and others conceptualised RMC as what it was not i.e. the absence of discriminatory and abusive care. This systematic review included 11 papers from six countries and findings were synthesised using a pre-existing conceptual framework of the drivers of disrespectful care

(Bradley, McCourt, Rayment et al., 2016). The review, however, included several studies that had explored D&A which may explain why RMC was conceptualised in terms of what it was not. The findings were, therefore, highly focused on mistreatment. Additionally, the authors only included studies from Sub-Saharan Africa, limiting the scope of the concept and the possibility of comparing differences by geographical location. Wilson-Mitchell, Eustace, et al. (2018), however, did not provide any typologies or domains for the concept. Though the reviewers had a section on the conceptualisation of RMC, they only provided an overview of various literature related to RMC and D&A, describing studies that utilised the domains of RMC, and interventions implemented to facilitate RMC as well as considering the application of these to the Tanzanian context.

Albeit several empirical studies (not included in the reviews described above) have been published that have elicited the views of both women and providers. Eliciting these views is significant for the development of components of RMC. The following sections will, therefore, describe the included studies that have utilised this approach and the findings obtained from these studies.

2.5.1. Perceptions on respectful maternity care

The last few years have witnessed an exponential growth in research on RMC, particularly research with emphasis on the perceptions of women and care providers. Since the initial scoping review in september, 2018, 71 new studies have been conducted and these studies have given increased attention to the perspectives of care providers. In addition to the reviews described above, 32 empirical studies (including 2 theses) from 20 countries and one global study were identified that had explored the perception and experiences of providers, women, and midwifery experts on RMC as compared to 3 studies from 3 countries in the initial review. The majority (15) of studies were undertaken in Sub-Saharan Africa, 1 in Northern Africa9 in Asia, 1 in Europe, 2 in North America (USA), 1 in South America, 1 in the Caribean, 1 in multiple locations, and 1 worldwide study. One study (Wilson-Mitchell,

Marowitz, et al., 2018) conducted in Jamiaca had focused on the provision of RMC for adolescent women. Eleven studies explored the views and experiences of midwives only, 12 women only, 2 health professionals including doctors and nurses, 1 midwifery experts, 5 a combination of either midwives or providers and women, and 1 assessed health facilitties. Fifteen studies were conducted using qualitative methodologies, 12 quantitative, and 3 were mixed method studies. The studies were published between 2014 and 2021 with majority (13) of them published in 2020. Fourteen of the studies utlised pre-existing frameworks for RMC as a guide for data analysis. The frameworks mostly adopted include the White Ribbon Alliance's (2011) RMC Charter, Bowser and Hill's (2010) 7 domains for D&A, and the 12 RMC domains by Shakibazadeh et al., (2018). The utilisation of pre-existing frameworks for data analysis can present challenges for extending the concept beyond the absence of D&A.

Based on their findings, Stein (2019 p.iv) defined RMC as follows: "Respect in the maternity setting is a multivariate concept based on women feeling well cared for by health workers based on their attitudes and actions: attentiveness, a high level of knowledge, kindness, a focus on patient preference, and providing a safe environment to put women at ease." Using frameworks that are based on the identification of D&A resulted in the development of an RMC concept that was underpinned by the absence of D&A which is a partial representation of RMC. For instance, RMC was conceptualised in some studies as friendly care, abuse-free care, timely care, and discrimination free care (Dzomeku, Mensah, et al., 2020b; Hajizadeh, Vaezi, et al., 2020).

The human rights perspective was another approach to RMC and this was propounded by 7 studies (Ackers et al., 2018; Dzomeku, Mensah, et al., 2020b; Jolly et al., 2019; Miltenburg et al., 2016; Moridi et al., 2020b; Ndwiga et al., 2017; Uwamahoro et al., 2021) included in this review. These studies recognized the rights based approach from varying persepctives. For instance, Dzomeku, Mensah, et al. (2020b), Moridi et al. (2020b), and Uwamahoro et al. (2021) explored the understanding of midwives as part of a wider RMC study. Midwives highlighted that women had the right to the safequarding of their dignity and to equal care

(Moridi et al., 2020b) as well as to components of care such as information, privacy, and companionship (Dzomeku, Mensah, et al., 2020b; Jolly et al., 2019; Uwamahoro et al., 2021). Miltenburg et al. (2016) on the other hand explored the perpectives of women and according to the researchers, women's understanding of their human right related to the provision of personal care and the avaliability of medical and non-medical equipment. Women in this study also perceived their rights as captured within the notion of being treated well, thus with dignity, autonomy, equality, and security. These shared similarities with those perceived by midwives.

The human rights approach has, however, been critiqued by De Kok et al. (2020). Based on context specific nuances observed by the researchers in Malawi, they purported that in this high mortality context, survival was the priority. Adiitionally, the marked socio-economic difference between providers and women limited the effectiveness of rights-based RMC campaigns and these campaigns may be resulting in unintended negative consequences such as the abuse of providers. They, however, highlighted the importance of attention and talking lovingly rather than respect. These findings make context highly significant during the development of concepts such as RMC as emerging evidence continue to highlight some varying domains of emphasis depending on the geographical location. To exemplify this, studies conducted in Califonia, Hungary, and Mexico focused primarily on women's agency, autonomy, choice, and informed decision-making regarding interventions such as CS and induction of labour (Declercq et al., 2020; Montoya et al., 2020; Rubashkin et al., 2021). Factors that influenced women's experience of RMC in these locations were disproportionately linked to maginalised populations. For instance, Declercq et al. (2020) reported in their study of women's experience of RMC based on the type of insurance that, women with Medicaid (medical assistance program for low-income individuals in the United States and which covered 42% of births in 2018 and assists marginalized populations) had less control over their care experience, less choice, less likely to be consulted before an intervention and less likely to be invloved in the decision-making process. Though this study

is not generalisable due to its limitation to Califonia which has a predominant number of women born outside of the US and who identify as Latina or Asian (Declercq et al., 2020), it offers a strong comparitor for women within maginalised populations and supports arguments for context specific approaches.

The domains of RMC were not only perceived through the human right lens. Components such as dignity, safety, privacy, provision of information, and consent were pervasive in the studies included in this review and some were linked to the evidence synthesis by Shakibazadeh et al. (2018) described in section 2.3.1. above and to other pre-exisitng frameworks on D&A. There is also a growing body of work in other geographical locations that is highlighting key concepts such as woman-centred care (Moridi et al., 2020b), client-centred care (Dzomeku, Mensah, et al., 2020b; Ndwiga et al., 2017), patient-centred care (Stein, 2019), and continuity of care (Andru et al., 2020). Apart from the continuity of care concept, these different typologies have the same connotation of information giving, women's unique experiences, and women's active engagement in the decision-making process. However, continuity of care was denoted by researchers as having knowledge, tools to monitor women, and being able to provide timely and collaborative care (Andru et al., 2020). These shared no similarity with the predominant usage of continuity of care as a model encompassing continuity across the pregnancy childbirth continuum.

The review also identified research conducted on behalf of ICM to ascertain RMC essential competencies for midwifery practice (Butler et al., 2020). This study identified 115 RMC items pertaining to knowledge, skills, and professional behaviours pertinent to midwifery practice. Shakibazadeh et al's, (2018) domains of RMC, was used as the organising framework for these 115 items. The focus on these specific comprehensive set of professional behaviours is highly significant in ensuring that RMC is understood professionally as more than just the absence of D&A and embedded into the midwifery philosophy of care. These professional behaviours have not yet been strongly evidenced in practice as research continues to highlight discrepancies between midwives'

conceptualisation of RMC and their practice of it. Thus, their exhibition of professional behaviours or competencies relating to RMC and as experienced by women were not congruent. The section below will present findings in this regard.

2.5.2. Women's experience of respectful maternity care

Women's experiences of RMC have been varied, according to the findings. While some studies reported women's overall positive experience of some domains of RMC (Christe and Padmanaban, 2021; Dynes et al., 2018; Mousa and Turingan, 2018; Rosen et al., 2015; Sheferaw et al., 2017), others reported otherwise (De Kok et al., 2020; John et al., 2020; Montoya et al., 2020; Raval et al., 2021). In a direct observation of 2,164 labour and births conducted in Ethiopia, Kenya, Madagascar, Rwanda, and the United Republic of Tanzania, women were mostly treated with dignity and supported during the delivery of care, though there were elements of poor interaction and lack of information (Rosen et al., 2015). In quantitative studies that analysed women's experience of RMC, the percentage of women who had positive experineces ranged between 20.2% and 96.3% (Deki and Wangmo, 2020; Dynes et al., 2018; John et al., 2020; Pathak and Ghimire, 2020; Sheferaw et al., 2017). The outcomes of interest included non-abusive care, freindliness/comfort/attention, information/consent, absence of discrimination, motivating positive behaviour, being supportive, greeting the pregnant women, and urging women to ask questions.

These percentages did not pertain to the domains as a whole but were scores for single variables that were analysed. For example Dynes et al. (2018), analysed provider and client attributes and their association with RMC and noted that 96.3% of women stated that on admission they were greeted respectfully and 94.3% said provider was friendly while only 45.6% of women had providers introducing themselves. Even where there was adequate provision of some domains of RMC, physical abuse was considered when women were uncooperative and in potentially life threatening conditions (Ige and Cele, 2021). Midwives confirmed the presence of disrespectful care which fitted into Bowser and Hill's (2010)

categories of D&A. According to Pathak and Ghimire (2020), the most prevalent form of abuse was shouting (30%) and the least was being slapped (18.7%). The lack of RMC was not limited to the interpersonal domains of the concept but extended to domains pertaining to the faciltiies as a whole. In a recent study to assess infrastructure, policies, provision and women's experiences of RMC in Bangladesh, Ghana, and Tanzania, Manu et al. (2021) noted that facilitites had systems that facilitated RMC but structural constraints and disparities in policy posed challenges. For instance, the researchers' found that 20% of facilities in Bangladesh, 25% in Ghana, and 25% in Tanzania had no toilets for women and half had no facilities for handwashing. Furthermore, even though 81% of facilitites in Ghana, 73% in Bangladesh, and 50% in Tanzania had RMC policies, responses to these policies were poor. It is, therefore, not surprising that findings from the review indicate discrepencies between the conceptualisation of RMC and its practice.

Several studies highlighted the disconnection between providers' ideal understanding of RMC and their provision of it (Ackers et al., 2018; Andru et al., 2020; Bradley et al., 2019; Currie et al., 2021; De Kok et al., 2020; Deki and Choden, 2018; Dzomeku, Mensah, et al., 2020b; Erlandsson et al., 2014; Moyer et al., 2021; Uwamahoro et al., 2021). The cause of this disconnection has been multifactorial; from health system challenges including lack of resources, high caseloads, the pressure to achieve safe outcomes, and institutional policies, to the low status of midwives within the health system hierarchy (Bradley, 2018; Bradley et al., 2019; Currie et al., 2021; De Kok et al., 2020; Declercq et al., 2020; Deki and Choden, 2018; Ndwiga et al., 2017; Wilson-Mitchell, Marowitz, et al., 2018). In addition to the conceptualisation of RMC described in section 2.3.1. above, Bradley et al. (2019) synthesised their findings according to micro and meso levels, with the micro-level focusing on midwives' interactions with women and the meso-level on the wider health system. The two overarching micro-level themes synthesised by the reviewers, 'power and control and maintaining midwives' status, highlighted how midwives capitalised on their knowledge on childbirth to control women's bodies during the childbirth process and maintained their

professional status and that within the society through the reinforcement of their inequity with women. The meso-level themes highlighted the constraints within the working environment including the lack of resources and the low status of midwives within the hierarchy of the health system which were strong drivers of mistreatment. These studies presented a notion of providers as perpetrators of abuse and women as victims but did not highlight the causal connection between these systemic constraints and midwives' agency or the empirically observed events.

Nonetheless, this disconnection was not limited to the concept and its practice but also included how the concept was translated from universal policies to local standards. In an ethnographic study conducted in Malawi to investigate how international standards were applied to local realities, De Kok et al. (2020) did not only emphasise on the disconnection between conception and provision of RMC but between the universal principles of RMC and local notions of good care. According to the researchers, women and their guardian's conceptualisations of good care was that of love and not respect. Additionally, the utlisation of the human rights approach for the promotion of RMC, indicated earlier, was noted to be ineffective because it was yielding unintended negative consequences such as the abuse of providers. It, therefore, surfices to reiterate that whilst RMC is a universal concept, the findings in this review emphasise a critical need to consider socio-cultural and contextually relevant approaches to the conceptualisation of RMC and the translation of universal frameworks aimed at promoting RMC. This is because the application of these frameworks determines the strategies that are developed to facilitate the provision of RMC and to enhance women's positive childbirth experience. Hajizadeh, Vaezi, et al. (2020) found a statistically significant correlation between RMC and women's positive childbirth experience with the RMC sub domains of friendly care, abuse-free care, timely care, and discremination free care. Though the outcomes of interest emphasised on the absence of D&A which does not necessarily imply the presence of RMC, it is expedient that strategies adopted by

agencies to promote RMC are locally relevant and strongly address contextual concerns. The following section focuses on the determinants of RMC identified in this review.

2.5.3. Determinants of respectful maternity care

The review identified that specific categories of women were more or less likely to receive RMC. Eight studies (Adane et al., 2021; Afulani, Sayi, et al., 2018; Arsenault et al., 2020; Bante et al., 2020; Bulto et al., 2020; Dynes et al., 2018; Wubetu et al., 2020; Yosef et al., 2020) and one qualitative literature review (Mgawadere and Shuaibu, 2021) were identified that focused on investigating the predictors, determinants, enablers, or associated factors for the provision of RMC, all of which were identified in the updated scoping review. None of the empirical studies in the qualitative literature review were included in this current scoping review. The empirical studies were conducted in 5 African countries; Tanzania, Kenya, Ethiopia, and Malawi, majority (5) of which were conducted in Ethiopia. All but one study (Adane et al., 2021) (which focused on ANC) focused on RMC during labour. All the studies utilised quantitative methodologies with 6 out of 8 studies conducting cross sectional studies. The determinants, predictors, or factors associated with RMC examined by the researchers included household income, employment status, educational status, marital status, type of facility (health centres, public facilities, private facilities), experience of domestic violence, time of birth (daytime or night-time), cadre of nurses/midwives versus clinicians, presence of companion, age, provider pay, number of ANC visits, planned pregnancy, gravidity, and previous history of facility birth.

Bivariate and multivariate analyses were conducted by researchers to assess the linkages with these determinants. Women who had secondary or higher educational status, had a birth companion, delivered in the day time, had a history of institutional birth, and had more ANC visits had a better chance of receiving RMC than the non-educated, delivered at night, had no birth companion, no history of institutional birth, or received less ANC visits respectively (Adane et al., 2021; Arsenault et al., 2020; Bante et al., 2020; Wubetu et al., 2020; Yosef et

al., 2020). Wealth, parity, type of facility, and planned pregnancies were also significant determinants of RMC. According to the studies by Adane et al. (2021), and Afulani, Sayi, et al. (2018), women with bigger household income, lower parity, delivered in private facilities or health centres, or had a planned pregnancy were more likely to receive RMC. On the contrary, Bulto et al. (2020), asserted that women with an unplanned pregnancy had a better chance of receiving RMC than those with planned pregnancies. The researchers suggested that this could be related to the lack of worry about care experience and childbirth outcome for women with an unplanned pregnancy. Afulani, Sayi, et al. (2018) who compared household wealth, personal empowerment, and the type of health facility with the provision of Person-centred Maternity Care (PCMC) also emphasised that even within the same type of health facility, women with higher household wealth were more likely to receive PCMC.

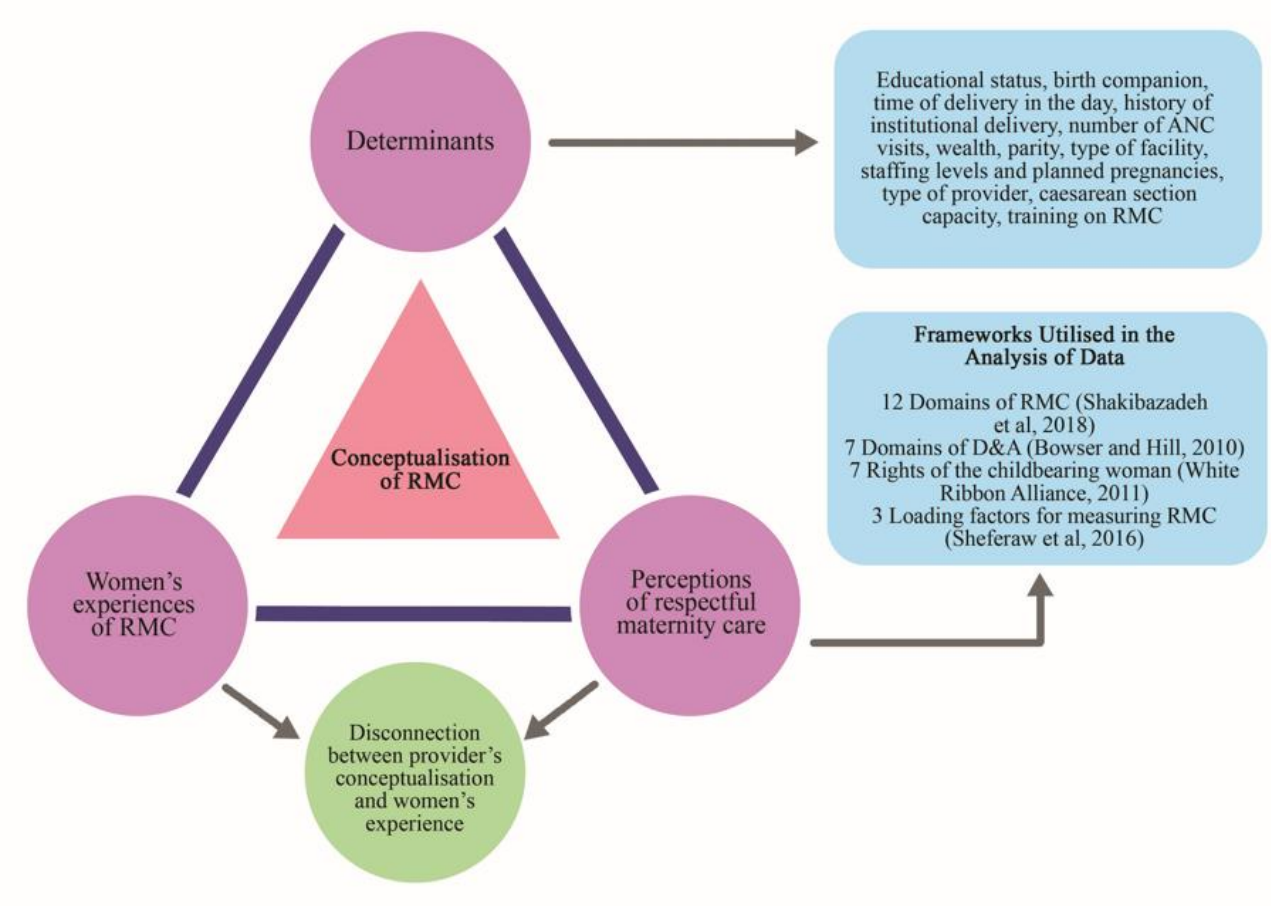
Whilst higher caseload has been cited as a factor influencing the provision of RMC, Dynes et al. (2018) found that the number of deliveries a provider attended to in a month had no significant association with the provision of RMC (information and consent). Arsenault et al. (2020) also noted that facilities performing more than 1,500 deliveries a year, those with facilities for CS, and those that were better staffed were more likely to provide competent care. In addition, male providers and professionals trained in RMC were more likely to offer RMC and less likely to perform interventions such as episiotomies (Bante et al., 2020; Montoya et al., 2020). These findings have significant implications for the development of interventions aimed at improving RMC particularly those focusing on system strengthening. More system specific multi-level needs assessment ought to be carried out to ascertain priority areas to guarantee maximum impact. An exposition on the interventions identified during the review will be presented in the section 2.6.

Summary of findings

The findings presented above explored how RMC had been conceptualised. The evidence obtained indicates an emphasis on D&A, RMC as the absence of abuse, and a reliance on pre-existing frameworks for the development of the RMC concept. However, the absence of abuse does not necessarily imply the presence of RMC, and the over-reliance on pre-existing frameworks may present limitations in the capacity to identify contextual nuances and the propensity to extend the concept to reflect contextual needs. Nonetheless, there were studies that conceptualised RMC as not merely the absence of D&A. A key approach to the conceptualisation of RMC was the human rights perspective. This was, however, critiqued by midwives in some studies as it did not consider contextual factors that influenced their provision of care and the needs of midwives.

It was also highlighted that midwives' perceptions of RMC were not congruent with practice as there were reports of D&A. The factors associated with this disconnect were multifactorial, including systemic difficiencies and factors relating to midwives' professional status. Household income, employment status, educational status, marital status, type of facility, and time of birth were noted to be some of the determinants of RMC. There seemed to be a protrayal of health providers as perpetrators of abuse without the identification of the real causative mechanisms and how they powered the observable events. This can hinder the development of strategies that target the relevant mechanisms. The figure below provides a visual summary of these findings. In this figure women's experience of RMC has been distinguished from how RMC has been perceived by both women and health providers to enable the demonstration of discrepancies between the conceptualisation of RMC and women's experience.

Figure 2: Summary of findings on conceptualisation of RMC



2.6. Interventions to promote respectful maternity care

Reviewing literature on interventions implemented to promote RMC was necessary to clarify key concepts, gain a full scope of the concept, and the specific questions that can be valuably addressed. It also has the capacity to facilitate an understanding of how the conceptualisation of RMC influenced the interventions implemented. Interventions adopted to promote RMC were heterogeneous. This scoping review identified a total of 23 studies: 18 empirical studies (10 more studies than the initial scoping review), 1 commentary, and 4 reviews, from 10 countries and 2 with a global focus. All but 3 studies (conducted in Guatemala, the United States, and the UK) had been conducted in Sub-Saharan Africa. The review also identified various levels at which interventions had been implemented and they are reported using categorisations used in the papers identified.

2.6.1. Policy level interventions (local, national, and international)

Four studies including one review (a thesis) (Ratcliffe, 2013) and two primary studies (Reis et al., 2012; Warren et al., 2017) demonstrated evidence of the implementation of interventions to promote RMC at the policy level. Another review (Downe et al., 2018) was identified that was conducted as part of the development process of the WHO intrapartum care guidelines. None of the empirical studies included in these reviews were included in this current scoping review. Warren et al. (2017) reported on the implementation of the Heshima project[1] that facilitated the incorporation of RMC training into the national nurse's curriculum by the Nursing Council of Kenya and the incorporation of RMC language and goals into the technical content of maternal, new-born and child health bill. The study, however, did not state the RMC language or goals that had been incorporated into these technical contents.

Downe et al. (2018) and Reis et al. (2012) emphasised that RMC multicomponent policies such as incorporating RMC into curricula, setting up quality improvement teams, adequate budgetary commitment, and having a strong political commitment and influence from national, regional, and local governmental levels were more likely to lead to a more respectful care, and reduce disrespectful care. Though Downe et al. (2018) established the effectiveness of the introduction of multicomponent RMC policies, the reviewers reported low clarity on the sustainability of these policies and their demonstrated effect as well as the elements of the programmes that had the most effect. The researchers, however, excluded studies that were designed to improve only one specific aspect of intrapartum care (such as communication or companionship), although one study (Brown, Hofmeyr, Nikodem et al., 2007) that was conducted to promote childbirth companions was included in the review. This meant that some relevant studies might have been excluded as these single attributes also contribute to the

[1] Heshima ("dignity" in Kiswahili) project in Kenya was tasked in 2011 to determine and measure the prevalence of disrespect and abuse, conduct implementation research for developing and validating tools for assessment, to design interventions to address determinants of disrespect and abuse, and finally evaluate the effects of the interventions (Warren, Njuki, Abuya et al., 2013)

provision of RMC. Nonetheless, the paucity of strategies at the policy level indicates that even though RMC has been conceptualised above as a system wide concept, the focus remains on care providers as demonstrated in the section below.

2.6.2. Women, provider, and facility level interventions

Interventions have been implemented with the aim of improving the direct relationship between childbearing women and their caregivers. Twenty-one studies that focused on the implementation of interventions to promote RMC at the facility and provider level were identified. The studies included three reviews (including one thesis) (Namusonge and Ngachra, 2021; Ratcliffe, 2013; Rubashkin et al., 2021), one commentary (Austad et al., 2017) and seventeen empirical studies (Afulani, Aborigo, et al., 2019; Asefa, Morgan, Bohren, et al., 2020; Asefa, Morgan, Gebremedhin, et al., 2020; Dzomeku, Mensah, et al., 2021; Geddes et al., 2017; Green et al., 2021; Hall and Mitchell, 2017; Kujawski et al., 2017; Mengistu et al., 2021; O'Connor et al., 2019; Ouedraogo, Kiemtore, Zamane et al., 2014; Ratcliffe, Sando, Lyatuu, et al., 2016; Reis et al., 2012; Smith, Schachter, et al., 2020; Warren et al., 2017; Webber et al., 2018; Wilson-Mitchell, Robinson, et al., 2018). None of the empirical studies included in these reviews were included in this current scoping review. Only 2 of the studies (Green et al., 2021; Hall and Mitchell, 2017) were conducted in a high-income country (UK).

In the systematic literature review by Namusonge and Ngachra (2021), the authors identified 13 studies with a focus on capacity building for health workers, 9 with a focus on clinical audits and feedback, and 3 with a focus on performance improvement and supervision for health providers. However, it could not be ascertained from the paper how the synthesis was carried out and which specific research articles contributed to these findings as no summary of findings or articles were provided. Another systematic review (Rubashkin et al., 2018) was identified that focused on person-centred care (PCC) interventions to enhance institutional deliveries; this was one of two studies with Ratcliffe, Sando, Lyatuu, et al. (2016) which focused on women only. Rubashkin et al. (2018) categorised the interventions into five PCC

objectives: autonomy, supportive care, social support, health facility environment and dignity with autonomy being the most common intervention and dignity the least. The researchers concluded, based on their findings, that interventions generally enhanced or made no difference to PCC outcomes.

The overall findings of this scoping review highlight the need for multistakeholder and multifaceted approaches to the implementation of RMC. The approaches utilised included awareness raising (O'Connor et al., 2019), interventions to promote autonomy and supportive care such as informed choice leaflets, and quality improvement (Mengistu et al., 2021), and these involved women, healthcare providers, RMC activists, and non-governmental organisations. For instance, in the development and implementation of interventions to promote RMC, Geddes et al. (2017), Kujawski et al. (2017), O'Connor et al. (2019), and Warren et al. (2017) employed a participatory approach involving multi-stakeholders including policy makers, healthcare providers, and community members and adopted multiple theories. This approach enabled the researchers to develop context specific interventions and the adoption of an already existing dormant client charter aimed at addressing inherent challenges. This led to the development of a sense of commitment by the various stakeholders towards the promotion of RMC. The use of multiple theories was also strategic in addressing the multidisciplinary and multistakeholder nature of RMC (O'Connor et al., 2019).

Several interventions were targeted at transforming the behaviours of providers and improving their service provision. These included values clarification and attitude transformation (VCAT originally developed by Ipas), mentorship, counselling for health providers in maternity units, client-oriented provider-efficient services (COPE), sensitization and mindfulness training, and leadership skills for midwives. Others were also aimed at transforming health facilities and these included maternity open days, privacy curtains in wards, nametags for providers, supportive supervision, professionalising midwifery, development of quality improvement teams, reporting mechanisms for D&A, clinical guidelines and protocols, and placement of posters in labour rooms (Asefa, Morgan, Gebremedhin, et al., 2020; Ratcliffe, 2013; Reis et

al., 2012; Smith, Schachter, et al., 2020; Warren et al., 2017). The literature review by Ratcliffe (2013) included some interventions such as COPE that have been implemented in other clinical settings besides maternity units but have not been evaluated for their potential to contribute to RMC. It also included interventions such as mindfulness training and evidence for this was obtained from high-income countries and countries like China where such practices are widely accepted, and this may not be applicable in other settings. Regardless of these, the interventions within the included papers may reflect specific country interventions implemented not just to promote RMC but to improve maternity care.

A consistent approach to provider attitude transformation was the training of providers with 11 out of 18 empirical studies focusing on this approach (Afulani, Aborigo, et al., 2019; Asefa, Morgan, Bohren, et al., 2020; Asefa, Morgan, Gebremedhin, et al., 2020; Dzomeku, Boamah Mensah, Nakua et al., 2021; Geddes et al., 2017; Mengistu et al., 2021; Ouedraogo et al., 2014; Reis et al., 2012; Warren et al., 2017; Webber et al., 2018; Wilson-Mitchell, Robinson, et al., 2018). One study focused on training student midwives (Hall and Mitchell, 2017). These took the form of workshops, simulation training, and role plays, and some adopted participatory adult learning where providers were introduced to activities to reinforce RMC skills. Evaluation for impact involved baseline and follow-up comparisons. Some of these interventions were integrated into other training modules or programmes (Afulani, Aborigo, et al., 2019; Mengistu et al., 2021). Mengistu et al. (2021) integrated their RMC intervention into a bigger maternal and newborn health programme aimed at quality improvement in Ethiopia and Afulani, Aborigo, et al. (2019) incorporated components of RMC into a simulation based training on obstetric emergencies in Ghana. Findings from these studies suggest the capacity for improvement in components of RMC whether the training was offered on an integrated basis or as a standalone module. Mengistu et al's. (2021) intervention consisted of a training module including videos. Researchers evaluated intervention for its capacity to address only privacy and the presence of a birth companion and the result indicated an improvement of these even a year after the intervention ended. Though this study was part of a bigger quality

improvement programme, the researchers did not indicate how the quality improvement initiatives impacted on the outcomes of the intervention.

Albeit the emphasis of RMC interventions on the training of care providers without simultaneous attention to systemic improvements reflects how RMC has been mostly conceptualised, as the absence of D&A. This also suggests that D&A is deemed an attitudinal problem of health providers or providers as perpetrators and women as victims without an equal attention to the systemic inadequacies that enable D&A or the real causative mechanisms that interplay to produce these outcomes. This could become a bottleneck to the achievement of RMC as this scoping review has highlighted that improvement occurred when systemic interventions were implemented together with provider training rather than provider training without the necessary systemic improvements. Furthermore, in systems where providers perceive that their rights are also being violated, a lack of attention to this may continue to limit the impact of training interventions. This necessitates the need for a context specific concept of RMC and the exploration of how causative mechanisms interact so that system related interventions can be intensified.

Context was also an essential factor that shaped the nature of interventions. In a human rights approach to RMC conducted in Malawi, midwives found the content educational and engaging but were also of the view that the content needed to be context specific (Geddes et al., 2017). This indicates a need to incorporate midwives' rights and professional needs into the RMC concept in the contexts where it is deemed appropriate to ensure that the components of the phenomenon are practiced. To address the disparities faced by Black birthing people in the United states, Green et al. (2021) through their study developed an actionable cyclical framework to address this disparity. The framework inculcated a plethora of components with valuing patients' Black Intersectionality, Birth Equity, Reproductive Justice, the Professional Pledge/Oath healthcare professionals commit to at the start of their career, Holistic Maternity Care, Humanity, and Love of self and others as the core values. The incorporation of context specific training and education is vital not only for providers but for students. Hall and Mitchell's

(2017) study conducted in the UK which utilised creative methods as triggers and individual experiences for learning among student midwives illustrated how different approaches to learning impacts on practice. Though this study is rather small it provides evidence on the importance of integrating RMC into educational programmes not just for midwives but also for students. Similarly, Wilson-Mitchell, Robinson, et al. (2018) in an intervention implemented in Tanzania also observed that midwives who had three or four years of formal midwifery education had more confidence in incorporating what they had learnt and had the capacity to develop self-directed, independent, and creative solutions. This was observed during the evaluation process although the researchers did not elaborate on the reason for this. Further research could explore the level of education and the impact it has on the provision of good quality care and identify the context specific characteristics that could be integrated into the development of training approaches and midwives' philosophy of care.

Additionally, a study by Austad et al. (2017) focused on the introduction of care navigators in maternity care in Guatemala. These laywomen in the community were trained to gain the trust and respect of women, traditional midwives, and biomedical providers and equip them with the needed skills to offer women companionship and a doula-like support during labour to improve women's labour experience. They were also trained to assist in the referral of women from traditional midwives to healthcare facilities and to navigate the healthcare system. Though most of these interventions were targeted at providers, some studies were identified that had reported on interventions implemented at the community level and these are highlighted below.

2.6.3. Community level interventions

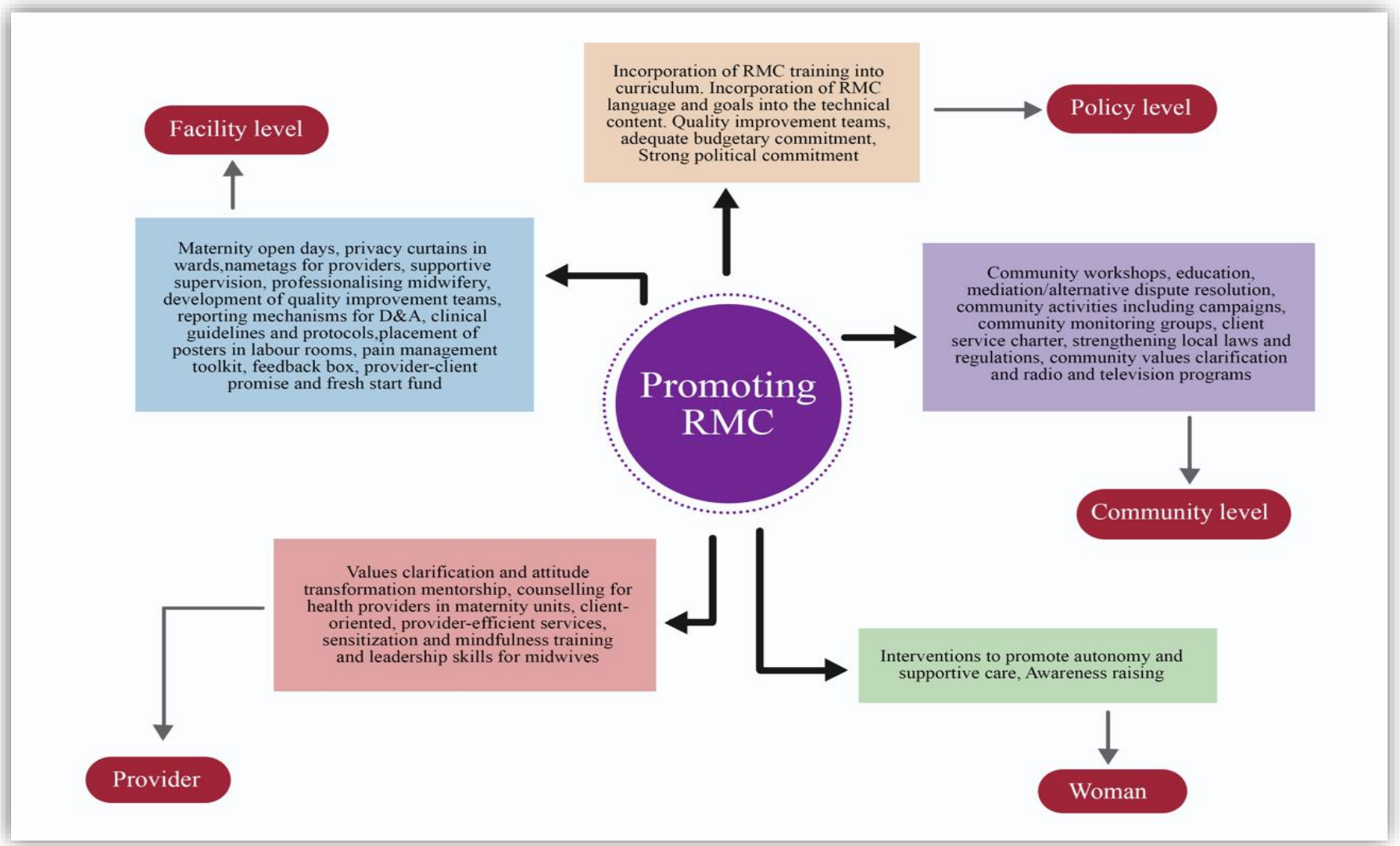
Contrary to provider interventions, there has been little research focused on implementation of interventions at the community level, though strategies adopted to develop interventions were multistakeholder driven. Only four studies were identified (Kujawski et al., 2017; Ratcliffe, 2013; Reis et al., 2012; Warren et al., 2017). The interventions implemented included

community workshops, mediation/alternative dispute resolution, community activities including campaigns, community monitoring groups, strengthening local laws and regulations, and radio and television programs to disseminate RMC content. The inclusion of the community reinforces the significance of a multisystem approach to the implementation of interventions not just to promote RMC but maternity care and the health system as a whole (Kujawski et al., 2017; Warren et al., 2017).

Kujawski et al. (2017) employed an iterative participatory process with local community and health system stakeholders to develop the Staha[2] intervention. This approach facilitated participants' capacity to analyse their own experience of mistreatment and develop possible actions to limit them. It also resulted in the adoption of a client charter promulgated by the MOH and Social Welfare in 2005 but which had been inactive since its promulgation. The activation of this charter at the second stage of the project resulted in system changes such as moving admissions area to a private room and using curtains for birth and physical examinations. An evaluation of the intervention a year after its implementation resulted in a significant reduction (66% reduced odds) in self-reported experience of abuse with the largest reduction being physical abuse. Researchers also noted reduction of abuse in the comparison facility which was attributed to quality improvement in the comparison facility during the duration of the study, reinforcing the significance of wider system improvement for the provision of RMC. Figure 3 presents a summary of the levels of interventions implemented as discussed in the sections above. Evaluation of the interventions to promote RMC was a vital aspect of the implementation process. The factors considered during the evaluation process are further explored in the section below.

[2] The Staha study was carried out in Tanzania and resulted in the development and implementation of two interventions; 1) client service charter: consensus on rights, responsibility, and accountability and 2) maternity improvement process: activation of the charter content

Figure 3: Summary of interventions to promote RMC



2.6.4. Factors to be considered when evaluating RMC interventions

Some studies identified in the review considered factors that impacted on the outcome of RMC interventions. Broader health system interventions and specific characteristics of participants were identified as factors that can impact on RMC interventions, and this should be accounted for when reporting on the outcomes of interventions. To exemplify this, Afulani, Aborigo, et al. (2019) noted when comparing baseline and follow-up score of RMC on the PCMC scale, that women in the follow-up group had a relatively higher score of 43% more than those in the baseline, with scores almost doubling for communication and autonomy. Researchers, however, reported a small but statistically significant difference in attributes between participants in the baseline and follow-up groups. For example, women in the follow-up group were marginally better educated and literate, from households with higher income, and their partners were better educated which may have contributed to their being more empowered to advocate for themselves and capable of affording care at facilities with better quality of care. Additionally, Asefa, Morgan, Bohren, et al. (2020), also noted that the number of respondents with good perspectives on RMC after the implementation a training program was not statistically significant. Despite the reported positive outcome of the training, implementation of recommendations stalled since training did not focus on structural problems which were the main drivers of mistreatment. Participants also reported a violation of their rights, another contributor to the mistreatment of women and criticised the intervention for its lack of attention to providers' rights. Therefore, to understand the full scope of benefits of RMC interventions, health system interventions and specific participant characteristics should be accounted for when evaluating the impact of an intervention. As such in Smith et al.'s (2020) behavioural design approach, a difference-in-difference analysis was conducted to ascertain the findings and offset their inability to mitigate the impact of other factors on the intervention. Qualitative data was also employed to obtain an in-depth insight into the result.

As discussed in section 2.6.3. above, the incorporation of multi-stakeholders in the development of strategies to promote RMC is highly significant in ensuring the sustainability

of interventions. There were, however, some challenges related to the implementation for these interventions. The implementation was affected by challenges associated with biomedical principles of care which did not account for social determinants of health, policy, governance, and the structural limitations that remained unchanged during the implementation of interventions (Asefa, Morgan, Bohren, et al., 2020; Ratcliffe, Sando, Mwanyika-Sando et al., 2016; Reis et al., 2012). This demands the development of an RMC concept that takes into consideration systemic nuances that affect midwives' professional capabilities. Other factors included justification of D&A by providers (Ackers et al., 2018; Erlandsson et al., 2014), lack of integration of RMC into policy guidelines and best practice curricula, and a lack of community involvement in the promotion of RMC (Hall and Mitchell, 2017; Ouedraogo et al., 2014). In some cases where findings reported a change in behaviour, individual measures showed little change. Peer pressure and environmental culture affected the capacity of individuals, who seemed to have internalised RMC, to practice it effectively (Ndwiga et al., 2017).

To assess the impact and effectiveness of these interventions, it is also necessary to develop robust tools that have been tested through research to measure RMC. Significantly, the review identified some tools designed to measure the provision of RMC. These studies were explored, and a narrative summary of the studies identified is presented below.

2.7. Measuring respectful maternity care

This review explored the development of tools to measure RMC in order to gain an understanding of their psychometric properties to further clarify the key concepts in RMC and whether the measurement reflected the conceptualisation. This enhanced the understanding of RMC in its full scope and ensured the identification of gaps within the literature for further research. Twenty-one studies focused on the development or validation of tools for measuring RMC and all but one study conducted in India (Scott et al., 2020) utilised quantitative methodologies in determining the psychometric properties of the RMC tools. The studies

included one rapid review (Afulani et al., 2020), one systematic review (Dhakal et al., 2021), two mixed methods empirical studies (Moridi et al., 2020a; Sheferaw et al., 2016) and sixteen quantitative empirical studies (Afulani et al., 2017; Afulani, Diamond-Smith, et al., 2018; Afulani, Feeser, et al., 2019; Ayoubi et al., 2020; Dzomeku, Boamah Mensah, et al., 2020; Esmkhani et al., 2021; Feijen-de Jong et al., 2020; Hajizadeh, Asghari Jafarabadi, et al., 2020; Jenkinson et al., 2021; Rubashkin et al., 2017; Sheferaw et al., 2021; Singh et al., 2021; Taavoni et al., 2018; Vedam, Stoll, Martin, et al., 2017; Vedam et al., 2019; Vedam, Stoll, Rubashkin, et al., 2017).

These studies were conducted globally with 6 being conducted in high-income countries: three in British Columbia Canada (Vedam, Stoll, Martin, et al., 2017; Vedam et al., 2019; Vedam, Stoll, Rubashkin, et al., 2017), one in Hungary (Rubashkin et al., 2017), one in Queensland Australia (Jenkinson et al., 2021), and one in the Netherlands (Feijen-de Jong et al., 2020). Five of the studies were conducted in Iran (Ayoubi et al., 2020; Esmkhani et al., 2021; Hajizadeh, Asghari Jafarabadi, et al., 2020; Moridi et al., 2020a; Taavoni et al., 2018), two in Ethiopia (Sheferaw et al., 2021; Sheferaw et al., 2016), three in India (Afulani, Diamond-Smith, et al., 2018; Scott et al., 2020; Singh et al., 2021), one in Kenya (Afulani et al., 2017), one in Ghana (Dzomeku, Boamah Mensah, et al., 2020) and three in multiple locations (Afulani et al., 2020; Afulani, Feeser, et al., 2019; Dhakal et al., 2021). This scoping review included 6 primary studies that were included in the reviews by Afulani et al. (2020) and Dhakal et al. (2021). This is because this current scoping review is intended to provide a wider exploration of the included papers beyond that which was carried out by the reviewers. For instance, Dhakal et al. (2021) critiqued the process of developing the psychometric properties of tools whilst Afulani et al., 2020 reviewed the evidence that informed the indicators for evaluating RMC. These did not compare variations in context or whether they measured a distinct concept of RMC which were important in this current scoping review.

The last three years have seen a proliferation of research and since the initial review, seventeen new studies have been conducted necessitating an investigation of the domains

being measured and whether the conceptualisation of RMC influenced its measurement. The review identified initial scales which measured different constructs of RMC. Sheferaw et al. (2016) developed a scale of 15 items (based on four components of RMC; friendly care, abuse-free care, timely care, and discrimination-free care) that measured women's perceptions of RMC in public hospitals in Addis Ababa, Ethiopia. As reiterated in this scoping review, these loading factors reflect the partial conceptualisation of RMC; as the absence of D&A. Vedam, Stoll, Martin, et al. (2017), and Vedam, Stoll, Rubashkin, et al. (2017) in studies conducted in British Columbia Canada, focused on measuring the experience of RMC as it relates to women's sense of autonomy and their experience of disrespect and discrimination respectively.

The Mother's Autonomy in Decision Making (MADM) scale measured a single construct; decision-making during maternity care (Vedam, Stoll, Martin, et al., 2017) and the Mothers on Respect Index (MORi), assessed the nature of respectful interactions between women and their providers and how that influenced women's sense of comfort, behaviour, and perceptions of racism or discrimination (Vedam, Stoll, Rubashkin, et al., 2017). Afulani et al. (2017) also focused on measuring PCMC, another typology of women's experience of maternity care. The authors developed a 30 item PCMC scale with three subdomains: dignified and respectful care, communication and autonomy, and supportive care. The generation of items for these scales and subsequent ones were carried out using a review of existing literature, face validity established through expert reviews with criterion related validity, reliability of construct, and content validity further undertaken through the completion of questionnaires by women, the community, and midwives in one study (Moridi et al., 2020a). Thus, indicating limited attention to the opinions of midwives in the development of these scales. All researchers evaluated their scales for the potential to measure the particular phenomenon.

The development and validation of several other scales has benefited from the items generated in these initial scales and the validation of these scales in other contexts besides the ones they were developed in have confirmed (or not) their content, criterion, and face

validity and reliability. The review identified other instruments that were developed using these scales as a guiding framework. Dzomeku, Boamah Mensah, et al. (2020), Esmkhani et al. (2021), Hajizadeh, Asghari Jafarabadi, et al. (2020), and Scott et al. (2020) utilised the 15 item scale by Sheferaw et al. (2016) developed in Ethiopia as a framework to guide the construction of scales in Ghana, Iran, and India respectively. The MADM and the MORi scales were also utilised as guiding frameworks for the development of scales in Hungary, Australia, and the Netherlands (Feijen-de Jong et al., 2020; Jenkinson et al., 2021; Rubashkin et al., 2017). The PCMC scale developed in Kenya has also been validated in Ghana, India, and Kenya (Afulani, Diamond-Smith, et al., 2018; Afulani, Feeser, et al., 2019; Scott et al., 2020).

Researchers adopted scales that had similarities to the context where the new scales were to be developed or validated. For instance, in the validation of scales within the Australian context, Jenkinson et al. (2021) adopted the MADM and the MORi scales which were developed in a similar context, Canada. Similarly, Esmkhani et al. (2021) and Hajizadeh, Asghari Jafarabadi, et al. (2020) used Sheferaw et al's. (2016) scale developed in Ethiopia as a guiding framework for the development of scales in Iran. This indicates that in lower-middle income countries, the absence of D&A seems to be the predominant RMC construct. However, even where the contexts were similar, adaptations needed to be made to the scales as some items were either not valid or relevant in different settings.

This demonstrates that recognition of context specific situations in the generation of tools for measuring RMC was vital as some behaviours were rarely reported in certain contexts. For instance, Sheferaw et al. (2016) included items relating to D&A such as insulting, slapping, and shouting which were not mentioned by Vedam, Stoll, Rubashkin, et al. (2017). Additionally, the validation of scales in other settings resulted in some items being deleted and others added as they were either not valid or relevant to these settings. Jenkinson et al. (2021) adapted the original wording in the MORi scale relating to type of health insurance or lack of health insurance as Australia had universal health insurance. Researchers also adopted the use of the word 'strongly' instead of 'completely' as participants in Australia perceived

completely to be too absolute. In Hungary and Canada, significant contextual differences were found in terms of informal payments, informed consent practices, and women's perceptions of autonomy and this culminated in some adaptations to the MADM scale to reflect the practices within the Hungarian context and resulted in the addition of 9 new cash payment questions (Rubashkin et al., 2017).

The contextualisation of constructs was relevant not just in the development of the domains but also in the use of language to ensure that questions reflected women's actual experience. To exemplify this, Scott et al. (2020) conducted cognitive interviews in India on pre-existing scales used in Kenya, Ethiopia, and India to investigate how respondents understood the questions in the survey and response options given. The researchers found that the response options were problematic, vocabulary was inappropriate, and there was failure of questions to resonate with the respondent's worldview and reality. According to the researchers, there were mismatch between what the questions intended and how respondents interpreted these questions, response options to Likert scale were incomprehensible, and many key universal RMC concepts were not well understood and had limited significance for respondents. Therefore, variations in settings besides where tools were developed require that robust testing is always carried out to ensure new tools address vital contextual nuances. The necessity of contextual realities is, therefore, highly significant in all facets of the RMC phenomenon, especially in how it is conceptualised because this influences the interventions developed to promote it and the tools created to measure it. Hence, it is expedient to establish domains of RMC that extend beyond the absence of D&A and incorporates contextually relevant practices, and the development of tools and interventions ought to address these distinct domains.

The 49 indicators for monitoring and evaluation of RMC identified in the rapid review which spanned several domains of RMC and D&A included some facility level domains such as the facility environment and culture (Afulani et al., 2020). Therefore, whilst measuring the psychometric properties in relation to the care providers is vital, the review has also revealed

the necessity of an enabling work environment for the provision of RMC. Hence, developing a tool to measure institutional level RMC was expedient. A cross sectional study of the 2016 census of 3,804 health facilities in Ethiopia resulted in the development of the institutional level RMC scale (Sheferaw et al., 2021). The researchers computed the items on the institutional level RMC index as loading on three factors: RMC policy, RMC experience, and facility provision of RMC. The conceptualisation, promotion, and measurement of RMC should thus be context specific, multistakeholder driven, and underpinned by RMC domains that extend beyond the absence of D&A in order to achieve set targets.

Summary of findings

The findings presented in the above section explored the various interventions and tools that have been developed and implemented to promote and measure RMC. The review indicated that RMC interventions have been categorised into policy level interventions, women, provider, and facility level interventions, and community level interventions. Interventions implemented at the policy level included incorporating RMC into curricula, setting up quality improvement teams, and having a strong political commitment and influence from national, regional, and local governmental levels. Community level interventions included community workshops, mediation/alternative dispute resolution, and community activities including campaigns. Though the evidence indicated a multistakeholder involvement in the development of interventions, the interventions implemented were mostly aimed at provider attitude transformation. The most predominant strategy was the training of providers on RMC which suggests that RMC has mostly been conceptualised as an attitudinal problem of providers without parallel attention to systemic constraints that have the potential to influence the attitude of providers. This limited attention to broader health system challenges had an impact on the capacity of provider training to achieve expected outcomes. The evaluation of interventions revealed that better outcomes were achieved when provider training was carried out as part of broader health system interventions. The tools developed

to measure RMC also demonstrated the need for the consideration of context. Though several tools used pre-existing tools from similar settings as frameworks, there was the need to modify new tools to reflect contextual dynamics even in situations where the settings were similar.

2.8. Conclusions from the scoping review

The scoping review provided an in-depth highly comprehensive overview of the existing literature on RMC. Eighty-eight studies were included in the review, and these were categorised into three broad themes: conceptualisation of RMC, interventions to promote RMC, and measuring RMC. The conceptualisation of RMC is highly important in ensuring that it can be measured and where it is lacking, interventions appropriately developed and implemented. The conceptualisation of RMC had been carried out by eliciting the views of women, healthcare providers, and other relevant stakeholders in maternity care. There were very few studies in the initial review that had done this, indicating a low focus on the development of the concept which became the rationale for this study. However, within the past few years there have been an exponential growth in attention to RMC and to the perceptions of both women and their care givers. Additionally, research had also focused on interventions to promote RMC and the development of tools. The updated version, therefore, incooperated these new studies to reflect current trends in RMC and enable the understanding of the concept in its full scope.

The findings indicate that RMC is a universal concept, which encompassed common underlying factors irrespective of the context such as communication, information giving, informed consent, and women's involvement in the decision-making process about their care. The concept also has specific constructs that reflected contextual situations such as the provision of privacy and confidentiality which were not conceptualised in all settings. Evidence obtained indicated that in some settings there was an emphasis on D&A, RMC as the absence of abuse, and a reliance on pre-existing frameworks on D&A for the development of the RMC

concept, interventions for its promotion, and measuring tools. However, the absence of abuse may not necessarily be commensurate with the presence of RMC and over reliance on pre-existing frameworks may present limitations in the capacity to identify contextual nuances. This deductive approach also restricts the possibility of extending the concept to reflect contextual issues and needs. Therefore, eliciting the views of midwives through an inductive approach to explore a context specific concept of RMC that extends beyond the absence of D&A and addresses contextual nuances is required.

Nonetheless, to affirm this universal rights-based approach, international organisations like FIGO in their approved guidelines for mother-baby friendly birthing facilities affirm women's right to be treated with dignity and respect. It called for the protection of women against procedures and actions that do not respect their culture, bodily integrity, and dignity (International Federation of Gynecology and Obstetrics, International Confederation of Midwives, White Ribbon Alliance et al., 2015). They have further described D&A as a violation of women's rights and called for the reinforcement of the principles of beneficence, nonmaleficence, justice, and autonomy (International Federation of Gynecology and Obstetrics (FIGO), 2021). However, this does not take into consideration the evidence of concerns raised by care providers. While the universal rights-based approach is vital in ensuring women's rights are promoted, evidence from this review highlights that it is also vital to promote it in a manner that acknowledges contextual realities.

This universal approach particularly to the translation of the concept and to its promotion was, therefore, critiqued because it lacked an interest in the needs of care providers and it also yielded negative consequences in some settings (De Kok et al., 2020). Eliciting providers' views, which has only gained recent attention as noted in the updated version of the review, enabled the discovery of this disconnection between the universal concept of RMC and local interpretations as well as the disconnection between providers' ideal conceptualisation of RMC and its practice. The conceptualisation of RMC was not commensurate with its practice and the review identified that mistreatment was adopted by care providers on the grounds of

safety and the presence of various health system and professional constraints (Bradley et al., 2019; De Kok et al., 2020; McFadden, Gupta, Marshall et al., 2020; Shakibazadeh, Namadian, Bohren et al., 2017). This disconnection was, however, only interpreted as justification of D&A (Ackers et al., 2018; De Kok et al., 2020; Erlandsson et al., 2014) and there was limited causal connection between the identified systemic constraints and midwives' D&A.

This situation of the RMC concept as the absence of abuse and the notion of care providers as perpetrators of abuse were reflected in the interventions adopted to promote RMC and tools developed to measure it. The review revealed that although a multistakeholder approach was adopted in the development of some interventions, the dominant intervention was the training of health providers with limited attention to quality improvement of the health system. Such interventions were found to have limited impact whereas the few interventions that were implemented along with quality improvements within the health system had higher impact. This highlights that RMC is not limited to only interpersonal relationships but extends to wider system related issues. This review also highlighted the importance of context within the RMC discourse. Context was vital in shaping the typology and defining components of RMC and the items and loading factors of tools for its measurements. Therefore, this needs to be taken into consideration during the development of specific strategies for improvement and tools for measurement (World Health Organisation, 2018). Furthermore, context needs to be a significant factor when defining, promoting, and measuring RMC to ensure that the relevant issues are addressed. This also necessitates further exploration through research to identify the context specific aspects of care that can be integrated into the conceptualisation of RMC as well as the causative mechanisms and how they function to impact midwives' agency to gain a full understanding of the real situation.

2.9. Justification for the study

In the initial scoping review, no studies were identified that had elicited the views of midwives within the Ghanaian context. This dearth of information became the rationale for this study.

However, similar to the findings of the scoping review, there has been an enhanced interest in RMC within the Ghanaian context with the identification of 7 studies that had Ghana as its major focus or as part of the study population (Afulani, Aborigo, et al., 2019; Afulani, Feeser, et al., 2019; Dzomeku, Boamah Mensah, et al., 2020; Dzomeku, Mensah, et al., 2021; Dzomeku, Mensah, et al., 2020b; Manu et al., 2021; Moyer et al., 2021). These studies also investigated the views of midwives, explored interventions to promote RMC, and developed tools to measure it and their findings were similar to those described in the sections above.

In some of the studies conducted in Ghana, the conceptualisation of RMC was based on pre-existing frameworks and the views of midwives were partially interpretated as justification of D&A without parallel attention to the illumination of causal connections between the issues raised and midwives' agency. Additionally, training of care providers was the only form of intervention implemented (Dzomeku, Mensah, et al., 2020a; Dzomeku, Mensah, et al., 2020b; Moyer et al., 2021; Moyer et al., 2016; Rominski, Lori, Nakua et al., 2017). As reiterated, this presents a partial representation of the RMC concept that is grounded on the absence of abuse, midwives as perpetrators of abuse, and the lack of investigation of the causal connection between the systemic challenges and midwives' agency, hence the adoption of training as the only intervention to promote RMC. Furthermore, Dzomeku, Mensah, et al. (2020b) and Rominski et al. (2017) who elicited the views of care providers only used interviews and FDGs respectively to collect data and with an interpretivist philosophical underpinning limiting the capacity to identify causative mechanisms when RMC was lacking.

There continue to be reports of D&A in Ghana (Moyer et al., 2021) and whilst the perceived justification of the D&A by midwives including students (Rominski et al., 2017) is alarming, the gaps in the development of evidence to conceptualise RMC and develop appropriate interventions are bottlenecks in the promotion of RMC. Therefore, though there has been increased attention to RMC, further research is still required to first investigate the full scope of the RMC concept to make it sensitive to midwives' needs and the context specific realities of care. Secondly, there is the need to identify the real causative mechanisms and explain

their causal connection with midwives' agency. Finally, recommendations need to be made based on the 'real' to enable a wider focus from only the training of care providers and assist in the development of frameworks that can be integrated into midwives' philosophy of care. Hence, using an inductive approach, with multiple data collection strategies and a critical realist philosophical underpinning is appropriate to facilitate the conceptualisation of RMC, the identification of contextual issues not captured within universal frameworks, and the understanding of causal connections. This study, therefore, sought to elicit the views and beliefs of midwives and other stakeholders like ward managers on RMC and investigate the facilitators and barriers for the provision of RMC to enable the identification of causative mechanisms. Choosing the Ghanaian context where there has been widespread reports of D&A in research and mainstream media and few interventions implemented will enable recommendations to be made for the development and implementation of strategies to promote RMC.

2.10. Research question

What does RMC mean to midwives within the health system in Ghana and what are the factors that affect the provision of RMC by midwives in Ghana?

2.11. Aim and objectives

The overall aim of this study was to understand midwives' views and beliefs about RMC and how RMC was enacted, influenced, and experienced in everyday practice. The following objectives were considered to address this broad aim:

- To understand what RMC meant to midwives working in a maternity unit
- To explore the factors that influenced the provision of RMC
- To explore the facilitators and barriers for the provision of RMC

CHAPTER THREE: METHODOLOGY AND METHODS

3.1. Introduction

The previous chapter presented a report of an extensive and highly comprehensive scoping review conducted on the available literature on RMC and identified research gaps which underpinned the current study. This chapter will describe the research strategy adopted to facilitate the understanding of midwives' views and beliefs about RMC, how they enact these views, the factors that influenced their ability to provide RMC, and their experiences of RMC in their everyday practice. The chapter is divided into three sections: study design and methodology, methods, and then data management and analysis. The methodology section will describe the framework adopted for the conduct of the study and this incorporates the philosophical underpinning of the research. The methods adopted, that is study population, access to the study sites, data collection techniques, and the ethical issues considered during the conduct of this study are discussed. Finally, the third section will describe the approach to data analysis, the maintenance of quality and rigour, and a reflexive account of the research process is presented. The application of the key principles of abduction and retroduction in CR and how they facilitated the identification of causative mechanisms in RMC is also described in this section.

3.2. Study design and methodology

3.2.1. Qualitative research approach

A qualitative research design was the most suitable approach because it seeks to describe and explain events from the perspective of those who participate in them in order to provide an understanding of social realities whilst drawing attention to underpinning processes, meaning patterns, and structural features (Flick, Von Kardorff, and Steinke, 2004). According

to Braun and Clarke (2013), qualitative research is about meaning, experiential knowledge, context, and offers varied approaches to making meaning from research data. The term 'qualitative research' encompasses different research approaches that have differing theoretical assumptions, understanding of the object under investigation, and methodological focus. The methodologies utilised within qualitative research offer an inquiry into human conditions to obtain an understanding of the meaning attributed to various human experiences (Taylor and Francis, 2013). These methodologies are the theoretical and philosophical frameworks that underpin the process of inquiry (Brewer, 2000). The methodologies utilised with qualitative research include phenomenology, grounded theory, ethnography, and narrative inquiry. This study adopted a focused ethnographic approach as its methodological focus. The rationale for this choice is explained in detail below.

3.2.2. Ethnography

The focus of inquiry of most forms of ethnographic studies is with the lives of the research participants as lived within their context (Atkinson, Coffey, Delamont et al., 2001). Therefore, ethnography endeavours to understand the culture (social interaction, behaviours, perceptions) of groups, teams, organisations or communities from within the group, through the eyes and ears of the researcher (Reeves, Kuper, and Hodges, 2008; Walsh, 1999). The ethnographic researcher acquires knowledge of the social world under investigation through an intimate familiarity with the everyday activities and meanings ascribed by participants to their social world (Brewer, 2000). Ethnography, therefore, results in a holistic understanding of human culture and specific environments through chosen method(s) (Reeves et al., 2008).

However, the lengthy time needed to immerse in the lives of participants within traditional approaches to ethnography has led to the emergence of new approaches, especially in health research such as auto-ethnography, critical ethnography, and focused ethnography (FE). In auto-ethnographies, the focus of inquiry is the researcher's own lived experiences using an analytic approach to interpret personal and cultural experiences (Ellis, Adams, and Bochner,

2011). Critical ethnography focuses on addressing injustice and unfairness within the social world, thus changing the status quo within the culture (Madison, 2011). Within the focused ethnographic domain, the focus of inquiry is a specific or selected aspect of a field (Knoblauch, 2005). This approach to ethnography is, therefore, more appropriate for understanding the specific concept of RMC among midwives within their specific context and culturally situated work environment. FE was congruent with the aim of the study which was to obtain an understanding of the beliefs about RMC that midwives used to shape their behaviour within their culturally constituted work environment.

3.2.3. Focused ethnographic approach

FE evolved from classical anthropological ethnography and maintains distinct features derived from this association, such as participant observation and attention to the role of cultural and social norms in influencing behaviour (Cruz and Higginbottom, 2013). It is suitable when answering specific questions that focus on a phenomena, discrete community or organisation, it is context specific, and involves a limited number of participants (Higginbottom, Boadu, and Pillay, 2013). Rather than gaining insight into the culture of a group in its entirety, FE adopts a narrower scope of inquiry. There is a growing interest in the use of FE in healthcare research, including maternity care due to its ability to enhance understanding of practice through the study of a distinct phenomenon among a specific client or professional culture (Higginbottom, Safipour, Yohani et al., 2016; Higginbottom, Safipour, Yohani et al., 2015; Sullivan, O'Brien, and Mwini-Nyaledzigbor, 2016). For instance, Sullivan et al. (2016) explored the perception of support amongst Ghanaian women who were experiencing or had experienced obstetric fistula and their close associates. The researchers utilised in-depth interviews, participant observations, and analysis of documents to obtain an emic perspective of this phenomenon within the discrete community.

FE is appropriate in midwifery research when the emphasis of the researcher is on an issue or situation distinct to a small group of practitioners or clients with a shared culture within a

specific context. This focus on shared features within a target group enables focused ethnographers to investigate common behaviours and experiences (Roper and Shapira, 2000). When utilized in health research, FE presents a pragmatic means of capturing data that is topic specific and is of importance to practitioners for the improvement of care and care processes (Higginbottom et al., 2013). The conduct of FE research is distinguished by short field visits which focus on communicative activities, it is time intensive, utilises a small sample size but with large data and scrutiny of analysis, and the researcher enters the research field with specified research questions and previous information about the field or phenomenon under investigation (Higginbottom et al., 2013; Knoblauch, 2005; Wall, 2014). Using FE in this study enabled me to examine midwives' beliefs about RMC. It also enabled me to meaningfully contextualise the components of RMC and aided by the philosophical underpinning discussed below, considered the personal, institutional, systemic, and societal influences on the provision of RMC within the maternity units involved in the study.

3.2.4. Philosophical underpinning

The central focus distinguishing qualitative from quantitative research is the understanding of the nature of reality or the world as it is; referred to as ontology, and the assumptions underlying the means adopted to obtain knowledge about this world which is referred to as epistemology (Nairn, 2012). Epistemological and ontological positions are important philosophical stances that researchers assume and these may differ between researchers leading to differences in research approach or methodologies adopted to investigate the same phenomena (Scotland, 2012). Quantitative researchers believe that there is a single objective reality. This positivist philosophical standpoint underpins quantitative research methodologies such as randomised controlled trials that are carried out under rigorously controlled conditions (Nicholls, 2009a). Qualitative research, on the contrary, is premised on the assumption that there are multiple realities and unique individual experiences of this reality (Bleiker, Morgan-Trimmer, Knapp et al., 2019). Hence multiple philosophical standpoints underpin the various

methodologies within qualitative research. These philosophical positions include but not limited to interpretivism, constructionism, and critical realism. Interpretivism, mostly adopted by phenomenologists, concerns how individuals perceive the world around them and research into this social world reflects the uniqueness of the individuals within it (Bryman, 2016). Constructionism studies participants' construction of meanings and actions in particular situations (Andrews, 2012). Social constructionists, therefore, assert that social phenomena are produced through continuous revision by the social actors not merely through social interaction. Critical realism differs from these philosophical assumptions by asserting that the social world does not just consist of experiences, events, phenomena, and interactions but also of underlying powers, structures, and mechanisms that exert a causal effect on experienced phenomena and actual events (Patomäki and Wight, 2000).

These philosophical assumptions significantly influence the methodologies adopted in the conduct of research, so choosing a position was a fundamental aspect of this research and it had direct influence on the methodologies and methods adopted. As discussed earlier ethnographies illuminate social patterns or conduct that might not be obvious even to the members of the culture and ethnographers do not take things at face value (Morse and Field, 1995). Therefore, Bhaskar's CR (Bhaskar, 1998b) best suited my views about the context specific concept of RMC and the objectives that guided the conduct of the study. The epistemological and ontological assumptions of CR are discussed in the following section.

3.2.5. Critical realism

The critical realism movement emanated from Roy Bashkar's work, 'A Theory of Science' (Archer, Bhaskar, Collier et al., 1998). Though not fully restricted to Bhaskar, his work has transformed the intellectual scene in philosophy and the human sciences. CR embraces both constructivist and positivist epistemology and delivers an in-depth account of both ontology and epistemology (Fletcher, 2017; Guba and Lincoln, 2011). It is, however, argued that it prioritises ontology over epistemology (Nairn, 2012). This prioritisation was not a limitation in

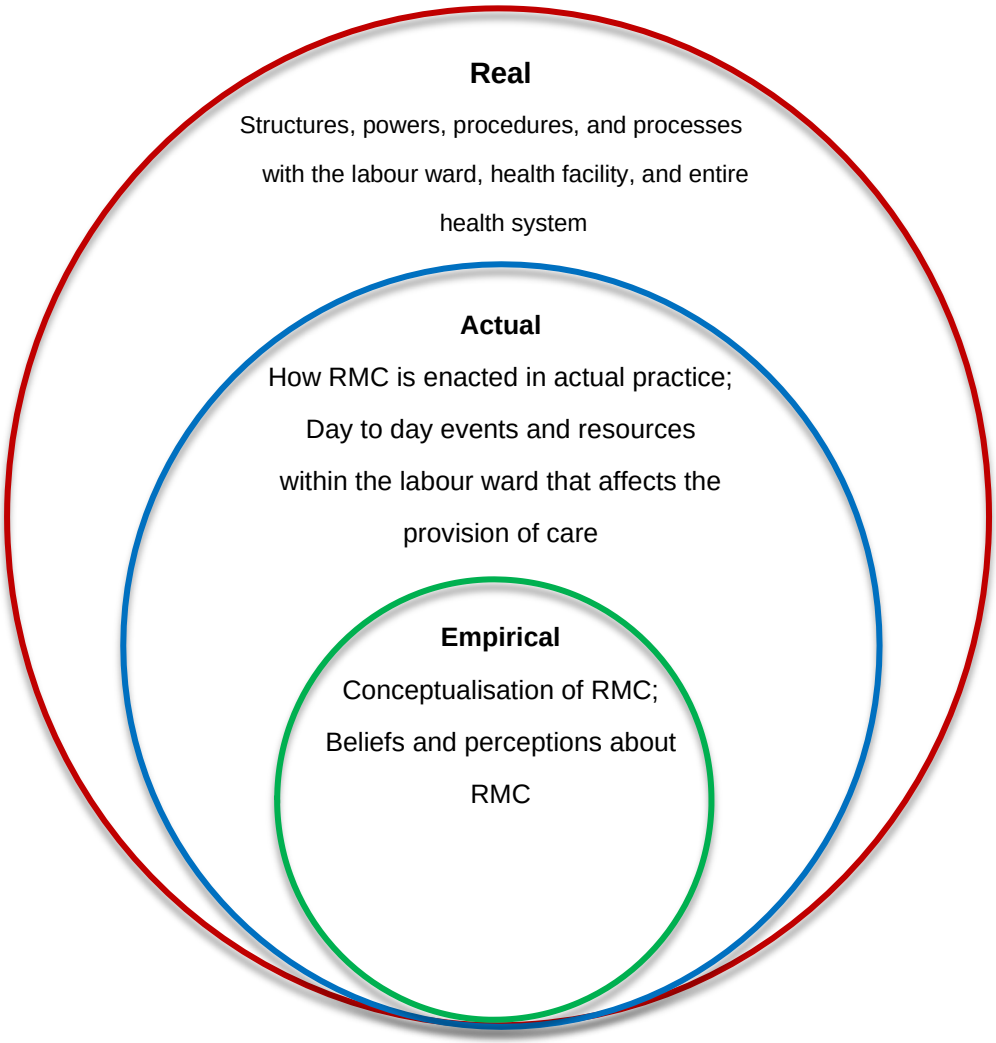
this study because of CR's ability to uncover the real and its valuing of context specific situations was vital in this study.

Ontologically, according to Bhaskar, there is the idea of an external reality (Intransitive domain) and this reality is independent of human perception or knowledge (Archer et al., 1998), a notion that is similar to positivism. Contrary to positivism, however, the understanding of this reality sees human action as hinged on the processes, i.e. facts, theories, models or techniques (Transitive domain) that are used for the production of knowledge about the world (Zachariadis, Scott, and Barrett, 2013). In addition to these two dimensions (transitive and intransitive), Bhaskar stratified reality into three levels: the empirical, actual, and real (Walsh and Evans, 2014). Bhaskar described the empirical reality, which is superficial, as the experience of events or observations made (Bhaskar, 1998b) and this level lends itself to empirical measurements (Zachariadis et al., 2013). In more simplified terms, the empirical is what is seen, heard, felt, and experienced through perception using the senses (Nairn, 2012). This level is also influenced by how individuals attribute meaning to key events and processes giving it an interpretive dimension which is influenced by culture and social or organisational norms. The actual, which is the middle level, is what really happens or the events that occur. It consists of events which are independent of experience or observations (Walsh and Evans, 2014) and controls the empirical. The last level, which is the real has been considered the central tenet of Bhaskar's work (Houston, 2001). This level comprise of structures and processes with innate causal powers which may not be observable (Zachariadis et al., 2013) and their analysis is one of the distinct characteristics of CR (Sayer, 2000).

Thus, this study sought to understand the empirical, actual, and real realities surrounding RMC within the contexts of the chosen facilities. Underpinned by this philosophical standpoint, data was collected to inform the understanding of the meaning and beliefs attributed to RMC which formed the empirical reality. The actual reality was the actual enactment of RMC within these contexts: this was how midwives practiced RMC within their context specific work environments. However, none of these provided an understanding of why RMC was perceived

and enacted in the way it was manifested. Obtaining an understanding required an exploration of the causative mechanisms within these contexts and the wider healthcare system to identify the 'real' underpinning reality of RMC. The real were the structures, powers, procedures, policies, and processes within the labour ward, health facility, and the entire health system that affected the provision of care but may not be observed empirically (see figure 4).

Figure 4: Three ontological levels in relation to RMC adapted from Mingers and Willcocks (2004)



Using a CR epistemological position, researchers seek to identify structures, powers and tendencies, understand their interactions, and give explanation of the components and how they facilitate the occurrence of a phenomenon of interest (Fletcher, 2017; Patomäki and Wight, 2000), thus encouraging a thorough exploration. This is achieved through the process of retroduction which is further explained in section 3.6. As discussed earlier, FE is underpinned by the study of human actions. However, Bhaskar asserts that these actions cannot be understood by simply exploring an individual's own construction of reality, though this contributes to the understanding of human actions. These human actions are not carried out at random but have patterns (Porter and Ryan, 1996). This is not to imply that human beings lack agency or automatically respond to the dictates of these structures. With society being an open system means that people's actions are influenced by both innate psychological and social mechanisms (Edgley, Stickley, Timmons et al., 2016).

Critical realism, therefore, asserts that human behaviour is influenced by both structure and agency (Bhaskar, 1998a). These social structures emerge from the actions of individuals and these have causal connection with other individuals within the structure (Cruickshank, 2012). The discovery of these overt and covert aspects of culture that may be known or unknown to the members of the culture is also an essential aspect of ethnography (Fetterman, 2010) and the 'Real' within CR which this study seeks to discover. CR espouses the use of a wide range of methodologies (Sayer, 2000), however, the specific subject or object of research will determine the particular choices. A CR approach to FE was, therefore, chosen with the purpose of not simply understanding midwives' constructed meaning of RMC but also highlighting the connection between midwives' knowledge and agency and the tendencies, processes, structures, and mechanisms within the labour ward environment and the healthcare system.

In addition to the CR philosophical underpinning, the study also utilised Foucault's theory of power (Foucault, 1979) and feminist interpretations as theoretical frameworks to explain the findings of the study and extend their theoretical interpretations. According to Foucault (1983),

power is central to the process that results in an individual being made subject to control and dependence. Therefore, Foucault's theory on power was chosen as a theoretical underpinning because it offered a framework for the discovery of the power inherent in the structures and processes within the health system that exert control on the individuals within the system and contributes to the actions of these individuals. Foucault believed that power was not an entity but a mode of action that only existed when it was exercised, making it suitable for interpreting the actions that resulted in the observable events within the study settings. Additionally, the participants involved in this study were all women and the focus of the study, RMC, involves mostly women, hence using feminist interpretations was expedient for highlighting women's voices and needs in general. Feminist theories emphasise on gendered inequalities, the many levels of power, and the dominant effect of patriarchal systems that influence women's experiences (Sprague, 2016). Issues of power used in controlling women's bodies have been identified by feminist researchers in discourses pertaining to the technocratic models of birth (Davis-Floyd and Sargent, 1997). The power (authoritative knowledge) that is used in controlling women's bodies within the technocratic model is the same as that used in mistreating women, making feminist interpretations significant in RMC. Therefore, in addition to CR, Foucault's theory of power and feminist interpretations were chosen to facilitate the deconstruction of the structures, powers, processes, and the gendered nature of the systemic inequalities that result in the observable events related to RMC.

3.3. Research methods

The methods adopted in the conduct of this study were underpinned by my FE approach and CR philosophical standpoint. These methods were utilised based on their ability to facilitate both the understanding of the RMC concept and to uncover the causative mechanisms influencing RMC. The study, therefore, involved a plethora of methods which were congruent with not only the methodology but with the epistemological underpinning of the study. Research methods are the technical procedures utilised in obtaining reliable and objective

knowledge (Brewer, 2000). Thus, Carter and Little (2007 p.1318) describe these methods as 'research in action'. These are the actual activities that are involved in the conduct of the research itself. They include recruitment of participants, data collection, and data analysis (Carter and Little, 2007). According to naturalism, methods that allow access to the meanings that guide human behaviour should be employed to understand this behaviour (Hammersley and Atkinson, 2007).

Qualitative research incorporates a variety of data collection strategies (Silverman, 2017) and these strategies should be purposely selected to meet the aim of the study. The proceeding sections will focus on the settings within which data was collected, the instruments used in collecting data and how they link to FE and CR, participants involved in the study, gate keeping and how the study setting was accessed, recruitment strategies, and the ethical considerations within the study.

3.3.1. Study settings and population

The study was conducted in public sector health facilities in three different study sites located in both urban and rural areas: the labour wards of a regional hospital (hospital A, 50 midwives), (ii) a Municipal hospital (hospital B, 40 midwives), and (iii) a district hospital (hospital C, 15 midwives) all within the same region. These facilities are, henceforth, referred to as hospital A, B, or C. A range of study sites were chosen to facilitate an in-depth exploration of the phenomenon of interest from different levels of facilities and cadres of midwives. The specific sites were selected for practical reasons (Miles, Huberman, and Saldaña, 2014) including accessibility to me. The facilities represent the types of hospitals found under the GHS within the various regions of Ghana. They serve as referral centres for other hospitals and health centres within the region, with the regional hospital being the biggest and the most specialist referral centre in the region. Two of the hospitals are affiliated to the three Nursing and Midwifery Training Colleges in the region and are also centres used by the Nursing and Midwifery Council (NMC), Ghana, for practical licensing examination for nursing and midwifery

students in the region. They have an average of 450 births per month with some facilities recording between 600 and 800 births during the peak seasons of May, June, and July. For the purposes of this study, the term “labour ward” will be used in accordance with common parlance in Ghana – defined as any location where women in labour are cared for, from the point they report to the hospital until the end of the fourth stage of labour (six hours after birth) (Ministry of Health, 2017).

The study aimed to collect data from two major groups: (i) midwives comprising of experienced midwives, rotation midwives, and student midwives working in the labour wards during the study period and (ii) stakeholders comprising of labour ward managers, senior nursing, and midwifery officers in the regional health directorate, the NMC, and the facilities, medical directors/ superintendents, and members of the quality assurance team. Accessing these study sites and participants is described below.

3.3.2. Gatekeeping and access to study site

Gatekeeping is an important aspect of conducting research and this has several meanings. Kawulich (2010) defined it as the process of gaining access to a field of study and the participants of the study. Hence, gatekeepers are the individuals within an organisation with the power to allow or refuse permission to access an organisation for the purpose of research. I began this process by initiating relationships with key informants who assisted in gaining access to the gate keepers. For the health facilities chosen for this study, the key gatekeepers were the medical directors or superintendents and the deputy directors of nursing and midwifery services (DDNS).

Prior to entering the field, I did not know anyone who worked in any of the facilities chosen for the study. I, therefore, made contacts with colleagues who may know employees within the facility. Due to the data collection methods that had been adopted for the study, I needed to be sure that there would be enough midwives within the labour wards of these facilities to

enable the formation of enough focus groups. This information and the contact details of these facilities were, however, not available online, and the key informants were helpful in obtaining them. Prior to the initial physical access to the facilities permission letters were sent to all the facility heads via email requesting for their permission to use the facilities. Though no written responses were obtained, there was verbal consent and a formal written permission letter from the director of the Regional Health Directorate. These initial contacts with the key informants were done via telephone from the UK, so on arrival in Ghana, I visited these facilities to introduce myself to the key informants and the gatekeepers whilst awaiting permission letter from the regional health directorate and ethics approval. Not all key gatekeepers were available to meet with me. In hospital B access, was obtained through the hospital administrator and the DDNS.

Following ethics approval from the University of Nottingham Faculty of Medicine and Health Sciences and the Ghana Health Service Ethics Review Committee, I met with the gate keepers to explain the purpose of the research, process of collecting data, inclusion and exclusion criteria of participants and the duration for the collection of data and confidentiality was assured. Due to the sensitive nature of the research topic, the medical superintendent in one of the facilities asked to review all documents including observation and interview guides to ensure no questions were going to be asked that would implicate the facility. I was then given an orientation to the facilities and introduced to the labour ward managers. I explained the purpose of the research, process of collecting data, inclusion and exclusion criteria for participants, and the duration for the collection of data and confidentiality was assured. I was asked to purchase and wear theatre uniforms to meet the infection control requirement on the ward. I was then given an orientation to the labour wards, introduced to the midwives and other professionals in the unit, and the purpose of my presence and research was explained to them. I familiarised myself with the facilities and staff members during this period. I wore a name tag with researcher attached to it to ensure that the observations were carried out

overtly. Recruitment of participants was achieved through the labour ward managers and the midwives themselves. The data collection techniques are described in the following sections.

3.3.3. Data collection techniques

Qualitative research incorporates a variety of data collection strategies (Silverman, 2017). Similar to other qualitative research methodologies, FE can incorporate a variety of data collection methods such as in-depth interviews, observation, analysis of personal documents, and discourse analyses of natural language (Higginbottom et al., 2013). Three different methods were utilised in collecting data which was carried out in three phases:

1) Firstly, participant observations were conducted to determine how RMC was enacted in actual practice and the facilitators and barriers of its provision which enabled the identification of mechanisms.
2) Secondly, focus group discussions on RMC were conducted with experienced midwives, rotation midwives, and student midwives who were available at the study sites.
3) Finally, semi-structured interviews with stakeholders: labour ward managers, key representatives of regulatory bodies, and health authorities who contribute to the care provided by midwives were conducted.

Focus group discussions (FGDs) and interviews were audio recorded and transcribed. Further exploration of these techniques is provided below.

3.3.4. Participant observation

Participant observation (PO) is the process that enables the researcher to study the activities of the research participants (Kawulich, 2005). In POs (often synonymous with ethnography (Pope, 2005), the researcher is exposed to the day to day activities of the research participants. The researcher establishes rapport within the study environment which enables him or her to blend in such a way that members within that environment act naturally (Bernard, 2018). This method was used to observe how midwives practiced and to explore the ways in

which RMC was manifested (or not) in different situations. This allowed for a degree of comparison between midwives' responses in the FGDs and actual practice (Marshall and Rossman, 2016). It was also utilised to gain better understanding of the phenomenon being studied (Kawulich, 2005) and to investigate the structures, processes, culture, and causative mechanisms that may influence the provision of RMC in the study settings.

The researcher can immerse herself to various degrees within the study settings. They could take one of four theoretical stances for observation; complete participant, participant as observer, observer as participant, and complete observer (Kawulich, 2005). The observer as participant role was taken. In this role, the researcher participates in the group's activities whilst collecting data and the participants are aware of the researcher's observational activities (Kawulich, 2005), though the aim was to be minimally intrusive in the day to day activities of the ward. For example, I did not actively participate in clinical discussions and did not provide clinical care. In the event of actions compromising the health and safety of participants, this was reported to the appropriate person and participants were made aware of this through the participant information sheets (see appendix 2). For instance, during a PO at hospital B, a woman nearly fell off a faulty birth bed and this was reported to the ward manager. In another incident in hospital A, a student midwife was going to inject a woman with a syringe she had stuck into the bed. This was because the midwife asked her to palpate the woman's abdomen for the presence of a second twin before giving the injection and she stuck the needle into the bed in order to perform the palpation. I saw this, stopped her, and alerted the midwife who was providing immediate newborn care. The observer as a participant role also presents the most ethical approach to observation since the group being studied was aware of the researcher's activities (Kawulich, 2005). Data was collected through note taking during observation and a fieldwork diary kept and participants were made aware of this.

3.3.5. The observation

Observations were made from the point women were admitted to the labour ward up to the end of the fourth stage of labour (6 hours after birth). Each observation lasted four hours,

varying the times at which the observation began helped to capture activities such as handing over, taking up, and ward rounds. Observations were undertaken across all the shifts; morning, afternoon, and night and was scheduled to take place over a one-week period in each hospital. In hospital A this began at the triaging unit and in hospitals B and C this was from the labour ward. Information sheets (see appendix 2) about the process of observation were given to midwives and labour ward managers prior to observation and consent obtained (see appendix 3). During and after observations, I asked midwives questions when there was the need for clarification of actions or inactions. Midwives' and women's remarks and actions during observations were recorded verbatim or paraphrased.

To avoid observing the same participants multiple times, I liaised with the ward managers to know when other midwives who had not been observed would be on duty. This facilitated familiarisation and establishment of rapport with all midwives and recruitment of participants for FGDs. However, due to midwives' inability to come in from home for FGDs when they were off duty, they advised me to stay around to conduct FGDs whenever the opportunity arose. This resulted in longer observational periods. To minimize the observer effect, I took notes when alone and not in front of any of the research participants. Observations were guided by an observation guide developed (see appendix 4) using the components of the White Ribbon Alliance RMC charter (White Ribbon Alliance, 2011), USAID survey report (Reis et al., 2012) and aspects of the Nursing and Midwifery Council (NMC), Ghana procedure guideline that promote RMC. Due to the inductive nature of this study, this was only utilised as a guide on what to observe in practice in relation to RMC, as such I maintained an open mind regarding the observation of interactions within the ward.

Rapport was established quickly in each setting due to my positionality as a midwife and educator in midwifery. In all facilities, I was received warmly and encountered former students which facilitated a smooth integration and immersion into the labour ward environment. The first day in each facility was used to identify the various categories of midwives within the facility, familiarise with participants, the routines within the labour ward, and how duties were

scheduled to enable me to observe as many midwives as possible within the time frame of the study. The observation in each facility was followed by FGDs and this is discussed in detail below.

3.3.6. Focus group discussions

Focus group discussions have been widely adopted in health-related disciplines (Kitzinger, 1994b; McFadden, Renfrew, and Atkin, 2013), particularly methodologies in nursing and midwifery research including FE (Boadu and Higginbottom, 2014; Evans, Turner, Suggs et al., 2016). This method of data collection places emphasis on the interaction between research participants for the purposes of obtaining a rich collection of data. This interaction, which is particularly important within ethnography, can elicit differing opinions and explore a plethora of viewpoints.

This was a vital approach to collecting data on midwives' beliefs about RMC within their shared and culturally situated labour ward environment. The FGDs produced considerable information within a short period compared with individual interviews (Green and Thorogood, 2018). Contrary to group interviews (often conflated by some researchers), the researcher does not adopt an investigative role by asking questions and seeking answers (Parker and Tritter, 2006). The role of the researcher in FGDs is more of a moderator of discussion between participants, allowing the emergence of the inter-relational dynamics of participants within the groups (Kitzinger and Barbour, 1999). I had access to the interaction between participants (conflicting views, buttressing others' views, misunderstandings, etc.) which in some ways resembled the interaction within their naturalistic work environment (Green and Thorogood, 2018), making them preferable to interviews.

The explicit use of interaction among participants is the distinctive feature of FGDs (Kitzinger, 1994b) and this is what counts in the generation of data. This involves the generation of in-depth discussion via open ended questions facilitated in a logical sequence to inspire universal participation within the group (Parker and Tritter, 2006). The WHO's definition of RMC and a hypothetical scenario (based on actual occurrences during POs) were used as a vignette (See

appendix 4) to stimulate discussion. This definition encompasses vital components of the universal RMC concept. These were printed, read to midwives, and copies handed to them for further discussion. The hypothetical scenario was based on observations during POs and so this slightly varied between facilities. Participants discussed the factors that may have influenced midwives' actions, what they could do differently, and the resources needed to achieve RMC in the particular scenario were discussed. The successful facilitation of the FGDs, according to Kitzinger (1994a), produced a synergy between participants, which in turn generated a momentum that allowed underlying opinions and description of individual experiences to emerge. It also allowed for the clarification of points made by participants in the light of points raised by others, which otherwise would have been left undeveloped in a one on one interview (Powell and Single, 1996). Exploring this interpersonal communication was highly important for highlighting the cultural values or norms (Bloor, Frankland, Thomas et al., 2001) which is a very important aspect of FE and CR. It is, therefore, used by ethnographers seeking an understanding of the meaning of a phenomenon to a particular culture (Nicholls, 2009b).

One of the major criticisms of FGDs is the possibility of participants being unwilling to interact with each other or discussions drifting away from the subject area (Parker and Tritter, 2006). FGDs, therefore, need to be conducted in a manner that ensures that the underlying issues peculiar to the topic are the main focus of the discussion (Bloor et al., 2001). The use of the vignette was the key strategy utilised to mitigate this, as it offered a basis for midwives to unravel their shared experiences.

3.3.7. Semi-structured interviews

Interviews are another commonly used method of data collection in FE (Boadu and Higginbottom, 2014). Interviews can be structured, semi-structured or unstructured and the semi-structured are the most commonly used format of interviews in qualitative research (Gill, Stewart, Treasure et al., 2008). In a semi-structured interview (SSI) questions are asked in a

loose manner with no defined ordering of the questions (Flick, Kardorff, and Steinke, 2004). The questions mostly have a generalised frame of reference compared with structured interviews (Bryman, 2016). This form of interviewing allowed for elaboration of information which may not have been thought of by researchers but provided important details for the topic under study (Gill et al., 2008). Interviews were supported by an interview guide developed (see appendix 4) using the components of the White Ribbon Alliance RMC charter (White Ribbon Alliance, 2011), USAID survey report (Reis et al., 2012) and aspects of the Nursing and Midwifery Council (NMC), Ghana procedure guideline that promote RMC. Issues raised during FGDs and observations made during POs also guided the interviews. Participants were encouraged to talk about their experience with regards to the topic under discussion and the ordering of the questions proceeded from there. This facilitated an in-depth exploration into participants' views on the topic under discussion. This method was utilised to interview stakeholders recruited for the study.

3.3.8. Sampling and recruitments

Sampling and recruitment were carried out separately for each data collection method and different strategies were used depending on the method of data collection. In an observational study, it is often impossible to pre-determine who or what to observe. A convenience sampling strategy was, therefore, utilised for the observation. Convenient samples were selected based on their availability. Midwives and women in labour who were observed were not predetermined but were based on their availability at the study sites during the observation days. Women (and their companions where available) who came in labour were informed about the study by the midwife or researcher (as deemed appropriate) and verbal consent obtained. It was proposed that where a woman declined consent, observation would not be carried out, however, no such situation was encountered. For the FGDs a different strategy was utilised.

In FE, samples comprise members of the discrete community, culture or subculture who possess specific characteristics relevant for the study (Higginbottom et al., 2015). A purposive sampling technique, which is consciously selecting participants that will best help meet the aim of the study (Creswell and Creswell, 2018), was the most appropriate sampling strategy and this was utilised in sampling experienced midwives, rotation midwives, and student midwives for the FGDs. Experienced midwives as included in this study were midwives who had completed either a diploma in midwifery programme, a post-basic midwifery programme or a bachelor's degree in midwifery and had completed their mandatory one-year rotation. Rotation midwives were midwives who had completed their diploma in midwifery or post-basic midwifery programme and were undertaking their one-year mandatory rotation through the various maternity units in the study facilities. Only rotation midwives in the labour wards were recruited for this study. All these categories are henceforth referred to as midwives.

I purposefully sampled the participants by identifying the different categories of midwives within the maternity units of the study settings. The study focused primarily on midwives within the labour ward setting as such midwives working in the antenatal units were excluded. However, though postnatal wards are generally not considered a part of the labour ward, midwives in two of the settings were included because the labour and postnatal wards in these facilities were merged. One of the settings also had a triaging unit and midwives there were first to encounter the labouring woman when she first reports in labour as such midwives in this unit were also included in the study. All midwives regardless of their educational qualification or seniority, except midwives at the managerial level, were included in the FGDs. During the period of the study there were no student or rotation midwives in hospital C, hence the FGDs there only included experienced midwives. In hospital A, there were final year student midwives undertaking their labour ward assessment (the first part of the NMC's licensing examination), however, none of them were included in the study because their interaction with women were for examination purposes.

In ethnography, the number of participants is dependent on the culture or subculture under investigation and exact numbers may not be possible to specify in advance. In FE this number will be the specific individuals with the appropriate characteristics for the study. All members within this group may be contacted for the study (Higginbottom, 2004), thus all midwives were contacted for the study. Midwives were identified through discussions with the ward managers, and I informed them individually about the process for the FGDs. According to Powell and Single (1996), between one and ten FGDs are generally sufficient to reach saturation (the point at which no new information is generated (Green and Thorogood, 2014)). The study aimed to recruit 60 participants for 15 FGDs, this target was achieved, and it was also the point at which data saturation was reached. Data collection, therefore ceased. The category of respondents is summarised in table 6 below. Each group consisted of between three and four midwives grouped according to their ranks to facilitate or ease interaction and potentially provide access to shared culture (Green and Thorogood, 2014).

Table 6: Distribution of respondents in focused group discussions

	Student midwives	Rotation midwives	Experienced midwives	Total
Facility A	8	8	12	**28**
No of FGD	2	2	3	**7**
Facility B	4	0	20	**24**
No of FGD	1	0	5	**6**
Facility C	0	0	8	**8**
No of FGD	0	0	2	**2**

The process for the FGDs was explained to midwives during PO after which they were given participant information sheets. Midwives made their expression of interest after which their availabilities were obtained. Due to other commitments, most midwives were unwilling to return to the study site during their days off and this posed problems initially for the scheduling of the focus groups. However, midwives and the Labour ward managers suggested that we conducted FGDs immediately after their shifts and others came in early for the FGDs before

their shifts began. Midwives and the managers were very helpful in putting focus groups together. In my absence at the study site, they would sometimes put groups together (as they knew the number of participants expected to be in a group) and then inform me that they were ready. Though this was sometimes inconvenient, I readjusted my time to ensure that the scheduled times suited midwives. Discussions lasted between 45 and 60 minutes and were conducted in the staff rooms of the study sites due to unavailability of meeting rooms. Some participants were sceptical about speaking English, thus opted to speak Twi, one of the commonly spoken languages in Ghana. My fluency in Twi enabled me to conduct FGDs according to the preferred choice of the participants. Though they had the option of choosing their preferred language, all FGDs involving student midwives were conducted in English with occasional references in Twi where participants wanted to make a quotation that was said in Twi. Experienced and rotation midwives spoke in their preferred language.

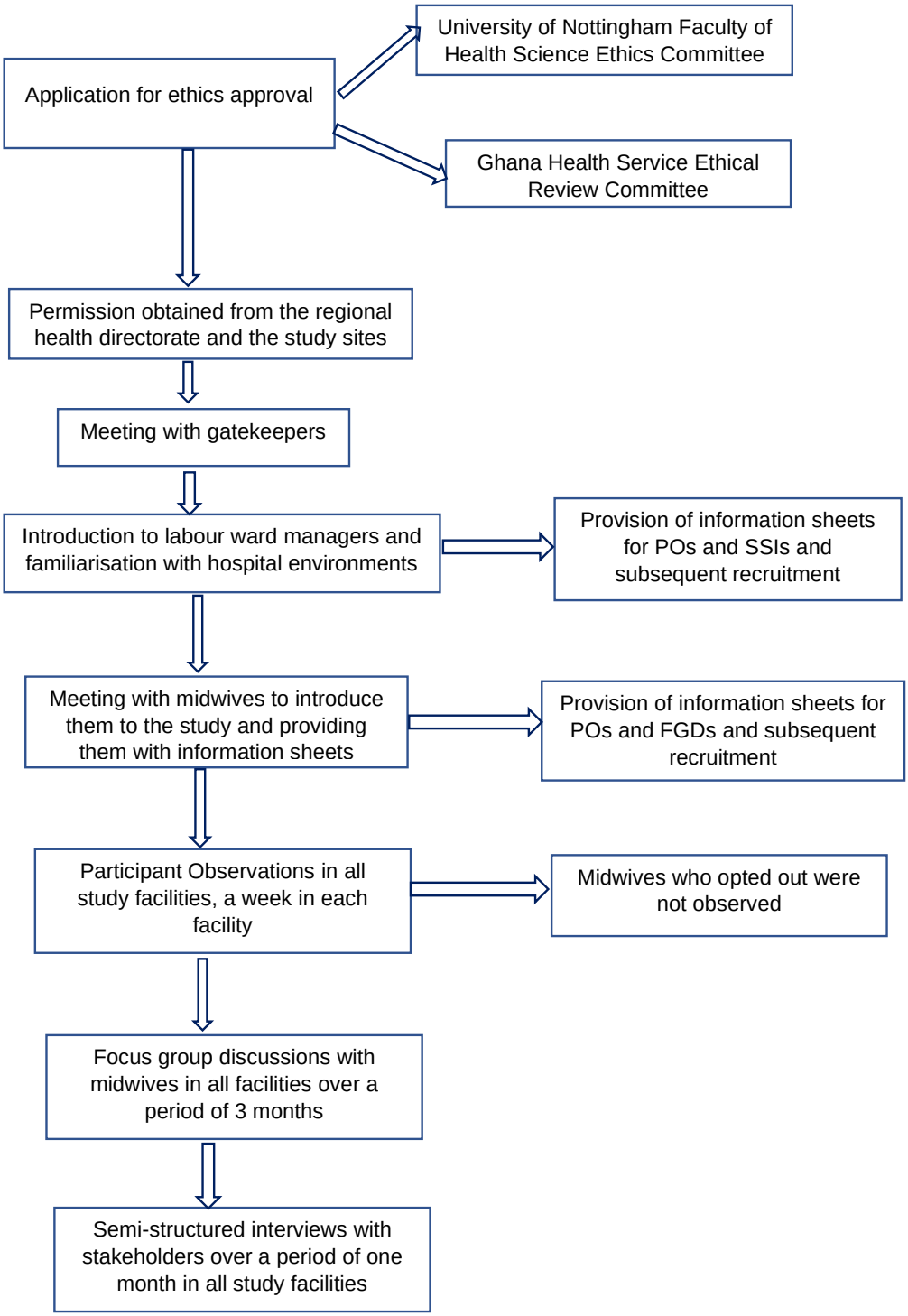
A purposive sampling technique was also utilised to select key stakeholders who were identified during the process of accessing the study facilities as some were gatekeepers within these facilities. During the familiarisation process, some of the identified stakeholders were informed about their possible involvement in the study and were invited to participate. The sample size for this was determined by the key contributors identified in the facilities and the region. A total of 14 stakeholders were identified during the period of the study and were invited to participate in the SSIs. All were provided with information sheets (see appendix 2) on the study, 5 declined and 9 agreed to participate in the Interviews. All 9 were interviewed and due to the limited number of stakeholders, saturation of data could not be achieved. It was proposed that interviews would last between 45 and 60 minutes, however, all stakeholders were sceptical about the time frame. SSIs, therefore, lasted between 30 to 45 minutes and were audio recorded. Table 7 below summarises the distribution of respondents for the SSIs.

Table 7: Distribution of respondents in semi structured interviews

	Labour ward manager	Deputy Directors of Nursing Services	Senior nursing and midwifery officers in the regional	Medical director	Member quality assurance team	Total
Facility A	1	1	2	**1**	**1**	**6**
Facility B	1	0	0	**0**	**0**	**1**
Facility C	1	1	0	**0**	**0**	**2**

The interviews were conducted either in the study facility or in the office of the stakeholder involved in the study. Only two SSI were conducted in the offices of the stakeholders involved and these were located outside the facilities. Figure 5 below is a flow diagram summarising the process of accessing and recruitment of study participants.

Figure 5: Access and recruitment process



3.4. Ethical considerations

Ethics within the conduct of this study was not considered as a distinct stage of the research to navigate but a component that permeated the entire research process. The general ethical standards that are applied to research include respect for privacy, confidentiality and anonymity, informed consent, and the right to withdraw from the research during and after the study without reason (Braun and Clarke, 2013). Ethical approval was obtained from the University of Nottingham Faculty of Health Science Ethics Committee (see appendix 5 for approval letter) and the Ghana Health Service Ethics Review Committee (see appendix 6 and 8 for approval letters). The ethical considerations within the study will be discussed under three subheadings namely: informed consent, privacy, confidentiality, and anonymity, and mitigating potential risk.

3.4.1. Informed consent

Informed consent is the foundation for ethical conduct in research. Ethnographic studies involve the development of relationships between the researcher and participants and informed consent is central to the interactions that constitute the research encounter (Davies, 2008). This may not be a single event but a negotiated process (Birch, Miller, Mauthner et al., 2002). It may be readily given at the onset but in ethnographic studies that involve observation, as the research becomes more embedded, participants may need to be reminded of the study objectives and consent continuously given (Pope, 2005). The aims and objectives were explained thoroughly to research participants through information sheets. The voluntary nature of the study and the right to opt out without explanation were also stressed and each signed a consent form (see appendix 3) prior to the collection of data.

For POs I ensured that midwives signed consent forms prior to observation, and it was explained to them that field notes would be taken. One midwife in hospital A opted not to be observed because she was my former student and was not comfortable being observed as it felt like she was being assessed. It was noted during POs that midwives may have

misunderstood what the observation entailed because the first few midwives to be observed explained every procedure to me as though I was supervising or assessing them. This led to the utilisation of a one-to-one method of educating participants about the observation process. Flory and Emanuel (2004) noted that the use of one-to-one education improved research participants' understanding of the information needed to obtain informed consent. Participants were encouraged to ask questions and clarifications were provided.

As a midwife registered with the NMC, Ghana, and in good standing, during emergencies where I deemed appropriate, assistance was offered in the absence of other available help from the labour ward staff. For instance, during the first day of observation in hospital C, the midwife was alone on duty with two student nurses. I, therefore, volunteered to assist her in conducting deliveries and other procedures in line with my professional expectations. This was also to avoid the perception of prioritising my research over women's need of competent care in a setting where such situations were categorised as neglect and as such D&A. I, however, continued to collect data though care was taken not to influence the midwife's actions and inactions in any way to prevent influencing the data collected. This occurrence offered a personal insight into participants' assertions about shortage of staff during FGDs.

FGDs commenced with a detailed explanation of the research process and the ethical considerations because researcher noticed information sheets had been left in the staff rooms indicating that participants may not have read them. They were also informed that audio recording and note taking would be carried out during data collection. In some settings participants were uncomfortable with being recorded and they compared it with an investigative journalist in Ghana who conducts covert investigations in various institutions. They were, however, reassured that it was not an investigation of their practice but an opportunity to share their experiences and practice as midwives in relation to the topic under study. They were also encouraged to ask questions about the research and clarifications were given. It was stressed to participants that participation in the study was voluntary, and withdrawal could be done without prior notification at any point during the FGD and without

explanation and that their participation would not affect their jobs or education. Two midwives opted out without explanation prior to a FGD though they had been observed previously and given verbal consent to participate in the FGD. These participants were made aware that should they withdraw, the data collected to date could not be erased and may still be used in the final analysis. This FGD was cancelled as there were not enough midwives to make up a group. Sensitivity of issues discussed were of equal importance during the FGDs. When issues arose which participants found distressing, they were offered the opportunity to pause or discontinue if they found such circumstances stressful for them. This situation occurred twice during the FGDs, however, participants opted to continue with the discussion.

In ethnographic research, there is the potential of encountering a wide spectrum of people who may not be the focus of the research especially within a focused ethnographic study. During the study, I encountered people such as cleaners, doctors, pharmacists, laboratory technicians, anaesthetists, nurses, and health care assistants. It was practically impossible to provide information sheets to all professionals who may have been observed within the labour ward. Verbal information and consent were, however, obtained where deemed appropriate. Women admitted in labour were informed by the midwife about the study and verbal informed consent was obtained before the observation of their labour. In situations where informed consent could not be obtained from women (e.g., admission with imminent birth) consent was sought after the observation and when the woman was able to consider the information. In hospital A, women often had birth companions and they were also informed about the study and verbal consent obtained.

3.4.2. Privacy, confidentiality, and anonymity

Privacy, confidentiality, and anonymity were considered paramount in this study, considering the sensitivity of the topic, the study setting, and midwives' scepticism about the recording of the FGDs. To protect the privacy of participants, consent was obtained prior to POs, FGDs, and SSIs. The first step in ensuring confidentiality in this study was to anonymise the facilities

and participants involved in the study. The study hospitals and participants were given pseudonyms and participants were assured of this during the provision of information and obtaining informed consent. Participants in the FGDs were also encouraged to ensure each other's anonymity and emphasis placed on voluntary participation and withdrawal from the research. Documents obtained during the study included consent forms, field notes, interview and FGD transcriptions, and audio records. Documents were held securely, in a locked room and in locked cabinet. The computer held data including the study database is held securely and password protected. Only study researcher and supervisors have access to study documentation other than the regulatory requirements.

3.4.3. Benefits and mitigating potential risk

The information obtained from participants was to ensure that the perspectives of midwives were considered in the strategies aimed at ensuring RMC and the provision of maternal healthcare in Ghana as a whole. These will inform the development of strategies and policies to improve the conditions of service for midwives and the provision of care for women. Most midwives prior to FGDs were interested in the benefit they were to derive from this study and the above were explained to them. I did not anticipate any risk, and none occurred. However, there was the possibility that participants could find discussing some aspects of their experience distressing which was mitigated by encouraging participants to pause or discontinue if they found such circumstances stressful for them. Though participants chose to continue with discussions during the distressing moments encountered, discussions were paused to allow participants involved to recover before continuing the discussions. The process adopted in the analysis of the data obtained is discussed in the following sections.

3.5. Data management and analysis

This section presents details of how data was managed and analysed. The data analysis phase in qualitative research has been referred to as the most complex stage of qualitative research (Thorne, 2000). To generate new knowledge from raw data, the qualitative researcher must engage in a transformative analytic process throughout the research. This section will, therefore, describe the process I undertook to transform data into new knowledge.

3.5.1. Thematic analysis

Gavin (2008) refers to thematic analysis as an explicit process utilised by researchers to highlight the structures and meanings embodied within the research data. It facilitates the identification, analysis, and reporting of patterns (themes) within the data (Braun and Clarke, 2006). Thematic analysis can be useful in analysing large data sets, providing step by step description of the analysis process and a clear description of this process enhances the authenticity of the findings obtained from the research (Nowell, Norris, White et al., 2017). One of the benefits of thematic analysis is its flexibility, in that it enhances the capacity to answer any type of qualitative research question and can be used in the analysis of any type of qualitative data (Braun and Clarke, 2013). There exists a plethora of approaches to thematic analysis including interpretative phenomenological analysis, theoretical thematic analysis, constructionist thematic analysis, inductive thematic analysis, and experiential thematic analysis.

This study adopted the inductive approach to reflexive thematic analysis as described by Braun and Clarke (2006) and (2020). Unlike approaches such as the interpretive phenomenological analysis that is grounded on pre-existing theory and epistemology, inductive thematic analysis is a theoretically flexible iterative process that is not grounded on existing theories. The data analysis process is approached from the data upwards though researcher's philosophical standpoint and disciplinary knowledge can influence it to a certain degree. The reflexive nature of this approach suited the analysis of the data as it facilitated

the integration of my philosophical assumptions into the analysis process and enabled adaptations suitable for achieving the study objectives. The inductive process involves familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing a report (Braun and Clarke, 2006). These stages were not linear but iterative, encompassing backward and forward movement which resulted in the development of themes overtime. These phases are described in further details below.

3.5.2. Familiarisation with data

This phase practically began during the data collection process when initial opinions on the data were developed. Following data collection, verbatim transcription of recorded data from FGDs and SSIs was carried out. A full transcription of data was carried out to avoid the risk of overlooking relevant materials as what was considered relevant or irrelevant may change over time (Hammersley and Atkinson, 2007). Audio records that were in Twi were translated into English. This initiated the process of becoming fully immersed in the data and it was further achieved by reading and re-reading the transcripts and field notes, actively searching for meaning and patterns before coding began. Transcripts and field notes were grouped according to the facility involved and the method of data collection and this data was managed using the NVivo software version 12.

3.5.3. Generating initial codes

Coding of transcripts and field notes were carried out using the NVivo software and these codes became the building blocks of the data analysis. Coding is the process of ascribing labels or names to segments that reflect the meaning derived from the text and codes facilitate the process of developing initial themes (Braun and Clarke, 2020; Bryman, 2016). Transcripts were grouped according to the different facilities, category of participants, and data collection method. Each transcript from SSI, FGDs, and field note was coded separately, and these initial

codes were constantly revised until codes that succinctly reflected the participants' meaning were generated. Braun and Clarke (2013) highlighted two types of coding: selective coding and complete coding. Selective coding highlights occurrences within the phenomenon of interest for coding, leaving the rest of the data. In complete coding, all aspects of the data set are coded instead of aspects. To achieve the inductive thematic approach without missing vital aspects of the data in the initial stages, a complete coding was carried out. This involved coding each sentence of the data and these codes were data-derived, reflecting the semantic content of the data. Thus, reflecting participants' language and concepts. This technique was piloted with a few transcripts and feedback obtained from supervisors before the entire data set was coded.

The analysis of data from FGDs present some key challenges (Parker and Tritter, 2006). Contrary to in-depth interviews, FGDs may include incomplete and interrupted speech (Kitzinger, 1994a). Parker and Tritter (2006) also emphasised on the shift in opinion by some participants as discussions progressed. Thus, care was taken not to take particular utterances as substantial views or opinions but to situate them within the interactive context within which they were produced (Green and Thorogood, 2018). On the other hand, fieldnotes collected during observational field visits were highly descriptive and often not direct quotes from participants. Therefore, they were coded according to the major issues highlighted and constantly compared with codes from SSIs and FGDs and all methods were interwoven during the generation of themes.

3.5.4. Generating initial themes

Searching for themes moves the data analysis process to the broader level of themes by categorising the different codes into potential themes (Braun and Clarke, 2013). This phase of the data analysis process was carried out in NVivo by collapsing and merging codes or nodes that were similar in meaning. This led to the creation of categories representing new layers of meaning or concepts developed from the codes. A mind map and notes were utilised

as visual aids to sort the codes into categories and then into themes. Notes in different colours were organised and moved around to assist in the cognitive process of identifying patterns across the data set, developing them into themes, and ensuring the relationships between codes, sub-themes, and the main overarching themes. The identification of the salient features of the data did not only comprise recurring concepts across the data set but also capturing elements within the data that were meaningful for answering the research question (Braun and Clarke, 2013). A miscellaneous category was created in NVivo to represent codes that did not fit into the emerging themes but were constantly revisited during the iterative process to ensure that they indeed did not fit in. This phase was completed with the development of candidate sub-themes and overarching themes.

3.5.5. Reviewing themes

The candidate themes that were developed were refined at this stage (Braun and Clarke, 2013). Some candidate themes which were not fitting stand-alone themes were merged with other more suitable themes as well as some changes in the concepts used in labelling the themes and sub-themes. Therefore, the five themes that were developed initially were merged into three and the data within each theme was a valid and coherent representation of the concepts and phenomena described in the theme.

3.5.6. Defining and naming themes

After several themes had been refined to represent the dataset, the three different themes that were developed had identifiable distinctions at the same time fitting together to answer the research questions (Braun and Clarke, 2006). The data was analysed under these overarching themes and the defining names given represented the phenomenon being described in each subtheme and in view of the research question.

As indicated earlier, Braun and Clarke (2019) and (2020) describe their reflexive approach to thematic analysis as theoretically flexible and the researcher's role is vital in this regard. In that, the researcher is cognisant of their philosophical assumptions and the influence of this during the thematic analysis and reporting of the research findings (Braun and Clarke, 2020). The flexibility in this reflexive approach facilitated the integration of a critical realist philosophical underpinning to the data analysis to assist in uncovering the real causative mechanisms that influenced the provision of RMC. The three main themes developed formed the analytical product of the reflexive thematic analysis and also abduction in CR. The CR principle of retroduction was applied within these themes enabling the identification of causative mechanisms. The following sections describe the process of retroduction in CR applied in the uncovering of the real causative mechanisms in RMC.

3.6. Identifying causative mechanisms

To facilitate the identification of causative mechanisms and further synthesis, inferences were made to the data through a process referred to in CR as retroduction. Though not necessarily linear, the CR analysis involved the following key steps; identifying demi-regularities (patterns in thematic analysis) at the empirical level, abduction or theoretical redescription (identification of themes in thematic analysis), and retroduction (Fletcher, 2017). Identifying demi-regularities is the initial step within CR analysis; these are patterns within the dataset and identified using data coding processes (Fletcher, 2017) and this was carried out during the reflexive thematic analysis. Abduction, which is synonymous to conjecturing, is integral in the critical realist scientific enquiry as many scientific concepts do not occur within the scientific data but are developed through robust analysis and synthesis of the data (Popper, 2003).

Abduction or theoretical re-description is theory laden (Bygstad, Munkvold, and Volkoff, 2016) and involves the use of theory for abstraction to facilitate the interpretation of the events within the new context being studied (Danermark, Ekstrom, Jakobsen et al., 2001). This differs from induction which is atheoretical and which was adopted in this study. Alderson (2021), however,

explains that abduction and retroduction can be synonymous as both make inferences from observation and offer explanation to events. As such, I maintained the inductive process as a means for the identification of patterns within the dataset. Sayer (1992 p. 107) described retroduction as a “mode of inference in which events are explained by postulating and identifying mechanisms which are capable of producing them”. Retroduction offered explanations into the conditions for the provision of RMC by postulating or conjecturing a set of generative mechanisms. The postulated generative mechanisms formed the ‘Real’ within the critical realist stratification of reality.

Another key feature of CR is the structure and agency interaction and a third aspect, culture which was identified by Archer (1988). The structures are the material, political, and economic systems, policies, resources, and processes. The agents are those who provide and receive maternity care and the culture is the subjective meaningful product of human interactions (Alderson, 2021). According to Alderson (2021), structures are objective, powerful, and enduring relations and resources not necessarily constructed by the agents but who have the propensity to reproduce, oppose or recreate them through their relations with them. Identifying these structures and the culture were necessary in determining how their interaction with the mechanisms produced the outcomes or events that were observed in this study. It is notable that structure, culture, and agency are distinct from each other and irreducible though their interaction with each other produces the observable events. Combining FGDs and SSIs with POs during data collection facilitated the identification and confirmation of structures and culture and the in-depth exploration of concepts to identify the mechanisms that triggered midwives’ agency. For instance, during FGDs midwives talked about the lack of support (structure) from managers whilst managers also asserted that midwives were supported. Midwives’ assertions about the lack of support within their work environment was confirmed when I observed how it manifested in abuse of midwives (culture) when a midwife who was being treated for malaria continued to provide care for women because she had been refused a sick leave. This structure and culture interacted to influence midwives’ agency and produce

causal events of D&A of women. The identification of these aspects of care enabled the postulation of causative mechanisms and these will be highlighted in the result chapters and further explanation carried out in the discussion chapter.

3.7. Achieving quality and rigour in qualitative research

There has been considerable debate on how to conceptualise the quality of qualitative research (Braun and Clarke, 2006). It has, however, been clarified that qualitative research has a specific logic and criteria for checking its quality (Hammersley, 1992). These comprise concepts for checking the trustworthiness of the research including dependability, credibility, transferability and confirmability (Bryman, 2016; Lincoln and Guba, 1985) and can be enhanced through triangulation and reflexivity (Braun and Clarke, 2013). The quality of the study was also ensured by collecting sufficient data (Morse and Field, 1995). Ensuring the trustworthiness and transparency of the research using these concepts is further discussed below.

3.7.1. Dependability

Dependability is vital in qualitative research as it ensures that the process involved in the conduct of research is consistent and attentive to the conventions of qualitative research methodology (Tolley, Ulin, Mack et al., 2016). This criterion was achieved by clearly stating the research question, the aim, and objectives, and ensuring that these were logically connected to the chosen methodology and the philosophical underpinning. These were parallel with the data collection methods which have described in sections 3.2 and 3.3. I conducted debriefing with supervisors to ensure that data collection was congruent with stated objectives and where necessary modifications made to probing strategies during interviews and FGDs to obtain additional data relevant to the research aim. Field notes were also taken on observations made during the data collection process.

3.7.2. Credibility

This criterion is also known as truth value (Lincoln and Guba, 1985) and it ensures that all relevant voices are captured using multiple accounts of the social reality (Bryman, 2016). The credibility criterion also recognises the value respondents' attribute to their situation and the truth of the findings that the researcher has derived from their social context, thus ensuring compatibility (Holloway and Wheeler, 2010). Strategies adopted to ensure credibility of findings involved carrying out research according to the principles of good practice, the discussion of data collection, analysis, and reporting of findings with supervisors, where necessary questions were reframed before and during interviews and FGDs, persistent observation over a period of three weeks, and attention to negative cases. In addition, triangulation was also carried, and this is further described below.

Triangulation: This is an approach to the data collection that enhances the full understanding of the phenomena by using various methods (Flick, 2004). According to Denzin (1989), method triangulation allows for a greater knowledge and understanding of the phenomenon under investigation and maximises the validity of the field work. In ethnography, triangulation can also involve the use of multiple data-sources (Hammersley and Atkinson, 2007). This type of triangulation involves comparing data relating to the same phenomenon but derived from different sources. For example, the account of different participants located in the same or different settings (Hammersley and Atkinson, 2007). In this study, triangulation was not just a means of credibility, but to extend the possibility of discoveries about the phenomenon under investigation, in-depth exploration of mechanisms, and achieve the aim of the study.

Two types of triangulation were adopted: method and data triangulation. Method triangulation involved the utilisation of FGDs, POs, SSIs. Method triangulation facilitated the confirmation or refutation of findings from one method of data collection with that of the other. Observation of midwives enabled the identification of some phenomena and complexities which were not

identified in FGDs and SSIs. For instance, in the conceptualisation of RMC, midwives did not identify the use of shared religious beliefs as a means of support for women, but this was identified during PO and similar components of RMC were developed from all three methods. POs, therefore, provided supplementary data for FGDs and SSIs and enabled an exposition of other aspects of reality. It also enabled the identification of the structures and mechanisms that facilitate RMC or otherwise. Data triangulation included using multiple data sources involving collecting data from three different sites and five categories of participants (three different categories of midwives, hospital managers, and higher-level nursing and midwifery leaders). During the analysis stage, findings from these categories were compared to facilitate the identification of areas of agreement and divergence. For example, some stakeholders indicated that there were supportive structures available to midwives, whilst FGDs with midwives and POs revealed otherwise. This also made method triangulation a necessity in ensuring credibility. Though data analysis was carried out separately for the different data sources and methods, the final themes derived were across both areas making the themes representative of the method and the data triangulation carried out.

3.7.3. Transferability

This criterion demonstrates the possibility of findings from the research being transferable to other similar contexts. Due to the depth rather than breadth that is characteristic of qualitative studies, findings are largely orientated to the contextual characteristics of the group and the part of their social world under investigated (Bryman, 2016). Denzin and Lincoln (1994), therefore, argue that an in-depth description of the context and participants provides a database to make judgements about the transferability of the findings. This description is provided in section 3.3. above. The degree to which transferability can be applied depends on the similarities between settings where the study was carried out and where the findings are expected to be transferable (Lincoln and Guba, 1985). The settings involved in this study share similarities with most public health facilities in Ghana in terms of resources, managerial

structure, and the organisation of care. They also shared similarities with low-income settings such as Malawi as identified by Bradley (2018) and De Kok et al. (2020). Participants in these settings also share similarities in terms of education, the cadres of professionals, and working models. Therefore, the findings are potentially transferrable to settings and participants that share the contextual and professional characteristics of the study sites and study participants.

3.7.4. Confirmability

To achieve confirmability, analysis of findings should be deeply rooted in the data and examined through of an audit trail (Lincoln and Guba, 1985). This accounts for the degree to which the findings of a study are the outcome of the experiences and ideas of respondents and not researcher bias, motivation, or interest. The researcher meets this criterion by demonstrating that the findings of their research are not influenced by their personal values or theoretical assumptions (Bryman, 2016). Lincoln and Guba (1985) proposed that the establishment of confirmability in qualitative research needed an audit and decision trail enabling the tracing of data to its source. Thus, readers can identify the process through which the researcher arrived at their interpretation of their data and their themes. Confirmability has been achieved in this study by providing an in-depth description of how study participants were recruited and the process of analysing the data obtained from participants in sections 3.3, 3.5, and 3.6 above. These included the strategies utilised in coding data, developing categories, sub-themes, overarching themes, and identifying causative mechanisms. These findings were checked and re-checked with support from supervisors to ensure that the extracts from the data utilised in the validation of the findings were legitimate. Confirmability is further enhanced by giving a reflexive account of the research process, how my personal characteristics may have influenced the research findings, and how these were mitigated. This reflexive account is provided below.

3.8. Reflexivity

Naturalism proposes that social researchers are participants in the context they are studying. It discards the positivist notion that social research can be conducted in an environment isolated from the broader context and from the researcher to an extent that the findings of the research are unaffected by these (Hammersley and Atkinson, 2007). Thus, in qualitative research it is critical to establish the role of the researcher in every aspect of the study (Shaw, 2016). This is achieved through reflexivity which represents the connection between the interpretation of data and how it is conveyed in text (Brewer, 2000).

Reflexivity means that the researcher is conscious that they are part of the environment, and the culture that she or he endeavours to comprehend (Davies, 2008). It is the critical element within qualitative research that has the propensity to recognise limitations and ensure methodological rigour (Cruz and Higginbottom, 2013; Dowling, 2006). Its importance stems from the relationship between the researcher and the participant and the interaction that occurs between them (Brewer, 2000). Reflexivity can be a reflection on issues such as the social location of the research, presuppositions of the researcher, power relations, and the impact of the relationship between the researcher and participants on the outcome of the research (Brewer, 2000). It could also be an analytical reflection on the theoretical framework and the methodological strategies utilised, ontological assumptions about the nature of reality and the researcher's beliefs about the topic and their approach to it that passionately resonates within them (Brewer, 2000).

Reflexivity also lends qualitative research an authenticity and honesty that is unique to this methodology (Walsh and Downe, 2006). Therefore, regardless of the approach, the reflexive report of the ethnographer's ideas and experiences will be a means by which readers can judge the possible impact of these on the study (Walsh and Downe, 2006). According to Enosh and Ben-Ari (2015), in the reflexive process, researchers strive to identify the incongruities within the conduct of the study; a process that leads to the addition of new knowledge. Some earlier ethnographers who took a realist stance often failed to demonstrate

reflexivity about the process that influenced the data, undermining the authenticity of their ethnographic descriptions (Brewer, 2000). Hammersley and Atkinson (2007), therefore, recommend that ethnographers, irrespective of their philosophical stance, ought to be reflexive in setting their data within its context. My personal reflexive account of the research process is, thus, described in the following sections.

3.8.1. Insider or outsider? Identity and positionality in focused ethnographic research

A continuous reflexive account was undertaken during the whole research process, beginning with the choice of research topic, to negotiating access, collecting data, and analysing the data. I considered how my own biography related to how I interpreted my field experience and the approaches I utilised to mitigate subjective interpretations enabling me to transform my personal experience into authentic knowledge (Denzin and Lincoln, 1994).

"Do not treat any woman badly" was amongst several words of advice my mother, a midwife then, gave me prior to commencing my midwifery education. Being the midwife, my mother described to me and which I experienced growing up became my focus. Therefore, prior to the conduct of this study, I reflected on my own ideologies, principles, and experiences that had shaped my interest in the study and posed questions to myself concerning the reasons for considering RMC as an area of research. These included my own experience of abuse of women and midwives, my assumption that mistreatment of women by providers was simply a behavioural problem that had resulted from bitterness about the mistreatment they experience within the health system, and the initiatives that we developed to mitigate the mistreatment of women which did not yield the expected results. Following the insights from Finlay (2002) on reflexivity as introspection facilitated the development of an awareness of the personal meanings and experiences underlining the generalized understanding and interpretations that will emerge from the research. This enabled me to gain an insight into my own assumptions about this important and timely subject in maternity care and to explicitly reflect on the links

between the knowledge claims I would make and the interconnected experiences of both the participants and I and the social context.

The challenges within maternity care in Ghana had shaped my professional practice and led to my involvement in the midwifery association and its activities and programmes and fuelled my desire for strategies and interventions for system strengthening and support of midwives. Completing my midwifery education with no prospects of further education in midwifery available and few opportunities for career advancement in midwifery, in addition to the poor quality of care midwives provided, I became actively involved in the midwifery association in Ghana and held various leadership positions. I contributed to the implementation of various strategies aimed at improving midwifery practice particularly through advanced education and continuous professional development. For instance, proposals written to the MOH during my tenure resulted in various service improvement for midwives including the initiation of bachelor's degree programmes for midwives which up until 2020 was the highest level of education for midwives in Ghana. I also travelled extensively and engaged with midwives in different regions in the country and the improvement in the quality of midwifery service was one of the key issues always discussed.

This orientation made me more knowledgeable about potential helpful information resources but it was anticipated that this could shape the nature of the relationship with participants either negatively or positively which could in turn affect the information participants were willing to share (Berger, 2013). Based on the sensitive nature of the topic and widespread discussions on D&A in maternity care on various professional platforms and on media networks, I also anticipated some level of reluctance to speak on the subject considering my position as an outsider in relation to the organisation. To mitigate this, I sought the views of 5 midwives from different facilities in Ghana and piloted the FGD guide with them four months prior to commencement of the study. Only minor changes were made to aspects of the guide, but the topic was not modified. Further discussions of my positionality and identity are presented below.

3.8.2. 'Outsiderness': From overcoming suspicion to acceptance

Unanticipated challenges began during the application for ethics approval phase. Two ethics committees were involved in the ethics process: The Faculty of Medicine and Health Sciences Ethics Committee and the Ghana Health Service Ethics Review Committee and the applications were submitted concurrently to these committees, but ethics approval was obtained in Ghana first. Corrections from the University of Nottingham involved changes to the General Data Protection Regulation that had come into effect and these changes needed to reflect in the documents submitted in Ghana to ensure uniformity after approval had already been granted. This posed challenges as the committee in Ghana argued that data protection regulations in the UK were unapplicable in Ghana and participants could not raise concerns in the UK without going through the GHS. Further discussions resulted in the two regulations being reconciled to meet the requirements of both committees to facilitate access to the study sites.

However, this experience led me to rethink my position as an insider because though I considered myself a Ghanaian midwife and a midwifery educator, pursuing a PhD in the UK had positioned me in a different contextual environment as a researcher and within the organisational sense, I was an outsider. It was, therefore, anticipated that this may pose further challenges. One of the challenges encountered in accessing some of the study sites was suspicion. Gaining access to the social setting is considered a key step in ethnography and the approach utilised will be dependent on the type of setting (Bryman, 2016). As stated earlier, the topic chosen for this study is widely spoken about in many public circles and unknown to me one of the study sites had been under investigation. Access to this facility was slowed by suspicion, scepticism, and rigorous scrutiny. Interviews and FGD guides were scrutinised, and copies of these documents filed. It is worthy of note, however, that this gatekeeper was not a midwife, and I was instantly accepted by all gatekeepers who were midwives or nurses. These gatekeepers were friendly and very open to discussing the topic and providing information necessary for the research, contrasting my pre-existing expectation.

Enosh and Ben-Ari (2015) considered such pre-existing expectations a mechanism for the discovery of incongruities. These incongruities according to the authors serve as the basis for the construction of new knowledge. Later in the study, it evolved into issues of lack of support from leaders facilitating the identification of some causative mechanisms influencing RMC.

3.8.3. 'Insiderness': Becoming the 'familiar face'

Contrary to the initial experience in some of the facilities involved in the study, meeting research participants within their social world was met with instant acceptance. Due to the unpredictable and demanding nature of the labour ward, becoming a familiar face was a significant phase in the data collection process. This instant acceptance by midwives was, however, anticipated as I had identities that may have facilitated this. I was a midwife who had been actively involved in the midwifery association (though not in the region the study was being conducted in, but I had travelled widely within the country and so may have met some of the midwives within the region), and I was a midwifery educator. On entry to all three facilities involved in the study, some of the first few midwives I encountered were former students of mine. Whilst this facilitated a smooth entry and familiarisation with facility and participants, in being introduced as an educator, I had established a relationship of power and I was inadvertently influencing participants' actions around me and what they were willing to reveal during FGDs and for me to see during POs.

For instance, during the first few observations, some midwives were constantly explaining what they were doing to me and one of my former students declined to be observed. There were also instances where other midwives complained about attitudes of my former students to me and though this was done jovially, it signified the continued awareness of the presence of an educator. Furthermore, during FGDs with students, there was some level of uneasiness amongst some students in the beginning which may have affected the information provided. Further explanation of the research process was provided, and I stressed on the role as a researcher not an educator. I went on breaks with midwives including students, joined them

during their meals, and joined in on casual conversations they had. I began to eat food brought in by the ward managers in some facilities, which I was not doing in the beginning and offered to assist in non-clinical activities, thus developing a sense of collegiality. This did not impact my researcher identity as midwives were continuously aware of my role. For instance, whilst a midwife was performing vaginal examination, a woman who mistook me to be a midwife, requested to have me do it because the midwife's fingers were too big. The midwife responded that I was a researcher and not able to perform any clinical procedures.

Nonetheless, this power relation did not have much effect on midwives' readiness to divulge sensitive information during FGDs. For instance, during a FGD in hospital B my former student said, "*but you cannot pamper someone who comes bare handed, nothing, (Twi) and say "I'm coming to check if I'm in labour", then I will say to her "you have done well by coming". No! definitely I have to say something to the person, (Twi) because it hurts. (English) because when you come like that you put pressure on us. Because we cannot use our bare hands to receive the baby."* This indicates that the participant recognised my role as a researcher and not as an educator and was willing to disclose information that could be classed as unprofessional. Overcoming power relations in this study did not only pertain to power being in my favour but in some cases being in favour of the respondents, which is discussed below.

3.8.4. Power relations in elite interviewing

Morris (2009) defined elite as those closest to power or possessing particular expertise. Elites can be corporate, political, or professional. Compared to nonelites, elite interviews continue to be rare, thus making elite-oriented studies significant in balancing the flow of knowledge (Mikecz, 2012). Researchers have documented various challenges associated with interviewing elites including access, building rapport, and developing trust and power relations being in favour of the respondent (Lancaster, 2017; Morris, 2009). Though this study was not solely focused on elites, data arising from this category of participants

extended the body of knowledge available on RMC. A reflexive account of the interviews with stakeholders provides a critical evaluation of my positionality in the research process and the outcomes.

My perception and expectations about elite interviewing had been significantly shaped by the available research and my personal experience of the elites within the healthcare system in Ghana. Similar to Mason-Bish (2019), I was under the illusion that elites were difficult to access and though it was true that I needed to be flexible, their flexibility was greatly underestimated. For me, this illusion was true for all elites who were not doctors. Perhaps my identity as a midwife and an educator was an equal power which balanced the dynamics of power usual in elite interviews. Of significance was also my position as a PhD student in midwifery, something that most midwives were encountering for the first time. Some midwifery managers addressed me with the doctor title which I discouraged but they insisted on calling me that because it was motivation for others. There was a lot of admiration and curiosity from both elites and non-elites, and this was an opportunity to engage, inspire, and become integrated into their social environment.

Whilst there was ease in the integration into the labour ward and a balance in power with ward managers, the perception of potential difficulty was with elite interviews of other stakeholders. For instance, due to previous personal experience with elites in midwifery, I became so nervous throughout my interview with one of the stakeholders that instead of saving the data I had collected, I turned off my audio recorder, losing all the data I had collected. It suffices to recognise that the preoccupation with issues of access and power led to a complete miss out on what actually transpired with this elite. In contrast to what I expected, I was warmly received, though she had a busy schedule, she made time for me the very first time she met with me. After explaining the research processes to her, she opted to be immediately interviewed because she was scheduled to travel the next day. After the interview ended, she volunteered 13 minutes' worth of extra information I had not requested to add to the depth of data being collected on the topic. She further suggested

other stakeholders who would be helpful in providing information relevant to the topic under study.

Positionality in elite interviews can be transitory and dynamic and the perception of power may only be attached to the title. Researchers should utilise their potential to exert a level of influence through their own expertise, networks, and strategic position within the social structure. In this study, whilst I encountered some challenges with interviewing some elites, my insider status, positionality, and identity as a midwife and educator provided an ease of access and some balance in power. Thus, a recognition of my role in the co-creation of knowledge and the intersubjective elements that impacted on data collection and analysis was vital throughout the research process. These make the 'how' of the acquisition, organisation, and interpretation of knowledge as relevant as the claim itself.

3.9. Conclusion

This chapter has presented the methodology and methods utilised in the conduct of this study. It highlighted the rationale for adopting the qualitative paradigm with particular focus on FE. It was evident that the FE approach provided an opportunity to study a discrete community within maternity care with the aim of answering specific questions significant to the phenomenon of interest. Taking a CR philosophical stance enabled me to discover the mechanisms, processes, and structures related to RMC. Data collection methods were adopted that integrated both the FE approach and CR underpinning. The integration of retroduction into the thematic analysis approach facilitated the discovery of causative mechanisms and these were discussed as well as the strategies utilised to achieve authenticity and trustworthiness of the research process and outcomes. The chapter concluded with the description of my reflexive account of the research process, highlighting how my identity and positionality impacted on the research process and outcomes and the strategies that were adopted to mitigate any potential influence. The next three chapters will present findings from the data analysis.

CHAPTER FOUR: RECIPROCAL RESPECT AND MUTUAL SATISFACTION: ESTABLISHING A VALUE-BASED MIDWIFE-WOMAN RELATIONSHIP

4.0. Demographic characteristics of respondents

The study included 69 respondents[3]; 60 midwives and 9 stakeholders. Only two of the participants were males. All student midwives were pursuing their diploma education and were from institutions located in two different regions in the country and rotation midwives were all diploma holders. Out of the 40 experienced midwives, 5 had a post basic certificate in midwifery, 23 had diploma in midwifery, and 12 had their bachelor's degree or were in the process of obtaining it. For the experienced midwives their experience ranged from 2-20years. Only one midwife had the 20-year midwifery experience, and she held a post-basic certificate in midwifery.

4.1. Introduction

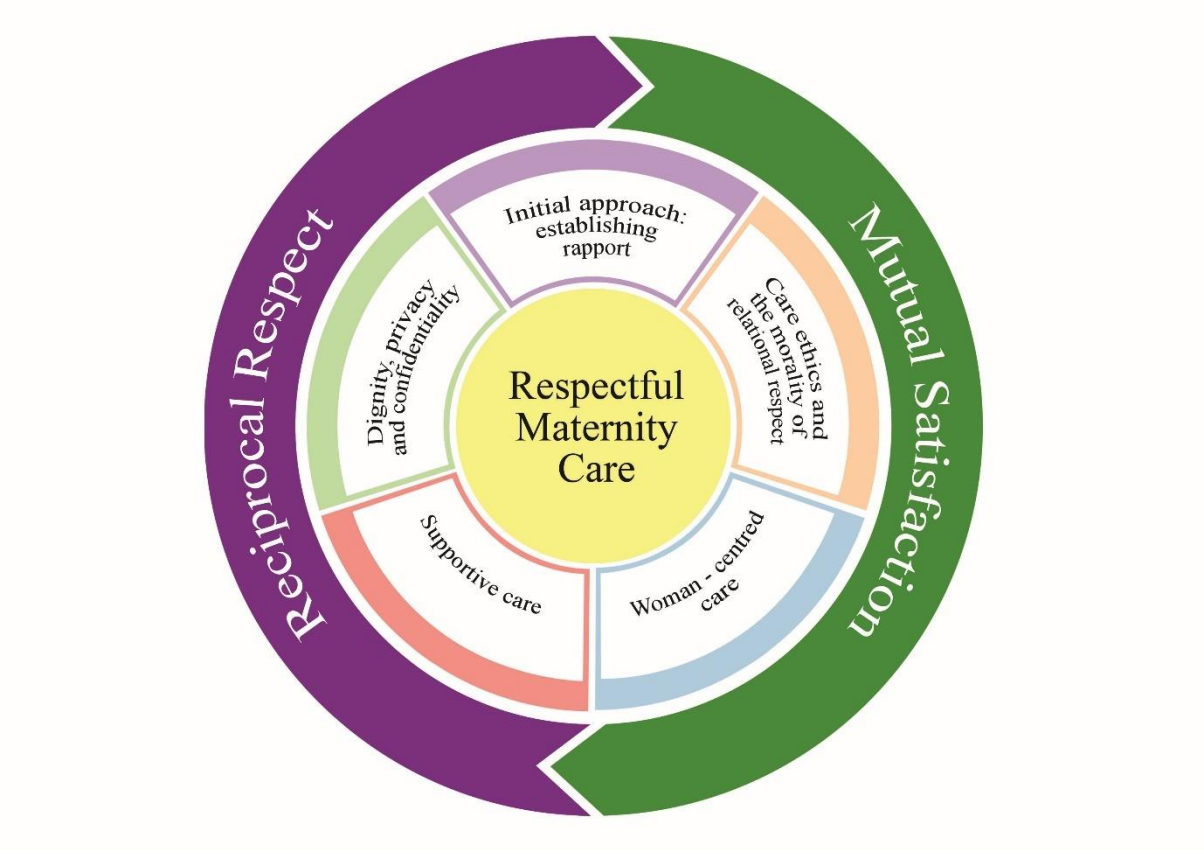
This chapter presents an account of how participants conceptualised RMC and how they integrated it into their daily activities. Most participants expressed that the period of pregnancy could be stressful for some women. As such, a cordial relationship with midwives provided a sense of assurance for them and this had a major role in women's decision to utilise facilities during subsequent childbirths. This relationship was, therefore, perceived as the core tenet of RMC which they conceptualised as a mutual relationship between midwives and women involving reciprocity of respect but focused on ensuring woman-centred care. The key principle of this relationship was that respect was reciprocal and satisfaction ought to be mutual. Thus, an equal degree of respect for both women and midwives but also with a woman-centred focus.

This relationship-based RMC concept comprised several aspects of care, but it began with the initial approach to the woman when she first reported in labour. For women who were

[3] Distribution of participants is provided in tables 6 and 7

reporting in labour, they were often meeting the midwives who would care for them during labour and childbirth for the first time, therefore, the establishment of rapport during this encounter was vital due to its propensity to influence the relationship negatively. Professional and moral values such as treating the woman as a relative, a notion utilised to stimulate the ethic of care, were adopted to engage with women and support them through the different phases of care provision. The morality underlining this relational approach to respect also included shared religious backgrounds that were used to create a supportive relationship with women. The woman-centred care principles included individualised care, communication, information, and informed choice. Various strategies were adopted that were deemed appropriate for effective communication, though ensuring informed choice was particularly problematic resulting in a lack of regard for women's choice. Other components of RMC were supportive care and ensuring privacy and confidentiality during the provision of care. This notion of RMC was, however, idealised in many ways as several factors had compromised midwives' ability to practice according to their ideal understanding of RMC. Using CR principles, a causative mechanism that had causal connection with the presence of RMC even when systemic constrains prevailed was identified. Figure 5 below presents a conceptual framework of RMC which highlights the various components. These components of RMC are further explored in the following sections.

Figure 6: Conceptual framework for respectful maternity care



4.2. Reciprocal respect and mutual satisfaction

While both midwives and stakeholders held a shared view of RMC as being grounded on the treatment of women, most midwives were also of the view that RMC was not a one-dimensional concept. Contrary to the definition of RMC (see section 1.1.4) that was based solely on the care provided for women, midwives perceived RMC as a mutual relationship between the woman and the midwife which culminates in a mutual benefit. This was characterised by a mutual understanding of the concept of respect *(because what I may see as being normal may be mistreatment to the client, Maya midwife FGD1 hospital A)* and a mutual satisfaction with the services provided as explained below:

Animwaa- respectful maternity care is the mutual relationship between a midwife and the pregnant woman so that at the end of the service the midwife provides no one will be …

Essuman interrupts- everyone will be satisfied with the care

Animwaa continues- yes both the midwife and the pregnant woman will be satisfied

(Midwives, FGD3 hospital A)

In addition, midwives viewed RMC as reciprocal, requiring all parties to be respectful to each other, the health system, and the professionals who provide the care. According to midwives, there must be good interpersonal relationship and the ability to understand each other within this cordial relationship and this was important for the midwife to work effectively and for the provision of safe care. Some midwives articulated this as follows:

Danny- I think it's also like, deals with good interpersonal care but it has to be reciprocal between the midwife and the client who is coming in for the care. If the interpersonal relationship between the two of you is good, I think the respect will exist between the two of you

Doya- and I also think it's a cordial relationship between you and your client, you understand. You should be able to understand each other and work effectively on her so that everything will be fine at the long run.

(Midwives, FGD3 hospital B)

Based on the necessity of reciprocal respect and the need for care to be mutually satisfying for both midwives and women, some midwives described the WHO definition of RMC, which was used as a vignette to stimulate discussion, as biased towards women. Specifically, they described the abuse they suffer from women (explored more fully in section 6.3) and the need for their own rights to be equally promoted. For example, in FGD3 in hospital A, midwives rejected the widely held view of RMC citing the abuse they also experienced and the need to also be respected:

Afoah- yes, is it just for the client

Gyekye giggles in displeasure

Afoah- No because seeing the definition, it's about the client alone

Gyekye- yes (Twi) we are not important oh sister

Afoah continues- but the midwife….

Essuman- (Twi) yes that is why we were saying that they sometimes verbally abuse us and things. (English) At least they should also know that since they have rights, we also have rights… Not always the client. And so, they should include something that is…..

Afoah- yes for the definition, it's all about the client. we midwives we also have dignity.

[…]

Gyekye interrupts- we will not accept this

(Midwives, FGD3 hospital A)

They further stated that women ought to respect midwives if they wanted to be respected and some demonstrated an unwillingness to respect women who did not respect them as highlighted in the following quotes:

you know the thing is respect is reciprocal so if you don't respect me, I won't respect you [….] You respect me and I respect you. There are some who don't respect (Naa, rotation midwife FGD6 hospital A).

The relational nature of RMC, therefore, denoted a two-dimensional concept involving mutual satisfaction with care and respect for both the woman and the midwife. Thus, midwives' views on RMC were not only based on how they treated women but how women also treated them. Nonetheless, establishing this reciprocally respectful relationship during the initial encounter with the woman was vital to midwives. This involved the establishment of rapport using various strategies which is explored further below.

4.3. The initial approach: establishing rapport

Participants identified the establishment of rapport with the woman as the first step to initiating the midwife-woman relationship. To many, how midwives approached the woman, taking cognisance of the state in which the woman presented, was essential in ensuring the initiation of a good relationship. The quality of this approach also affected women's perception of midwives:

> *In my opinion, I will start with how you receive the client the very moment you meet her, your approach towards the client because at that particular moment that client is in pain, so your first approach is very important. (Emma- midwife FGD1 hospital B)*

This initial approach, according to participants, involved greeting the woman and her relatives nicely, welcoming them, ensuring they were comfortable, and the midwife introducing herself to the woman and her companions:

> *you greet the patient because it is the right of the patient to be greeted (Oparebea, rotation midwife FGD4 hospital A)*

These assertions about the establishment of rapport were, however, not congruent with practice. Observational data indicated very few instances where midwives welcomed women. Midwives acknowledged that their ability to establish rapport with women was dependent on how the woman presented, as this could not be done if the woman arrived in a more advanced stage of labour or during emergencies. In these circumstances, rapport was established when the woman was in a calm state:

> *When the person comes in labour, she is in pain… is it now that you are going to welcome the person? We don't do it; we just lay the bed for the person and then we do our routine examination. Erm sometimes …….sometimes when the person is calm (Twi) we tell her 'maame this is your midwife… she is the one going to take care of you until you deliver' (Akweley, midwife FGD5 hospital A)*

Additionally, both midwives and stakeholders believed women and their companions usually came agitated and anxious, therefore, establishing rapport also meant allaying their fears and anxieties and ensuring that they were assured of the best care:

some will come in labour and it's painful, so I think you have to allay their anxiety so the way that you treat them…. (Linda, LWM INT1 hospital A)

They further expressed that labour pain often made women agitated such that they acted in an unusual manner. They reiterated that it was necessary to offer a comforting environment for her:

If you receive her well to make her feel at home even though some of them 'go beyond board' because of the pain, how you talk to them, then you make them comfortable (Emma, midwife FGD1 hospital B)

Another important aspect of establishing rapport with the woman and her companions was the midwife introducing herself by mentioning her name and asking the woman and her companions to do same. Though participants stated that they did not practice this often and it was observed only on a few occasions, some believed that it was important to do so because it ensured that midwives addressed women by their names and vice versa:

At the first sight of seeing you let the client feel at home and they normally come with their partners, so you introduce yourself (Linda, LWM INT1 hospital A)

To ensure that women knew who their midwives were and improve this midwife-woman relationship, hospitals A and B had implemented, though not effectively according to midwives and stakeholders, an initiative referred to as 'club 36'. This club was made up of women in their 3rd trimester and it involved introducing them to the labour ward environment and to the midwives who could potentially care for them during labour and childbirth. Women and their partners were educated on labour and what to expect during their time at the labour ward:

erm we have established a group known as Club 36. What we do, so what we do for them is that when they come, we send them round. We orientate them on the various stages in the labour ward. When they come, we send them to theatre, we send them to the scan room, we bring them to maternity; first stage room, second stage room

and the rest. Whatever activities that go on at the various stages we let them know (Matilda, LWM2 INT1 hospital B)

When they come, we even orientate them at the ward, the staffs on duty, even though he or she…she has not had an encounter with the person she will know that this is a midwife and if I go, I will find any of them at the place and they are always welcomed, so that also helps. (Enyo, midwife FGD6 hospital B)

Though this initiative may contribute positively to creating rapport between midwives and women and enable women gain familiarity with the labour ward environment, its impact needs to be investigated to ascertain its tendency to make positive contributions. During a PO in hospital B, a group of women belonging to club 36 were being oriented to the labour ward at a time when it was extremely busy. Midwives on duty were too busy to interact with them and their presence also compromised the privacy of women in labour. Additionally, the education on what happens within the labour ward appeared to be encouraging women to accept the care that was being provided as the best that could be offered, making it institution-centred rather than woman-centred. There were also indications of a lack of leadership and commitment to this initiative as midwives in hospital A were not even sure if this programme was still ongoing:

and then pregnancy school will also help. I know we started it, I don't know if it's still being done, but I know we started it. And they used to bring the clients here, so we orientate them to the ward. We take them round. There were two… I think it was done twice in a week or one. Either once or twice in a week (Maya, midwife FGD1 hospital A)

Participants further explained that their emphasis on building rapport was grounded on relational concepts such as religious, moral, and professional attributes, some of which were culturally situated. These are explored further below.

4.4. Care ethics and the morality of relational respect

Implicit in this relationship were concepts that are fundamental to midwives' professional identity and contextually relevant during the provision of RMC. First of all, the relationship between the midwives and women was a caring one and thus characterised by the exhibition of professional ethics involved in care. Hence, in providing RMC, participants posited that there ought to be the exhibition of emotional attributes such as being welcoming, patient, and loving. The need for these values within the context of this study could also be attributed to women's emotional, verbal, and physical reactions to labour pain (in the absence any form of pain relief) and the need for midwives to manifest these values to appropriately support women:

> *the way you receive them. I don't want to use the word respect again…like calm, loving (Ivy, midwife FGD1 hospital B)*

> *you first welcome all of them and you calm the relatives down (Abena, midwife FGD1 hospital C)*

The notion of being welcoming bore similarity with the Ghanaian value-based cultural facet which privileged welcoming a guest as a necessary form of behaviour. Within the labour ward context, however, this Ghanaian ethic of care assumed a much stronger emotional attribute. Some midwives stated that women's reaction to pain and the unavailability of pain reliefs required the exhibition of attributes that demonstrated a stronger virtue. Several participants recounted abuse that they had experienced from women as a result of their manifestations of pain and expressed the need to be patient and self-controlled in order to offer respectful care regardless of such abuse:

> *you have to control yourself in a respectful way, even when she insults you, you still render your services in a good way, and you don't use like harsh words or anything like that (Sala, rotation midwife FGD6 hospital A)*

Other professional values which were necessary for all service providers were highlighted by participants. For example, having a smiling face, being polite, compassionate, and having a sense of commitment to duty. Though not always, these were observed to be a part of the routine practice on the labour ward. In addition, there were occasional jokes and laughter between all categories of health professionals and women and their companions which created a friendly environment within the labour ward. According to participants, these positive attitudes towards women contributed to a relational respect which facilitated the building of trust. This cordial relationship ensured women's confidence in the midwife, enhancing women's ability to provide information necessary for their care:

> *Have compassion, be committed to what you are doing (QCO, INT2 hospital A)*

> *The relationship between them, it should be very cordial to the extent that your client can easily tell you anything going on. And then also the rapport should be so good to the extent that, let's say your client should, let's say, have some intimacy in you ah haa so that in case of anything they can just report to you. They can just tell you anything (Abena, midwife FGD1 hospital C)*

Underpinning these care ethics were the morality of this relational respect i.e., religious and cultural values. The values may be shaped by the three major religions in Ghana (Christianity, Islam, and the African traditional religion). Though no particular religion was mentioned by participants, their value reference was to God and their expression of faith often observed was through Christian prayer within the facilities as a whole and specifically within the labour ward. Morality concerned how midwives came to a decision of how to be or do. Ghana is considered a religious country and majority of the population have some form of religious affiliation. Public prayer and acts of worship are common, and this could be seen during observation visits to the included hospitals. It was, therefore, not surprising that some participants expressed that some religious values were inherent in the provision of RMC. These provided an explanation of why certain actions were wrong and why RMC should be provided in a certain way. For instance, Christian midwives articulated that the woman should be viewed as someone who

was to be served as one would Jesus and they perceived that midwives who had the fear of God were unlikely to mistreat women:

> *If we see the client as Jesus or as the God we worship, because there are other religions, [...] then we will give that client much respect (Efua, student midwife FGD7 hospital A)*

> *One, if the person is God-fearing. Yes, if you are God-fearing, you wouldn't do anything anyhow […..] yes, you will do everything and then show respect to others (Fosua-Student midwife FGD2, hospital A)*

These religious values not only served as a moral impetus for the provision of RMC but also as a source of strength to enable midwives maintain a respectful and professional demeanour in the face of difficulties. Considering the pressure that the lack of resources exerted on midwives, both midwives and managers took consolation in their faith and the strength they obtained from it:

> *You just offer your services …….. you just go like I'm doing it for God, I'm not doing it for human sake (Achiaa, student midwife FGD7 hospital A)*

> *So, do what is good and right for them so that at the end God will bless us all [….] …we will be going up and down, in the evening before you leave here you are tired but, in the morning, God still give you the strength to get up and you come and continue. (Linda, LWM INT1 hospital A)*

Some midwives were also seen joining women who were praying for safe childbirth outcomes. In a PO in hospital A, two rotation midwives sang for a woman who requested for them to sing her favourite gospel song for her, after the midwives had asked what they could do to help her cope with the labour pain. These shared religious traits were utilised by midwives during their interactions with women to offer supportive care. It was used as a form of encouragement for women during contractions, who were often not given any other forms of pain relief apart from sacral massage which women often refused. During POs, midwives were seen assuring women of the presence of God with them during labour and birth. In response to a woman

shouting *"(Twi) I will die ooo, Aunty nurse I want to die"* during contractions in hospital A, midwife Emefa responded:

> *(Twi) Why will you die? you won't die here; you will give birth safely. Why, don't you believe in God? God is with you, so you won't die. Why don't you pray instead of saying that (Emefa, midwife PO hospital A)*

The morality of this relational respect was further expanded on by participants to include the culturally situated notion of attachment to the woman: regarding her as a relative. Within the Ghanaian context, a relative does not only refer to someone related to by blood but could broadly be used to refer to persons to whom one owed a duty of care or a moral obligation of care. The notion of kinship attachment, therefore, ignited ethics of care for participants. Extending this received principle to the midwife-woman relationship, both midwives and stakeholders concurred that firstly, the woman was to be treated the way they as midwives would like to be treated if they were in the same position:

> *there is a saying that goes 'do unto others as you want others to do onto you'. So, what you don't want anybody to do to you, you don't have to do to a client (Asarebea, Rotation midwife FGD4 hospital A)*

> *oh for me, we think that as I said earlier on we think that doing good and asking ourselves that what should the ideal be and if we were, I'm a man though but I mean if I were to be labouring, under what condition will I want to labour? (George, MD, INT6 hospital A).*

Secondly, they believed that the notion of kinship attachment applied to the providing RMC meant the midwife treating the woman as she would treat a family member to whom they owed a moral duty of care:

> *whoever you see, see the person as a relative. See the person as your sister, an aunty, an in-law and give that person that treatment you will give your relative. If we put this thing in our heads, we might step on somebody's toes, but it will be minimal (Ama, midwife FGD4 hospital B)*

if you take the client there as your own sister and do unto others as you want others to do onto you. [….] you are taking care of somebody one day somebody will take care of you. As you are taking care of somebody here, somebody too will be taking care of your relatives far away somewhere (Linda, LWM1 INT1 hospital A).

Nonetheless, based on the same principle of kinship attachment that stimulated the ethics of care, midwives reiterated the concept of reciprocal respect explored earlier, and the need for women to also regard them as sisters and treat them with respect:

We are also humans, we have families at home that love us, you understand. And so, whatever you are doing to us, if it's your sister who is a nurse won't you love the person? (Ivy, midwife FGD1 hospital B)

The above suggests a recognition of the utmost importance of culturally situated and religious notions of care and these had capacity to shape a strong midwife-woman relationship. It could, however, be noted from the findings that this relationship had been negatively affected by several challenges, which had left midwives feeling disrespected, thereby, fostering the concept of reciprocal respect and mutual satisfaction. Though midwives rejected the view of RMC, which is solely centred on the care women received, they embraced an approach to RMC that was grounded on the principles of woman-centred care. Therefore, though they perceived and acknowledged the need for reciprocal respect and mutual satisfaction, they emphasised that care needed to be responsive to the unique needs of women. These are explored further in the section below.

4.5. Woman-centred care

The woman-centred care concept emerged because the findings from midwives included individualised care, information, and informed choice, concepts which are central tenets of woman-centred care. Woman-centred care is fundamental in midwifery practice and is grounded on the provision of holistic care for childbearing women. Participants' views of RMC also assumed a holistic nature encompassing an individualised approach to care

where social and cultural diversity were integrated into the care. It further integrated the most appropriate means of communicating with women, provision of information, and facilitating women's informed decision-making about their care. Some midwives expressed that women ought to be considered as unique individuals with distinct characteristics, thus, no two individuals should receive the same treatment. Individualised care was also viewed as a woman having the constant presence of a midwife to care for her during labour and childbirth, though this was often not the case in practice in some facilities:

> *So, I think that respectful maternity care is treating every individual uniquely. Erm (Twi) how do we call it, our elders give a proverb that our fingers are all not the same (Ivy, midwife FGD1 hospital B)*

> *It is one on one personal care at the labour ward and then when you get to your delivery suite it is you and your midwife and the relative that you trust to be there (Joana, student midwife FGD2 hospital A)*

This one-to-one personal care was very much the situation observed in hospital A. There was the constant presence of rotation midwives, sometimes more than one, with women. This may have resulted from the fact that during the study, there were rotation midwives in hospital A and not in hospitals B or C. Participants iterated that RMC was a holistic concept of care that involved the care provider adapting to the woman's culture, religion, and wishes. With most communities being made up of people of diverse culture, respecting the demands of each woman's culture was viewed as an integral aspect of RMC:

> *culture will play a role here. You know City C or Region C is not a monoculture centred region. There is diverse of cultures here. When you pick the Krobos, the Krobos have a different culture, when you pick the Kwahus, the Kwahus have a different culture. When even..... if you pick indigenes of City C, they have different cultures. So how one client will relate to what you are…… the instructions or whatever it is you want the client to do will be different from how the other person will relate to it, so it makes er giving out the service kind of difficult. It's like you are not following a specific …. You know…..routine. You will need as a midwife to adapt into a particular culture (Agbeze, midwife FGD1 hospital A).*

In accordance with the tenets of this culture, however, individualised care went beyond the holistic provision of care for the woman to integrate her family and her community. This belief may have resulted from the family-centred approach to maternity care where members of some closely knit communities become involved in the care of their community members:

> *to me, respectful maternity care will just be the kind of relationship that is built between the midwife or health care provider, the client, the family and then the community. Because at the end of the day it's not just the client you are dealing with, you are dealing with an entire community. And then building on that positive relationship, it bouncing back with a positive result. [….]. That is to get a healthy baby, a happy mother, a happy family, and a happy community and that should be it. (Abgeze, midwife FGD1 hospital A*)

This diversity did not only pertain to culture but could also be seen in other areas such as race, religion, and social status. Socio-economic status and religion were the most cited examples by participants who highlighted that women from poorer socio-economic and different religious backgrounds needed to equally be offered respectful treatment:

> *Yayara- (Twi) someone will say that maybe eiii as for this person […] She may be a (English) prominent person*
>
> *Sala interrupts- appearance*
>
> *Yayara continues- (Twi) so she will treat her fine. Someone too will come in rags, and she will not treat her fine. (English) No! respectful maternity care is not about that. (Twi) Someone may come and is wearing rags, even if she didn't bring anything, it doesn't matter because the, … (English) the same way you will give equal care to everybody […]*
>
> *Otema interrupts- no tribalism, no (Twi) saying that she is not a Krobo so I will be lazy, or she is not a member of my church*
>
> *(Rotation midwives, FGD6 hospital A)*

Observational data, however, provided evidence contrary to this. Due to the unavailability of resources, women were required to provide their own personal effects such as baby dresses, cot sheets, and mackintosh to cover the birthing beds (discussed further in section

6.4). Women who came without these mandatory items or without the money to purchase them often encountered disrespectful care. Though midwives provided these from available stock, they would often stress on the need to pay for them before discharge. These views shared by participants highlight the socio-cultural and religious diversity that is characteristic of the women midwives cared for and a possible socio-economic gap between midwives and these women. However, deficiencies in resources presented challenges for the practice of an individualised care (discussed further in section 5.2).

Communication, information, and informed choice were also considered highly significant in the establishment of the midwife-woman relationship. As midwives articulated, communication was vital in the initial approach utilised in establishing rapport with women and their companions as well as ensuring woman-centred care. Approaches used in establishing rapport such as greeting, welcoming, allaying fears and anxieties, and the use of shared religious values to provide spiritual support were all forms of communication which were individualised to ensure a woman-centred approach to care. Communication was defined as how the midwife spoke to the woman and the quality of this was mostly influenced by the content of the communication and how this content was delivered. Effective communication (verbal and non-verbal) with women was not only viewed as an intrinsic aspect of women feeling well cared for but it was also seen to cause improvement in the midwife-woman relationship. It was a means of providing supportive care and helping women cope with labour pain as explained in the quotes below:

> *communication is also vital like what she's saying. Like sometimes someone….the pregnant women they may even come and then psychological you just tell them something …. something, even just touch the person and the person will be ok. It doesn't matter even taking drug or anything. The way you talk to the person, it's even something that will let the person feel fine, so communication is also a factor that will lead to the respectful maternity care (Ann, midwife FGD1 hospital B)*

The way midwives spoke to women was distinguished by the midwife's tone of voice and the type of words used. Participants further discussed the type of words used to include not just

polite words but polite means of addressing the woman. The local word for madam which is "maame" was utilized as a prefix to the first name and when the woman's name was not being mentioned, as a sign of respect. Participants also emphasised on the use of words such as please and sorry:

> *Akua interrupts- the respect mmm*
>
> *Abena- number one your attitude, and then your tonation…*
>
> *Ama interrupts (nodding head)- yea*
>
> *Abena- of talking and then the kinds of words that we use*
>
> *(Midwives, FGD1 hospital C)*

Another aspect of verbal communication that was vital for the provision of RMC as described by participants was the provision of information. Participants clearly articulated the importance of maintaining communication with women, especially during procedures. Procedures needed to be explained clearly, the rationale given, and findings communicated to the woman after the procedure:

> *There is this thing that I always do when they come in the first stage. After I've assessed you and communicated the findings to you, I tell them maybe 'madam that is how much you have dilated, you are supposed to go like 10cm, you are now 2cm. The pains you are feeling right now as you progress it will be more than you are feeling' (Lena, midwife FGD1 hospital B)*

Midwives were often observed providing information to women and their companions, sometimes in groups especially during discharge but also before conducting each procedure. In hospital B, a few midwives were observed using a dilatation board to explain dilatation of the cervix to women during their first vaginal examination and women were offered the opportunity to ask questions. It was also observed that there was often a struggle to explain diagnosis and medical conditions in local languages and in lay man's terms in order to ensure that women fully understood what was being said. For instance, in a PO in hospital A, during the process of educating a grand multiparous woman on family planning

before discharge, the midwife struggled to explain the physiological impact of multiple pregnancies on the uterus and the effect on subsequent pregnancies in the local language.

To ensure that the content of the communication was clearly understood by women, midwives employed various strategies. Some strategies adopted included using examples and feedback where women repeat the information given and miscommunications addressed:

> *Ama- so a feedback sort of thing. You give them the information and probably you ask them, 'can you repeat what I said'*
>
> *Yaa-and it will amaze you if you ask them to repeat*
>
> *all chuckle*
>
> *Yaa and Manu together- the kind of things you will hear*
>
> *Manu-then you get to understand that eii if I had not asked this question to the client this is what she would have sent away.*
>
> *(Midwives FGD4 hospital B)*

Effective communication was also viewed to be challenging as a result of language barrier as indicated by Esi in the quote below. Language hampered communication both during the daily interactions needed to provide care and more specifically during the explanation of pathophysiology in order to gain informed consent. Where language was a barrier, other midwives or women who spoke the same language with the recipient were asked to interpret:

> *And the language barrier thing too, the language barrier thing sometimes erm you will be fortunate to get a client who probably understands Twi and Ewe and the Ga language and sometimes ask the client to interpret it for you and it makes things a little bit easy. (Esi, midwife FGD4 hospital B)*

Further exploration of the impact of language barrier on the midwife-woman relationship is carried out in section 6.5. Regardless of this barrier, participants perceived providing

information as a means of obtaining informed consent very vital. In FGD4 with rotation midwives in hospital A, they attributed women's refusal of procedures to the lack of appropriate information:

> *so some…….that's what sometimes we do, as if we own them. We didn't ask them to come here. (Twi) "maame open your thigh and let me put my hand there". (English) And then the patient too will be like (Twi) "what are you putting your hand there for? And I will not open my legs" and that's when we encounter the problem of patients refuse VE (vaginal examination). […] (Oparebea, rotation midwife FGD4 hospital A)*

Lengthy discussions took place in most FGDs in each site regarding information giving and offering women choice. Albeit with exceptions (explored in section 5.5), participants agreed that women's wishes, and choices ought to be respected and that women needed to be given the necessary information about their care in an understandable language to facilitate informed decision-making:

> *for the informed choice sometimes maybe when you go into labour and there is something like CPD (Cephalopelvic disproportion) you know there's er..... it becomes an abnormal labour, so you have to rush the person for CS. You have to explain to the person well so that the person will know that the person will have to go for the CS instead of SVD (spontaneous vaginal delivery). That one too the way you talk to the person will make the person understand … (Adoley, midwife FGD5 hospital A)*

With regards to women's choice, one of the most frequently mentioned examples was offering their choice of birthing position. Whilst most women accepted what was offered (lying in the lithotomy position on a birthing bed), according to participants, women who had previously given birth with traditional birth attendants (TBA) preferred to lie or squat on the floor to give birth. Midwives who have mostly been trained to conduct deliveries on beds and in the lithotomy position expressed a general lack of preparedness to support this choice. Health facilities are perhaps experiencing an increase in facility deliveries by women who had previously delivered with TBAs and midwives may not have been trained to appropriately support such women. Nonetheless, whilst some midwives were reluctant to

support women who wanted to give birth in such positions, others including stakeholders were of the view that the woman's choice and wishes should be respected and all efforts made to support them as demonstrated in the quote below:

> *Let's say she wants to get down, bear down, deliver on the floor and the midwife will say, "no it's not good, you are not supposed to". But she's allowed to deliver in any position she likes and you the midwife you are there to supervise. […] We've had two issues where the woman was gravida seven para six, all the deliveries happened at home. She came here, you tell this woman to lie on the bed, definitely she will not (in a stern tone). […] (Linda, LWM1 INT1 hospital A).*

Woman-centred care was undoubtedly viewed as an important component of RMC. This component of RMC ensured that women were cared for as unique individuals whose care needed to be holistic, incorporating every aspect of their need. Woman-centredness was also ensured using appropriate means of communication to provide information and obtain informed consent. The provision of informed choice was, however, problematic because most midwives felt unable to support women's choices due to a plethora of reasons (further exploration of these reasons is carried out in chapter 5). The importance of communication in establishing this value-based midwife-woman relationship cannot be overemphasised due to its propensity to influence the initial approach adopted to establish rapport and to ensure woman-centred care. Additionally, communication has been deemed a vital means of supporting women during labour and childbirth which was also considered an important component of RMC. Further exploration of the supportive care provided by midwives is explored in the following section.

4.6. Supportive care

According to the findings, support referred to mechanisms within the care that were used to aid women's capacity to cope with the discomforts and anxieties of labour and childbirth and ensure that women's needs, and wishes were respected in this regard. Support was

conceived by participants as an integral component of RMC due to the emphasis on respecting women's wishes and choices as they harness their inner strength to progress through labour. These mechanisms were non-medical and spanned through the whole process of labour, from the initial encounter to the time of discharge. Though midwives in most of the facilities involved in this study felt unable to provide the support women wanted because of various inhibiting factors (See chapter 5), they, nonetheless, discussed what they offered women despite the challenges. Supportive care was offered by both midwives and companions, they were either verbal or nonverbal, thus communication was an important support strategy. As articulated in section 4.4, underpinning the ethics of care were moralities of relational respect which included the exhibition of shared religious values. Within these shared religious backgrounds, verbal communication was a vital strategy utilised to develop a supportive relationship with women, where midwives offered to pray with them or joined them in praying. These supportive elements were not only respecting women's need to integrate their religious believes into their childbirth experience but also enabled them to harness their coping mechanisms during contractions.

During PO in hospital A, the pastor of a woman in labour, upon the woman's request was given the opportunity to pray with her during labour. In hospital B, the midwife supported the woman and her husband's decision to confer with their pastor before agreeing to a CS. Companions also offered this form of spiritual support to women; they were often seen sitting by women and praying or praying whilst women were pushing. Verbal support also included other forms of emotional support such as words of encouragement, reassurance, and motivation to push during the second stage of labour which were offered by both midwives and companions where available. Some midwives explained this form of support as follows:

> *…you need to reassure the person because she is anxious, so you need to reassure her, tell them they are in good hands everything will go on well so that they will be ok a little, yes (Fosua, student midwife FGD2 hospital A)*

when they are in labour, when they are in pain, you just motivate them, (Twi) 'maame you are doing well, keep on, keep on, breath in, keep on, keep on, you are doing well' (Efua, student midwife FGD7 hospital A)

As part of this component of RMC, participants also stated the non-verbal strategies that were adopted to enable women cope with the labour pain. These involved the midwife's constant presence with the woman and her availability to respect and provide the woman's needs. Back rubs and sacral massages were also offered to enable women cope with the pain, and this was also viewed as an aspect of the supportive care inherent in RMC as explained by midwives in the quotes below:

Asarebea interrupts- and then we are always by your side, we don't leave you in the suite by yourself (shakes her head)

Boatemaa- yes, we are always with you so that in case of anything action will be taken

(Rotation midwives, FGD4 hospital A)

Because the support..... in the way that you see a pregnant woman in pain and then as she is in pain and then she will be like 'maame nurse hold my hand' and then you will have to hold the… you have to hold the hand. Then some will be like 'maame nurse er my abdomen is paining me I want you to rub my back' and they do that for them. (Nina, student midwife FGD2 hospital B)

This continuous presence and availability of midwives was, however, not observed in all facilities. Only hospital A offered the continuous midwifery presence for women during labour, and this was mostly provided by rotation midwives. Experienced midwives were also occasionally observed being with women, but their presence did not last as long as that of rotation midwives. This may have resulted from the fact that experienced midwives were often two on duty and were providing supervisory support and receiving babies from the theatre as well. In hospital B, during shifts where student midwives were available, they also provided this form of support for women.

Whilst midwives could provide this respectful support as described above, companions were also deemed important in providing it. However, most facilities did not have the required infrastructure to enable a companion to be with the woman, though they were available outside of the wards in case their presence was needed. Only one facility of the three involved in this study had a policy that enabled companions to be with women during labour and childbirth. According to both midwives and stakeholders, this was because the facility had labour suites where women could be alone with their midwives and companions:

> *Additionally, once this….the labour ward is compartmentalised it helps you to bring in a birth companion and which we here think that is also a very important part of respectful maternity care because having somebody that you are familiar with in that time of your pregnancy or delivery, in the moment of life if you like, the most vulnerable time having a familiar person I think is reassuring like your partner which is preferable or your mother. (George, MD INT6 hospital A)*

> *and for continuous support during labour and childbirth, for us, it's been good. We have husbands and partners, and we have mothers, we have … and we have er er er sisters. We allow….. we actually even insist on support, continuous support throughout. That's why we have the suites so that they can sit with them (Maya, midwife FGD1 hospital A)*

The presence of companions, according to midwives, not only ensure that women were adequately supported during labour and childbirth but also facilitated the involvement of partners and relatives in the care. Participants, even in facilities where infrastructural limitations did not permit a companion, perceived that the presence of companions ensured that women were not mistreated, and they served as eyewitnesses when the unexpected happened to ensure that midwives were also not unduly blamed:

> *I mean the presence of the companion in itself is a deterrent to, you know, the woman not being treated well (George, MD INT6 hospital A).*

If the relatives come and they are also talking to them, they know that you the midwife you've done your best. So, if anything happens at least there was a relative there (Abrafi, midwife FGD2 hospital C).

Companions, therefore, had multiple roles with regards to RMC, to be a supporter, an advocate, and importantly a witness. This was key because to midwives in these resource constrained contexts, RMC was not just to be provided and experienced but also witnessed. Albeit the facility decided the type of companion women could have; a partner or a close female relative i.e. mother, auntie, or sister. Participants explained that this was because the companion was a witness to all that the woman would do during labour and this could be used against the woman. As such persons such as neighbours who were not family members were not permitted. This could be due to a prevalent cultural practice where non-close relatives who witnessed women's manifestations during labour and birth used these to humiliate the women or as forms of insult. The stakeholders perhaps felt a need to protect women against this by deciding who the support person should be:

like your partner which is preferable or your mother (George, MD INT6 hospital A).

erm, some mothers come with like…their cotenants which is not advisable. A cotenant is a cotenant, anything can happen and if the person comes to see your nakedness one day, she can just say it anywhere. "That after all when this woman was labouring, she was doing that"……so we normally don't allow cotenants [people renting apartments in the same building] and friends. We want real relatives to be there and that is our challenge. (Linda, LWM1 INT1 hospital A).

With regards to the role of companions in RMC, participants perceived this as something that went beyond emotional and spiritual support to include informed choice and decision-making regarding care. Participants' family-centred approach to respectful care involved partners' participation in the decision-making process. Relatives were considered the most appropriate persons to make decisions on behalf of the woman and so were preferred as companions as explained by Fatia:

So relaying information …. because once the person steps here, it's just like any other patient. Once the person steps in certain decisions needs to be made by the person. So, if the person is one that cannot make certain decisions for you, you cannot … you cannot make the person to stand in for you. But it's always almost advisable if it could be your mum, your dad, or your husband. These three but mother-in-law, father-in-law, friends, certain decisions, certain information cannot be relayed to them. You can only give them the skeletons of the information but detailed information you can't give (Fatia, midwife FGD1 hospital A)

This, however, suggests greater respect for the culture within the society rather than the woman's choice. Furthermore, midwives from facilities that did not have the provision for companions also viewed the support from relatives as a form of assistance to ensure that women were not neglected when they were busy as expressed in the quotes below:

if the workload is high and the midwife or nurse can't come to you at a particular time, maybe she is with a different person, the relative can be with the person so that it will also help us in our field of work (Lena, midwife FGD1 hospital B)

Midwives working in facilities that had infrastructural challenges sometimes encouraged partners to be with the women if the woman was alone on the labour ward. Others managed to offer partners who insisted on supporting women the opportunity to do so, though this may be done to the discomfort of other women on the same labour ward. Cindy, a midwife in hospital C recounts how she was able to ensure that a husband who insisted, could be with his wife:

I had to move the other two to the ward so that the first stage will be free for only that woman. So, I had to invite the husband and I was able to teach the husband how to support the wife, so the husband was with her throughout. […] So, in this case, they were happy, I was happy everything was cool (Cindy, midwife FGD2 hospital C).

It is apparent that supportive care was viewed as an equally important component of RMC. Support was provided by both midwives and companions to ensure that the woman's spiritual and emotional needs and choices were met during labour and childbirth. Companions were also considered witnesses whose presence ensured that women were not disrespected and were witnesses of the RMC being provided. Nonetheless, there seemed to

be a greater respect for societal culture than for women's choices as facility policies determined the type of companions women could have. Though some adopted innovative ways of ensuring support for women, they often had to turn away relatives who wanted to be with women due to the unavailability of resources that facilitates the presence of companions. Resources did not only influence the capacity for supportive care, but also the provision of other components of RMC such as privacy and confidentiality, explored in the section below.

4.7. Dignity, privacy, and confidentiality

Participants perceived RMC as welcoming a woman into a facility with a conducive environment to ensure her comfort, dignity, privacy, and confidentiality. With regards to dignity, some participants articulated that the aspects of RMC discussed above were all geared towards ensuring a dignified care for both the woman and her family:

> *You respecting the patient, greeting, explaining procedure and other stuff to the patient, it means you are respecting the patient's dignity (Oparebea, rotation midwife FGD1 hospital A)*

Other participants also viewed dignity as interconnected with privacy and confidentiality which were described as key elements of RMC. Majority of participants in this study worked in facilities that had relatively limited resources. The provision of privacy, confidentiality, and ensuring the woman's dignity as described by participants were, therefore, highly linked to the availability of resources such as individual birthing suites, curtains, and screens. It was evidenced from the findings that these resources in addition to the general atmosphere within the labour ward and its surroundings facilitated the provision of the conducive environment needed to ensure that women's wishes and needs during labour and birth were respected. The ability to adjust to the unavailability of these resources determined whether midwives were able to provide these aspects of RMC.

Two of the facilities involved in the study were very noisy, crowded both inside the labour wards and outside, and hot as women could be seen naked or only covered with a piece of cloth and often fanning themselves with whatever they could find. It was, therefore, not surprising that participants in hospital A (where the facility was clean with labour suites that had air conditioning and fans) viewed having a conducive environment an aspect of RMC as highlighted in the quotes below:

> *And then the environment too, its very tidy and the place is attractive (Efua, student midwife FGD2 hospital A)*
>
> *it is welcoming your labouring mother in a clean and nice environment with a smiling face (Linda, LWM1 INT1 hospital A).*

Participants emphasised on the importance of ensuring that the privacy of the labouring woman was respected, and participants highlighted its importance in relation to RMC. The findings revealed that privacy denoted a sense of personal space to preserve the woman's self-worth and dignity and the establishment of boundaries between women on the labour ward. According to participants, the facilities within the labour ward environment was a major contributor to midwives' ability to ensure the provision of these integral aspects of RMC. Only one of the study hospitals had suites that ensured that women in labour had their personal space. In interviews with the heads of this facility, they stated that they had eliminated the normal system which existed in most facilities in Ghana including hospitals B and C, where all women laboured in one room, gave birth in another, and were transferred to yet another room after birth. This they accomplished by providing individual suites to ensure that women had the privacy and the comfort they needed to go through labour and childbirth:

> *For erm I know privacy is one for the most important things in respectful maternity care. Since I came here, we've been working on privacy. So, for instance, our labour ward now we don't have all in one room, for about 6 women to be there, everybody shouting and doing all sorts of things. So, if you go to the labour ward, we've demarcated one room to a client and a caregiver. (Dora, DDNS INT5 hospital A)*

Observational data confirmed this and clearly noted the difference between this facility and the other two. The labour ward was more serene and seemed comparatively more comfortable. Hence midwives in hospital A expressed confidence in their ability to ensure comfort, privacy, and confidentiality for women. In FGDs with midwives, they explained how the suites enabled them to do so:

> *so please erm like this facility like this you see everyone has a suite. So, with this one even if the client is not comporting herself'; if she is exposing herself there is no one from outside who is going to see her nakedness or something and then whatever you do for her is also enclosed no one sees it which ensures the privacy and also if she tells you something too no one is going to hear about it that's for the confidentiality (Afi, student midwife FGD2 hospital A)*

Furthermore, they highlighted that women preferred this hospital because they had their privacy and there was the continuous presence of a midwife:

> *(Twi) When you come here, you are given your own room, nobody sees your nakedness or anything like that and there's somebody sitting with you to take care of you. (English) that is what I hear them say. (Yayara- Rotation midwife FGD6 hospital A)*

This was, however, not the case in the other facilities that did not have suites. In hospital B, some women who were not in active labour would sometimes go out to sit outside due to the excessive noise and the heat in the rooms but would often come back immediately because it was noisy outside as well. It was observed that in hospital B and C, they had separate rooms for the different stages of labour. These rooms had limited forms of privacy which also affected their ability to ensure confidentiality. The second stage room in hospital B, however, had a wooden board which separated the two beds available. Midwives in these facilities complained about the effect of this kind of environment on the provision of privacy and confidentiality. Despite these challenges, participants viewed the provision of privacy and confidentiality as vital aspects of RMC and, therefore, utilised available resources such as curtains and screens, though inadequate, to ensure its provision:

With the privacy thing we have screens around, we have curtains around that help us though we don't have individual rooms with well-structured walls and doors, but we make use of the available ones that we have like the curtains and the screens (Ama, midwife FGD4 hospital B)

Participant observations in these facilities revealed midwives' commitment to ensuring this, however, in hospital B all the screens they used were worn out, difficult to move round, and ensured very little privacy. Midwives were constantly seen re-covering women who had willingly exposed themselves due to the heat and ensuring that students did not move in and out of the second stage room too frequently because it was only separated from the main ward with a curtain. During examinations, they also asked other women on the ward to face the opposite direction to avoid exposing the woman being examined. Nonetheless, ensuring confidentiality extended beyond the availability of suites, and the presence of curtains and screens were not enough. As noted in some of the quotes above, birthing suites enabled women interact with their care givers without any interference. This interaction could involve the exchange of information which needed to be kept confidential unless the woman gave consent for the information to be shared. In FGDs with midwives, they emphasised on the need to ensure confidentiality of information provided by women:

Akos- yes, so you have to respect that (Twi) when she says something to you, you have to… There are some who don't even want their relatives to be there

Asarebea interrupts- yes don't tell my family members

(Rotation midwives, FGD4 hospital A)

Participants discussed other detailed aspects of ensuring confidentiality, especially in situations where the labour ward environment hindered its provision. For instance, midwives expressed great concern about not mentioning disease conditions particularly in circumstances where there was more than one woman in the labour ward:

And confidentiality too you see most of our clients have erm conditions that we can't make mention of in front of other clients. Like erm retro, hep B, VDRL those conditions. (Ivy, midwife FGD1 hospital B)

As an essential part of confidentiality, there appeared to be a need to protect women from stigmatisation against HIV and hepatitis B. Midwives, therefore, utilised nationally recognised codes when discussing these conditions and during documentation. However, according to midwives, these codes had become known publicly leading to a potential breach in confidentiality when utilised:

> *Gyekye- and the [code used to designate HIV positive] that we've been writing*
>
> *Essuman continues- now they know it*
>
> *Afoah- (Twi) now they have become used to it. They know it*
>
> *Gyekye continues- some they see [code used to designate HIV negative] in other books and then they … they… so some will go extra mile to find out from a health worker who is a friend that what is the meaning of [code used to designate HIV status] and so if he finds out that my wife is… meanwhile, the husband is not aware that my wife is HIV positive ooo.. yes, and that one too*
>
> *(Midwives FGD3 hospital A)*

Therefore, to prevent this breech from occurring, some midwives ensured that the content of the woman's folder remained confidential by removing records that women may want to keep away from their relatives:

> *Love continues- and when they are going home too..... we just pick the necessary information that could be ……. that when you take home like other relatives can read and all that we take it out and we then..... we give them the empty folder we give it to them. And so, for the confidentiality, I think we are doing well*
>
> *(Love, midwife FGD6 hospital B)*

However, participants believed the maintenance of confidentiality was not the sole responsibility of midwives but others who are present during the provision of care. Therefore, whilst the presence of birth companions was deemed an important component of RMC, participants' responses indicate that this had the potential to affect confidentiality, as not all information about women was known to birth companions. Women's folders in some hospitals were kept at their bedside and antenatal booklets were given to them on discharge

making them accessible to companions who would want to read them. This was problematic as they breached confidentiality. Midwives highlighted these concerns in the following quotes:

> *Essuman continues- Ensuring the confidentiality too, sometimes it's not we the health workers that disclose their information. It is they themselves, because we've made it clear to them that when you are coming to labour, the birth companion that you come with will be there and whatever we discuss she has to be there. So, you have to bring someone that can keep your information to herself. (Twi) […] Because sometimes, if I'm discussing something with you and your birth companion is there, let's take it, for instance, there is an HIV positive client who comes and I'm discussing: (Twi) maame when you were pregnant and attending clinic, they did this and that and that, are you taking your medication?*
>
> *Gyekye interrupts- (Twi) what medication*
>
> *Essuman continues- once the companion is there she will definitely hear, or he or she will definitely hear (Twi) and if she takes it away (English) it's not me who leaked the information ah haa (Twi) and so they should include this*
>
> *(Midwives, FGD3 hospital A)*

These concerns may have contributed to hospital policies deciding the type of companions women came into labour with. Furthermore, the presence of companions could also interfere with confidentiality when the woman wanted to disclose confidential information to the midwife to enhance the provision of care, particularly in situations where women were experiences domestic abuse. Participants, therefore, highlighted the importance of recognising situations where a woman needed some privacy so that midwives could intervene appropriately:

> *Manu- more on the privacy issue. Sometimes there are information that the client wants to give, they are very sensitive, they don't want relatives to hear. Sometimes they give us a sign or….*
>
> *Ama interrupts- the person's body language will even tell you that I don't want my husband to know*

Manu- yes and so you the midwife you have to think of something else to do to help that client. So, for that instance..... you have to erm "go and get some particulars for this client". So, whilst you [the companion] are away we have the client to ourselves and then the client can give us the information that she doesn't want the other relatives to hear.

(Midwives, FGD4 Hospital B)

Non-disclosure of information did not only relate to relatives but also to other health professionals who were not part of the woman's care team. In an interview with the labour ward manager in hospital B, she explained further:

Except of course somebody comes from a different ward outside of this ward looking for an information of a client, we don't do that, we direct them to go to the management at the general administration (Matilda, LWM INT1 hospital B)

Many participants demonstrated their commitment to upholding the dignity, privacy, and confidentiality of women as components of RMC. Despite the structural deficiencies, midwives highlighted the strategies they employed to ensure the provision of these components. Participants were also quick to point out the role that companions involved in the care of women played in ensuring the provision of some components of RMC, noting the need to integrate the role these persons play in the provision of RMC. RMC is, therefore, grounded on several interconnecting facets, including culture and the care environment, and these have influenced how participants in this study conceptualised RMC. Inadequate resources were a hindrance to the provision of RMC, especially where companions could not be permitted into the labour wards with women.

Even though this concept of RMC was more idealised than practical, it was necessary to examine the 'Real' mechanism that empowered or enabled midwives to provide RMC even in the presence of systemic constraints. Through further analysis of regularities within the empirically observable events, I postulate, using retroduction, that embodied values whether professional, cultural, or religious have the capacity to ignite an ethic of care and a sense of commitment to the provision of RMC. These embodied values become the morality of this

relational respect that have causal connection with the presence of RMC even when other challenges in the care setting prevail. The embodied values identified in this study included shared spirituality, the cultural notion of kinship attachment, and reciprocity. Further explanation of this causative mechanism will be given in chapter seven and eight.

4.8. Conclusion

This chapter has explored how midwives and stakeholders conceptualised RMC. Evidence presented indicated that midwives constructed RMC as both relational and reciprocal. This involved the establishment of a value-based midwife-woman relationship, first through rapport during the initial encounter and maintained through woman- centred care. The key principle of this relationship, as perceived by midwives, was the value-based notion of reciprocal respect and mutual satisfaction. This was grounded on their own experience of mistreatment from women and their companions. Nonetheless, the initial encounter with the woman was considered important in establishing this relationship and midwives utilised various approaches to ensure that the woman felt well cared for. The findings suggest the convergence of both professional as well as cultural and religious underpinnings to this relational concept of respect. Care ethics were underpinned by a form of morality informed by cultural notions of care, kinship attachment to the woman, and religious values. These religious values facilitated an entry into a relationship with the woman using shared religious backgrounds to provide spiritual support and as a mechanism to cope with labour pain. Religious values and the principles of kinship attachment were also a source of strength, moral steer, and relational motivation to enable midwives maintain a respectful and professional approach even when circumstances were difficult.

Participants also regarded RMC to be woman centred. This component meant midwives needed to care for the woman as a unique individual with specific needs and choices. Various means of communication were used to provide information for women to ensure informed choice. Though midwives discussed at length the factors affecting the provision of

information and informed choice, they concurred that this was an integral aspect of RMC. The strategies utilised in communication and the religious values were also used in providing supportive care for women, another vital aspect of RMC provided by midwives, but which could also be provided by companions when they were available. The last component of the RMC concept was caring for women within an environment that ensured their privacy, confidentiality, and dignity which was very much influenced by the availability of needed resources. The absence of these resources in most of the facilities meant that these were not adequately provided. Though midwives saw the presence of companions as an integral aspect of RMC, especially for the provision of support, they perceived that their presence interfered with confidentiality of information, and this needed to be taken into consideration when discussing RMC. Through the process of retroduction it was postulated that even when systemic constraints prevailed, embodied values had causal powers for the presence of RMC and for midwives who embodied these values, their capacity to provide RMC was shaped by them.

As highlighted, the findings indicated that the concept of RMC as discussed by participants was not always congruent with practice. Midwives' ability to provide RMC had been beset by several factors and the proceeding chapters will provide an exposition into these.

CHAPTER FIVE: RESPECT IS SYSTEM-SHAPED: CAUSAL CONNECTION BETWEEN STRUCTURAL DEFICIENCIES AND INEQUALITIES ON CARE AND WOMEN'S AGENCY AND AUTONOMY

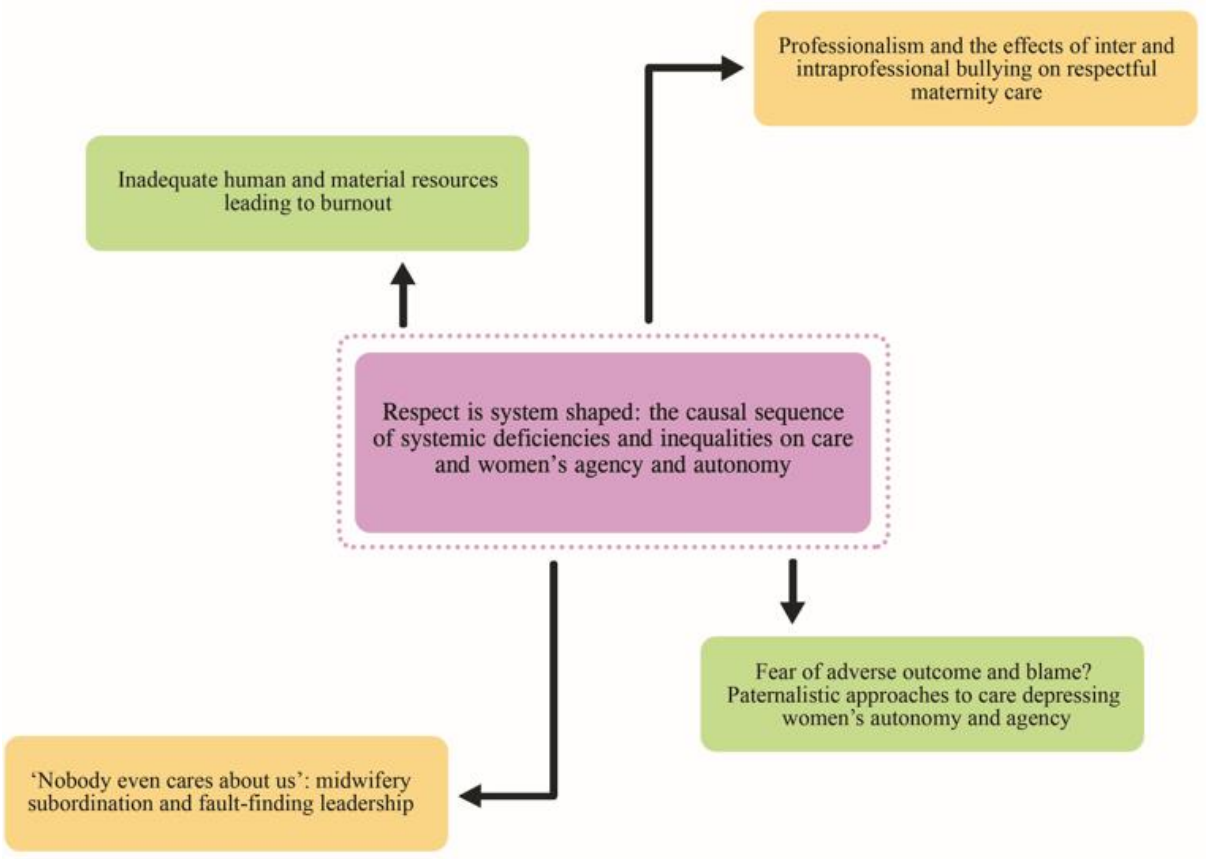
5.1. Introduction

The previous chapter explored RMC which was conceptualised as a value-based mutually satisfying and reciprocally respectful midwife-woman relationship. It was highlighted that this concept was idealised, and the presence of challenges had influenced the enactment of this concept. This chapter will, therefore, move beyond the social construction of this relationship to explore the care system within which the relationship is embedded, functions, and which shapes the nature of the relationship. A description is provided of the systemic deficiencies and inequalities, in addition to the identification of causative mechanisms and how these interplayed to influence midwives' agency and in some cases led to the abuse of women. This will include the identification of the structures, culture, and agency and how these influence outcomes.

The care system in the facilities involved in this study were marked by disparities in resources and imbalances in power between authorities, health professionals, and women and these formed the structures and culture within the care environment. The daily routines and agency of providers were influenced by these structures and culture. Poor leadership, poor organisation of care, contentious inter-intra professional relationships, and the exertion of the power that is inherent within the paternalistic approach to care that had depressed women's autonomy and agency were characteristic of the descriptions of participants' stories. Deficiencies in two major resources were highlighted: human and material. Human resources included the various types of health care providers in addition to the leadership that was needed to appropriately manage both the human and material resources. With regards to human resources, whilst stakeholders stressed the lack of staff, midwives stressed both the lack of staff and leadership within maternity care that had led to

inadequately supervised, mentored, and motivated staff resulting in the mistreatment of women and the absence of material resources. This chapter will be discussed under the subthemes summarised in the figure below:

Figure 7: Respect is system shaped: the causal sequence of systemic deficiencies and inequalities on care and women's agency and autonomy



In-depth description of these subthemes is provided in the proceeding sections. In addition, causative mechanisms will be identified throughout the section and explanation given on how these mechanisms interplayed to influence midwives' agency.

5.2. Inadequate human and material resources leading to burn out

5.2.1. Lack of human resources

During one of the POs in hospital C, there was one qualified midwife on duty with two student nurses and the labour ward manager managing the labour ward, the 35-bed gynaecology, and postnatal wards, and receiving babies from the theatre. The labour ward manager was not often available because she was attending various meetings. There were four women in labour, one undergoing CS, and another in waiting, and the gynaecology and postnatal wards were at almost full capacity. As I arrived, there was a woman on the ward whose baby's cord had prolapsed and needed to be sent to the theatre because labour had not progressed, the elevator was not working; the midwife was frantically trying to find a way to convey her using the stairway without the foetal head exerting pressure on the cord and relatives of women were on the corridor trying to draw the midwife's attention every time she passed; seeking information student nurses could not provide. The anger and frustration on the midwife's face as she went about her duties were difficult to miss and whilst she went about attending to this emergency, other women in labour were left unattended, thus neglected. Though this may not be enough to confirm, it perhaps reflects midwives' and stakeholders' descriptions of staff shortages and an indication of how the structures influenced midwives' agency and resulted in the lack of enactment of the idealised concept of RMC.

Such scenarios were common in hospitals B and C but were not observed in hospital A because during the time of the study there were rotation midwives available who helped to relieve the workload on midwives. Nonetheless, both stakeholders and midwives in all facilities highlighted inadequate staffing as a factor that influenced the absence of RMC as represented in the following quotes:

> *If we had enough staff…postnatal ward is a 40 bedded ward and we have just two staff with two rotation midwives who even don't come. So, two midwives with 40*

women. The place is even full, and some are sitting on chairs. (Dora, DDNS INT5 hospital A)

Akua- yesterday for instance, I was off oo but they called me because someone…..they were only two on the ward and one is on excuse duty (off sick) so..... she is pregnant
[…]
Abena- and you are also pregnant [pointing to Ama who is heavily pregnant]
Ama- oh that one is conditional [pregnancy is more advanced] than this one (giggles)
Akua- they have to call me from the house to come to the ward to come and help them. Meanwhile I have come to work for five days and so like eight days [because she had two more shifts to do] without any off so that one too is not good
(Midwives, FGD1 hospital C)

The heavy workload as described by participants negatively impacted on the provision of RMC. Midwives elucidated that they were often too busy to introduce themselves, spend time explaining procedures in detail to ensure informed decision-making, allow movement for fear that women will deliver on the floor when they were not looking, sit with women to offer a sacral massage to relief labour pain or respond immediately to women's demand for attention: *'you cannot do two things at the same time' (Yomi, midwife FGD3 hospital B)*. Women also expected equal attention regardless of the workload and became angry when ignored. These situations resulted in stress, frustration, pressure, tiredness, and anger, and these were vented on women:

Emma interrupts- yes because of the work pressure, when we become frustrated and we display the anger, it's not that we don't respect them. How can I see my fellow human being and I will not respect her? it's because of the workload. You come to work, and you can't even drink water oo. You can't get your hands to even drink water
Ivy- sometimes you are so pressed you want to urinate koraa you can't
(Midwives, FGD1 hospital B)

we have the whole suite full, and theatre too will be running. Who will be doing what for who? So, you see that when the midwife is tired, she will just go there and do

things anyhow, so the woman will not feel respected because she was not treated very well. (Asarebea, rotation midwife FGD4 hospital A)

Spending time with one woman to offer the support and encouragement she needed to give birth at her pace and time was considered a waste of time and a risk for other women giving birth without skilled attendance as expressed by midwives in hospital B:

Love - and then because of the pressure. Sometimes you come to duty you meet two staffs and then you are conducting like 15 deliveries within a night. Maybe this client is 9cm, 10, 10 you have to just finish up early and you come and deliver this person… so when you go here… here and you are like woman please bear down, bear down
Adzo interrupts- she's not cooperating
Love continues- she's not cooperating like you will be stressed up because you just want to move from this client and go and deliver [the next] …. because by the time you are here wasting time the other client will just scream and push baby out […] sometimes that's those things…those things also cause the relationship to …… (Midwives, FGD6 hospital B)

Midwives may have articulated the ideal in terms of their conceptualisation of RMC, but data from this study indicates that though aspects of RMC were practiced, the lack of resources were enduring structural elements of the care system that interplayed to influence midwives' agency- lack of time, verbal abuse, and neglect of women, thus mistreatment of women. This mistreatment may have become a normalised culture and a form of expressing burnout such that stakeholders expressed same sentiments:

Yes, and erm the number of staff too on the ground working too is a problem. Yes, and erm there may be the need for you to just be with a patient and see to the patient's welfare but the numbers on the ground will not give you that opportunity (DDNS, INT5 hospital A)

Then there's also this communication with the client by the staff, where because of probably stress or lack of satisfaction resulting in stress they sometimes throw caution to the wind. but like I said it's mostly because of stress and people are not able to manage their stresses so, yeah. (QCO, INT2 hospital A)

Though these stress inducing situations were very often observed during POs, this was not always the situation on the ward. There were times when women in labour were few and yet did not receive the necessary attention. Midwives may have seen this as an opportunity to rest, as noted in their response to researcher's comment about the labour ward not being busy: "(Twi) *eiii don't say it, if you say it, they will start coming (Love, midwife hospital C)."* Perhaps the shortage of staff has persisted for so long, it had become a welcome excuse for not living up to the duty of care or perhaps they felt they deserved a break to draw their breaths. The enduring structures that influenced midwives' agency were not limited to the deficiency of human resources, but also material resources. This is presented in the following section.

5.2.2. Lack of Material resources

Participant observations identified two categories of health facilities; one that I noted to be well equipped and two others which were not. In the well-equipped facility, there was a theatre within the labour ward and the constant presence of doctors attending to obstetric cases. There had also been a reorganisation of the care environment to ease congestion on the labour ward and improve service delivery. There was a triaging unit, preventing the admission of women who were not in active labour into the labour ward. These women were admitted to a prenatal ward and midwives in the labour ward were pre-informed before a woman was transferred there, thus they were often ready to receive her and her birth companion. Furthermore, according to stakeholders there was a quality assurance team in charge of ensuring the overall quality of care and a patient satisfaction survey to inform improvement strategies had been developed but not yet implemented:

> *well in terms of staff output we haven't had rigorous maybe questionnaire for the patients or anything like that. I mean we did develop one last year, but we are yet to put it into practice. We developed one we have a QA, a quality assurance team in the department so they have developed it and this year we are going to roll it out through the patient interviews and others (MD, INT6 hospital A)*

In this facility midwives and stakeholders expressed satisfaction with the strategies that had been implemented to facilitate the provision of quality care. Midwives felt fortunate to have basic equipment like gloves to work with, work in air-conditioned rooms, and be able encourage companions to be with women and contribute to the care that they provided for them. This indeed was a motivating factor for midwives and stakeholders who saw their facility as one of the best in the country:

> *But here we are fortunate to get er ….. It's just one or two (Twi) that maybe we don't get (English) aside that for you to get the bed for the patient to lie on it till delivery, after delivery that the patient will still lie on it, it's 'gyƐgyƐ' [perfect]. So that thing motivates me to work here. Other hospitals that you go, you monitor aaa when she is full that you are going to walk to another place to deliver her. The inconveniences that it comes with but for here other things we get. And at least now he [medical director] has given us AC [air-condition] […] Er er documents to work with, other monitoring charts and other things they are all there. (Essuman, midwife FGD3 hospital A)*

These sentiments were absent in the other two facilities where midwives sometimes found getting a bed for a woman to lie on difficult. In hospitals B and C, the unavailability of material resources was described by both midwives and stakeholders as a major contributor to their inability to provide RMC and this was evident during PO and hence a significant structural feature that influenced to midwives' agency. The provision of very integral aspects of RMC such as privacy, confidentiality, and ensuring the dignity of women, as indicated in section 4.6, were highly compromised due to the absence of these resources. In the labour and birthing rooms, there were no curtains to separate beds and women were often seen looking while other women were being examined and midwives constantly asking them to look away. As a result of poor ventilation women barely covered themselves even in the presence of visitors and midwives found this very disturbing.

The current policy in Ghana of admitting women when they report in the latent phase of labour led midwives to admitting women even when they were operating beyond capacity. Policies are considered social structures whose powers precede an individual's actions and

whilst these may not be observed during a midwife's interaction with a woman, they shape the nature of it. In this regard, during one of the POs in hospital B, two midwives had conducted 10 births excluding CS in the night and women were provided with mattresses to lie on the floor with their babies because there were no beds, and they could not be referred to other facilities because of the existing policy.

> *When the client comes in labour, you can't ask the person that we don't have beds so go to another facility. You don't know what will happen on the way. So, it's better to see the woman and the baby and let them lie on the floor than leaving them for something to happen on the way. So, we know, and the clients know that we are supposed to give some basic things but unfortunately our system doesn't give us that room. It's kind of difficult. (Ama, midwife FGD4 hospital B)*

In another incident, a labouring woman who was being transferred from the first stage room to a birthing bed in the second stage room, nearly fell off the bed. The quick intervention of the midwife and myself, as we were assisting her onto the bed, prevented her from possibly injuring herself. According to midwives and the labour ward manager, this faulty bed had been reported several times to authorities and no actions had been taken. These observations were confirmed by midwives in the following quote:

> *it's very bad, very very bad, so (giggles) they should provide certain things for us and then we need more beds and then some renovations because our place is too small. Sometimes we do like 15 to 20 deliveries per night, we have only three delivery beds, which is very small yes. (Frema, midwife FGD 5 hospital B)*

The outcome of the interplay of these structures and midwives' agency was the negative influence on the midwife-woman relationship and that of companions. To exemplify this, midwives' request that women lie on mattresses on the floor was often not understood by them and their companions. According to midwives, though they try to explain the reasons they had to do so to them, it was met with anger and insults. For instance, during a PO in hospital B, a woman had to be asked to get off a bed to give room to another who had reported with ante-partum haemorrhage and needed urgent attention. This resulted in insults

and shouting from the woman and her relatives which the midwife retaliated. Midwives explained that it was the responsibility of hospital authorities to provide these resources and not they the midwives. However, when that was not done, they bore the brunt of it:

> *and there are people who have already delivered, and they are there, so sometimes you come we put mattress on the floor. Sometimes, there is no floor bed [mattress to put on the floor] koraa so you have to sit in the chair. Then they will go out and (Twi) "even when I went to hospital B, I wasn't given a bed". Is it my… my duty as a midwife to provide a bed? no! If there is a bed, I won't ask you to lie on the floor, no I can't do that. But sometimes they don't bear with us. (Ivy, midwife FGD1 hospital B)*

Midwives also expressed concern about losing quality skills due to lack of utilisation. In these facilities, midwives improvised equipment, for instance, using a surgical blade instead of an episiotomy scissors, providing mouth to mouth resuscitation for asphyxiated newborns using gauze as a barrier instead of using an ambu bag (a portable bag-mask-valve ventilation device), and using 1:10 bleach solution instead of autoclave for sterilisation of instruments. These posed risks not just to women and their babies but to midwives and breached infection control and quality of care standards as highlighted in the FGDs below:

> *Boatemaa continues- (Twi) sometimes there is a shortage, and we may be forced to use cello tape [as adhesive for wounds], especially Sundays*
> *Frema- and then sometimes too the instruments we use for delivery (Twi) we can get shortage and we will have to use blade instead of the right instrument that needs to be used for the episiotomy. (English) we don't get the episiotomy scissors, so we have to use blade*
> *Owusua interrupts- surgical blade*
> *Frema continues- surgical blade which is very risky […]. so, it's also a very big problem*
> *(Midwives, FGD 5 hospital B)*

Midwives did not only complain about the unavailability of equipment but their durability. For facilities that were conducting high numbers of births in a month, having equipment that lasted was equally important to avoid being blamed for their breakage. According to midwives they sometimes were given already faulty equipment, were made to buy the

equipment if they broke it whilst using it or bought the equipment themselves to enable them to perform their duties. During PO in hospital B and C both the labour ward and postnatal ward had only one blood pressure monitor between them and for hospital B the midwives bought this monitor with their own money. Sometimes midwives moved from the labour ward to other units within the facility in search of these equipment to work with taking away time that could be used in providing care. In another PO in hospital B, there was a cut in the electricity supply and I and other student midwives available had to use the touch light on our phones to enable the midwife to see whilst suturing a tear. The interaction of these structural elements resulted in midwives' frustrations and anger and sometimes the outcome of this, according to midwives, was their venting on women and their companions leading to a lack of job satisfaction and disrespectful care:

> *Sometimes you don't have plaster [adhesive], syringes, maybe there's a shortage of these. That way you don't get any satisfaction from the work, but then where are the things that you are supposed to work with and then you know if you are working, and you don't have the things that you are supposed to work with you will definitely be angry (Amanda, midwife FGD2 hospital C)*

> *when we become frustrated and we display the anger, it's not that we don't respect them […] some midwives misplace their anger on the clients bringing about not respecting them. (Emma, midwife FGD1 hospital B)*

The frustrations that midwives experienced were recognised by a key stakeholder in hospital A who had implemented improvements in infrastructure and equipment needs of the facility. He agreed with midwives in expressing the impact it had on the provision of RMC:

> *if the infrastructure, equipment, and logistics are not there the care givers themselves are already frustrated and they carry it on to the to the patient. If there's enough sphygs [sphygmomanometer] to check blood pressure, enough sonicad [foetal doppler] to check foetal heart, you know these things, once they are there, ECGs, they help your staff so that they don't get frustrated but once the staff is frustrated with equipment, is frustrated with logistics, is not happy about the environment within which they are working, you don't expect the person to give off their best. (MD, INT6 hospital A).*

Contrary to this, assertions from midwives in hospital B and C suggested that authorities were not in favour of midwives complaining about the lack of supplies and equipment. In a FGD with midwives in hospitals B and C they described the situation as 'sensitive' and were sceptical talking about it because of the manner in which authorities responded to their complaints. Midwives were, however, reluctant to provide further explanation or cite examples but emphasised that these factors resulted in frustrations which affected their provision of RMC. The complain about authorities not responding to the request for more equipment and supplies was not limited to midwives. Labour ward managers in both hospitals B and C also highlighted the steps they had taken to request for equipment and supplies which had yielded no results:

> *during labour you see that we have to put them [women] together., the privacy is not there. I've talked to management, they said they will come and divide. So, they are yet to do it. They will come and do it, maybe by the time I go on pension [retirement] they will do it. They said it's in the pipeline, I don't know when it will flow. Maybe when I'm gone it will flow, the pipe is choked [sarcasm] (Getty, LWM INT1 hospital C)*

This indicates a lack of leadership, another structural feature, and an unsupportive culture which will be explored in depth in section 5.4. The necessity of these resources in relation to the provision of RMC was clearly stated by participants and these were enduring structural and cultural features that preceded midwives' agency and interplayed to influence the outcomes of interactions with women.

Although there appeared to be some improvements in certain facilities in terms of the infrastructure and equipment, human resources continued to be grossly inadequate. Midwives, therefore, stressed on the holistic provision of these resources to enhance the provision of RMC. Employing more staff was, however, not the direct responsibility of hospital authorities. New staff were posted by the GHS, which was a limiting factor for hospital authorities when addressing the problem. As such both midwives and stakeholders lamented about the large numbers of midwives and nurses who were unemployed during a continuing shortage in clinical practice. This deficiency in resources did not only affect the

provision of care but also influenced the intra-professional relationship amongst midwives and their inter-professional relationship with other professionals within the health team which in turn had very significant impact on the provision of RMC. This is further illustrated below.

5.3. Professionalism and the effects of inter and intra professional bullying on respectful maternity care

The different categories of healthcare professionals commit themselves to behave professionally as expressed within their codes of conduct, laws, and guidelines set out by government and regulatory bodies in Ghana. Abiding by these codes of conduct ensured that practice agreed with the ethics of care, thereby fostering a sense of professionalism, and safeguarding the safety of care receivers and providers. The concept of professionalism as utilised by participants denoted the education, skills, and attitudinal values that distinguished midwives as professionals. As discussed earlier, RMC involved the exhibition of an ethic of care which participants noted as aspects of the attitudinal values characteristic of healthcare professionals. However, in these three key areas participants highlighted a lack of professionalism within midwifery practice which had impacted on the provision of RMC.

The attitude of midwives was described as a problem by midwives themselves and stakeholders. Midwives complained about the fear of losing midwifery skills due to the constant improvisation and student midwives bemoaned the lack of mentorship from senior midwives to enable them to acquire the skills needed for practice. According to midwives, the lack of resources had led not only to the lack of adherence to the codes that governed their practice, but had also resulted in the improvisation of equipment and the adoption of practices that fell below the safety standards of their practice as highlighted in the quotes below:

> *Lack of professionalism…lack of professionalism. And it is the most important thing in our profession (Dora, DDNS, INT5 hospital A)*

I have to crack my head all the time or try to improvise all the time. The right things I learnt from school I may even forget them because I am always improvising for procedures and all that so… (Manu, midwife FGD4 hospital B)

Adhering to codes of conduct and the provision of safe care for women were articulated during FGDs on RMC. Though midwives asserted that professionalism was an important factor in relation to RMC, they also believed that a safe outcome was also paramount. Therefore, codes of conduct were not always adhered to during emergencies as indicated below.

it's…. overwhelming so it's difficult for you to take into consideration all the other….. […] But most of the time we …. do what is important, what is emergency first before you go on to the other stuff. Clients…. The number of staff on duty and the number of clients, that one also affects it. (Fatia, midwife FGD1 hospital A)

Additionally, the sense of professionalism was also in part affected by the intra and inter professional relationships within the care environment. Guaranteeing safe outcome during an emergency was achieved through harnessing the expertise of other professionals within the care team, according to midwives and this was the hallmark of professional collaboration. However, whilst it was necessary for health workers to nurture collaboration for the provision of safe woman-centred care, it's difficulty could well be underestimated considering the lack of resources. The lack of intra and inter professional collaboration was, therefore, identified as a structural feature which interacted with other features within the care system such as the culture of abuse to influence the provision of RMC.

Findings revealed a cordial inter professional working relationship but with elements of contention that arose due to limited resources which consequently influenced both their sense of professionalism and RMC. For instance, during PO in hospital B, a labour ward midwife borrowed diclofenac suppository from a woman in the postnatal ward for another at the labour ward who could not afford to buy one. When the former was being discharged, she angrily requested for the medication and the midwife at the postnatal ward, feeling disrespected, channelled her anger to the midwife at the labour ward and this led to friction

between the two midwives. The result of such frictions when dealt with inappropriately had the propensity of disadvantaging women as expressed in this quote:

> *even our colleagues, staffs, the seniors themselves, maybe someone has shouted at you, you have..... you have..... you have become bored, maybe your colleagues have made you angry or something. So sometimes it's not..... it's not from the patient. Sometimes even our (English) attitude towards each other (Twi) destroys the relationship we have with them [women] (Akos, rotation midwife FGD4 hospital A)*

The findings indicated that contentious relationships, and the manifestations of conflicts were visible on different levels, and this created an abusive and toxic culture that trickled down to women receiving care. Student and rotation midwives complained of being shouted at, disliked by qualified midwives, not being mentored appropriately to develop needed skills, and midwives deflecting pressure from managers and doctors onto them. During their clinical placements, these categories of midwives made vital contributions to augment the midwifery workforce, and this was noted during PO in hospital A. Thus, the poor treatment of this cadre had a direct impact on the acquisition of professional skills including RMC as expressed within this quote:

> *Sometimes when you do something and you don't do it properly, yes, they tend to shout on you, especially the doctors. [...] And the seniors [midwives] themselves too, […] Maybe you go and ask her something she will not mind you; you've done VE [vaginal examination], oh please come and confirm for me; "and so, you a rotation you can't do this". Sometimes the way they talk to us, in fact some of them are consoling others are not consoling. (Akos, rotation midwife FGD4 hospital A)*

According to rotation and student midwives, good mentors were those who were willing to teach professional skills, correct mistakes in a gentle manner, and are willing to have students shadow them. And to qualified midwives, good midwifery colleagues were those who would back them up and provide peer support. This notwithstanding, the manifestation of conflict within practice was not just intra-professional but inter-professional as well. Findings from FGDs and POs, indicated that inter-professional relationships were sometimes

characterised by tensions and not teamwork and collaboration and the impact on RMC was substantial. During a PO in hospital C, the resident, house officer, and midwives during ward rounds were openly discussing a woman's condition and care in English by her bedside and the resident rebuking the house officer for certain decisions made, all without the involvement of the woman.

Within the labour ward, the authority, professional knowledge, and skill of the doctor was the dominant factor especially during decision-making about care during emergencies and midwives often encountered difficulty accessing doctors resulting in contentions which affected RMC and the provision of care:

> *and sometimes too when you come for night shift and you have an emergency sometimes it is difficult to reach some of the doctors and the anaesthetist and all that and it also affects….. sometimes even when there is a foetal distress you try and call the doctor you are not getting him, anaesthetist is not around so by the time they get there, everything is out of place (Frema, midwife FGD5 hospital B)*

According to midwives, these professionals either felt midwives were giving them extra work to do when they were already overworked or providing preferential treatment to some women, which midwives stated was not the case. Doctors, therefore, shouted at midwives, questioned their clinical decisions, and disrespected them in front of women and their companions resulting in frustrations, and loss of confidence in their professional decision-making and skills. Though midwives felt disrespected when their clinical judgement was questioned in front women, they demonstrated an openness to correction but in a manner that would not lead to the woman questioning their professional competence as it impacted on the woman's attitude towards them:

> *And then adding up to the doctor nurse relationship, it's a very big problem in our hospital here. Me what I know is, maybe when somebody does something which is not right, you don't, give it to the person [speak harshly] in front of the client. At least call the person, ask for her side of the story and maybe if you are not too sure about what she is saying, you also go and ask the client and she will also explain it to you.*

But in our facility here the moment the doctor hears that you did something, he will just give it to you in front of the client. And then later on if you attend to the client....
Owusua interrupts- you don't have the zeal or the power to …
Frema continues- she will be like even this nurse koraa she doesn't know what she is doing, she did something and the doctor came to insult her in front of me so….. and because of that some of the clients even when you come, they don't want you to attend to her because a doctor said something in front of her…
(Midwives, FGD5, hospital B)

Nevertheless, the challenges encountered when accessing these professionals often led to stress and pressure from women and their companions and when tensions arose the women were often at the receiving end of the unprofessional and disrespectful care. During a weekend PO in hospital B, a midwife had to call an anaesthetist, a theatre nurse, and a laboratory technician, who were all at home, for an emergency CS. Some insisted on her calling the hospital driver to pick them up and these back-and-forth calls went on for about an hour. Coupled with the fact that there was no electricity, the midwife felt frustrated and angry which she deflected onto the companions of the woman who also kept putting pressure on her for the procedure. The anger and frustration were palpable during FGDs in all facilities and was consistent with some assertions by midwives as noted in the quotes below:

Danny- Sometimes when you get a case you become so frustrated, even you are calling for help from doctors and others, they won't come
Femi interrupts- they are not coming
(Midwives FGD3 hospital B)

Afoah- (Twi) sometimes when you call them to attend to a case it's as if the person is your relative [seeking preferential treatment for someone], but we are working hand in hand to save the person. "Monitor, I said do this, you are not doing it." Meanwhile you know that it is meconium stained
Gyekye- mean while the midwife knows that this thing if you don't do it within the next five minutes something will happen
(Midwives, FGD3 hospital A)

Emergent from midwives' expressions were issues of accountability, communication, confidence, competence, commitment, subordination of the midwifery role, and the ability to challenge and disagree with doctors' orders. Ineffective means of addressing these issues were perceived as unwise in terms of the preservation of that inter professional relationship, but it was deemed crucial for the safety and wellbeing of the woman and her baby. Some midwives, therefore, questioned the traditional authority of doctors to make decisions that they considered detrimental to the safety of women and their babies. They emphasised that all health professionals held an equal duty of care to women, as such some were unwilling to bear the brunt of the neglect of duty by doctors and other health professionals regardless of their reason. According to one midwife she would go to every extent to challenge this as explained in her quote below:

> *I will not come and call you that I have a case, for you to tell me that you are sleeping so I should go. Then you and I will both lie on the bed. [….] Because I have seen that the thing is beyond me. We midwives too that is why we have the….. when the thing is beyond me aaa I have to come and then call you. If I have come to call you and then you tell me that you will come, I won't go. Unless I see that the case maybe I am only doubting if she can. You know sometimes you just need a second opinion like in diagnosing or in doing something. [...] But for me to see with my real eyes someone will come three previous CS in labour, and you say, "oh you go and monitor her I will come". Me too I will sleep on the bed with you. We are both lying down to monitor her. If the uterus ruptures, we both slept so we will all be sued eh so sometimes you have to. […]. Because if you are not careful, excuse me to say, someone will do a foolish thing and it will put you into trouble. (Essuman, midwife FGD3 hospital A)*

It may be argued that these issues are quality of care related, however, the emerging evidence suggests that they are related to RMC specifically as tensions often impacted on women's choice and autonomy. As the African proverb goes; when two elephants fight it is the grass that suffers. Thus, the professional disputes and misunderstanding often led to the mistreatment of women, making the lack of interprofessional collaboration (IPC) a vital mechanism influencing RMC. Furthermore, the authority of doctors made great demands on midwives' negotiating and balancing skills especially in facilitating women's choice which is

inherent in the provision of RMC. It was noted from observations the frustrations that midwives' felt when desiring to support women's choice but perhaps to maintain a cordial relationship with doctors, chose rather to be assistants to them. Such situations fostered a midwifery culture which was incongruent with the autonomy characteristic of the midwifery profession. This set a bad precedence for some student midwives who felt the midwifery that was being practised was inconsistent with the autonomous practice that enabled midwives to support women's choices and thus provide RMC:

> *at times when you go to some facilities it looks like the doctors are overshadowing our work. They give command but to me I think we are all in a different part. I have my own role to play, and they have their role. (Afoah, student midwife FGD2 hospital A)*

Findings in this section have demonstrated the impact of professional collaboration on the midwives' agency and subsequently on the provision of RMC and the safety of women. The evidence presented suggests that interprofessional relationships were more contentious than collaborative, and this had resulted in the mistreatment of women who are the recipients of care. This mistreatment occurred when midwives channelled the stress, anger, and frustrations they felt as a result of the contentions to women. This was also characteristic of the unsupportive and abusive culture that prevailed within the care environment. Further analysis of this evidence enabled the postulation of real causative mechanisms that have power to cause these observable events. Therefore, in addition to the evidence presented in the proceeding section postulation of real causative mechanism will be carried out in section 5.4. Midwives' feeling of stress from the lack of resources and contentious professional relationships had been further aggravated by the lack of support from leadership of facilities and the feeling of subordination. Further illumination is provided in the subtheme below.

5.4. 'Nobody even cares about us': midwifery subordination and fault-finding leadership

Findings from the study not only revealed a lack of strong leadership but highlighted evidence of humiliation, insults for not putting in enough effort, blame for virtually everything that went wrong, and failure to give credit when due. Lack of support was a structural feature of the care environment that was reiterated by midwives in all facilities. They felt overworked, unappreciated, and blamed for adverse outcomes. Some stakeholders mentioned some forms of support given to midwives such as a clinical psychologist in hospital A and regular nationwide monitoring by representatives of the NMC. However, midwives themselves asserted that the support, supervision, mentoring, and monitoring needed to create an environment necessary for the provision of RMC were absent. They highlighted that the type of leadership they received was that of blame, fault-finding, and insults and never motivation, appreciation, or encouragement which they found demoralising. This enforced their need to control the birthing process to achieve required outcomes. Midwives recounted several occasions during which their hard work had been completely disregarded and unappreciated and instead insulted and blamed because of mistakes that could be overlooked as explained in the quote below:

> *Gyekye interrupts- someone will come and insult you. Someone who has slept in her house the whole night will come and insult you*
> *Essuman- look I came to duty with the sister who just left here. We were just two then we did 23 deliveries 4CSs that night eh. And do you know what happened, the morning that they came, do you know what the in-charge said? [..] They were triplets that's why CS was done, so we were bagging (resuscitating). I was bagging one here and …*
> *Gyekye interrupts- (Twi) one was bagging, and others were also bagging*
> *Essuman- (Twi) when she came because we had not put the ambu bag where we were supposed to put it because by then I had just returned from sending the case to NICU and I was writing my notes to send. Because of that the woman got so angry, she didn't consider the work we had done that night. Just because the ambu bag was not where it was supposed to be, she used that to insult us. That means all the work we had done was a COS 90 [irrelevant] job. That one was not seen*

Gyekye- not even ayekoo [well done] (Twi) it is very painful.

Midwives were not alone in highlighting the lack of appreciation, labour ward managers also emphasised likewise. There were no forms of rewards to serve as a source of motivation for midwives and they did not receive the appropriate supervision or support to enhance the provision of care:

> *from the top [managers] nil per Os, nothing. No, we don't get any supervision we are doing our own work (Matilda, LWM2, INT1 hospital B)*

Therefore, to keep midwives motivated, some labour ward managers sometimes bought food, drinks, and gave money for transportation to midwives and these were highly commended by the midwives, and I was a beneficiary of some of the food items during POs hospitals A and C. Some stakeholders in hospital A, where some improvements to the work environment had been implemented, posited that midwives were intrinsically motivated as a result of these improvements and the resultant appreciation of these from the general public:

> *we believe that the first motivation is the intrinsic motivation which we think we have and that is what we want to focus more on so that it's more of the satisfaction that both doctors and midwives get when we have good outcomes and I think one of the things too is that ever since we really started improving our facilities maybe three four years ago up to now, last year we did quite some, you know, other renovations and all that. I think ever since we started doing that erm the patients and their relatives also give positive comments and I think that these positive comments from the patients and their relations and the general public I should say, the general public being appreciative of what we've done and what we are doing here I think provides enough motivation I think for us if you like. (George, MD INT6 hospital A)*

This assertion by the medical director was contrary to midwives' and labour ward manager's account on motivation. They articulated that midwives were providing their services to women even when they were not paid their salaries and verbal motivations and concern for their welfare were not being provided:

At least we are doing our best, apart from them telling us that we are doing a great work they should motivate us. At times, these children [midwives], they will work aa water they… they don't get till they go out. Some are even not paid yet they come to the ward with their own money. Truly some don't have money and they will come they won't even get water to drink, when they are going home, they will take their own money for T&T [transportation] mmhmm. This facility too I don't know because we've worked at other facilities too, they don't know how to appreciate us, they don't know how to appreciate us. I'm not saying they should be giving us gifts or something but at least the thank you that comes from your mouth to somebody who has worked for you is even enough. So, I think er er the management are doing their best, but they should come down to see our welfare too mmhmm (Linda, LWM INT1 hospital A)

According to the midwives, their welfare was not a priority because the hospital managers were unapproachable and exhibited little or no concern for their health and safety. As such they were made to care for others when they lacked the physical, mental, or emotional capacity to do so. During a PO in hospital B, a midwife was on duty while receiving intravenous treatment for severe malaria. This midwife who looked very unwell was still going about her duties and receiving her treatment when she had time. She was not given a sick leave because the unit was short staffed. In hospital C, a heavily pregnant midwife had to climb the staircase several times to receive babies from the theatre to the labour ward because they were short staffed. Furthermore, a midwife was also recalled from maternity leave to augment shortage of staff. These observations were congruent with the assertions of midwives that 'no one cared' about them and they emotionally recounted occasions during which they had worked while sick or have had to bring their sick babies to work, admonished for skipping training sessions to care for a sick relative or not received any support whilst they grieved for miscarriages that resulted from the stress at work. Quotes below from a FGD provides a summary of these assertions:

Danny- no! please, no! please. Don't even end your question. No nobody even cares about us. "Oh, this happened to you and so what!". Nobody will even call you, "oh I learnt this" but if something bad happens [to the pregnant woman] you are the talk of it, you understand

Yomi- even if you are sick, they expect you to provide your services... the services to the sick people while you too you are sick. They don't care unless maybe you are collapsing. Because I quite remember about three weeks ago my child was sick and I was at the theatre. As I was breastfeeding, I had to stop and go and receive the baby and come and continue. I came back my mother-in-law was holding the baby. My in charge told me that (Twi) sit down because people are there to be taken care of (English) my baby too was sick ooo but (Twi) she said I should take care of others, so they don't care. (Twi) the only important thing to them is the service you are providing (English) no one wants anything to happen to any client but not you the midwife.

Doyi- I'm using a phrase like…. me that's what I'm using, we are saving them, but we are killing…we are killing ourselves. There was a time when I had a line [Intravenous cannula] on, I was having malaria treatment, hmm [becoming emotional]. With the line I was receiving infusion and I was working with it, so when a client comes in, I discontinue the infusion and then I will go inside and take care of the client. I was really… really burning up [high temperature], I will never forget this [emotional] because I was burning up and I had to go and take care of a client. There have been instances when people have had miscarriage…

Yomi interrupts- oh plenty, plenty miscarriages

(Midwives, FGD3 hospital B)

These assertions were consistent in all the facilities involved in this study. The expectation from hospital managers to provide safe, respectful, and dignified care for women was not consistent with the care, kindness, and support that midwives felt they needed to facilitate the delivery of this expected care. Some midwives purported that this may be emanating from the strong focus on customer care, however, when a midwife became a pregnant woman or was sick, she did not receive the same good customer care from her managers as she was expected to provide to other women. According to midwives this lack of concern stemmed from the fact that the midwife as a worker could be replaced but a lost client could not. Therefore, midwives' complaints were trivialised because of the need for them to continue working. For example, when a woman had light vaginal bleeding when pregnant, she was given sick leave for her employer, but a midwife in the same situation did not get same as highlighted in the quote below:

Yomi- when clients come here and they are bleeding PV [per vagina] they give them, they give them excuse duty [sick leave] to go and rest but you a staff you come and you are spotting [light vaginal bleeding], No!
Femi interrupts- you are pregnant, and you are spotting; they don't give you excuse duty. They will tell you (Twi) "this is nothing, it will go [it will stop]"
Yomi- yes, they will tell you (Twi) this is nothing it will go.
(Midwives, FGD3 hospital B)

Furthermore, *'nobody even cares'* also denoted the feeling of subordination by doctors and hospital authorities and the disrespect from them. In addition, while other professionals were provided transportation to and from work and lunch at work in some facilities, midwives were not. According to midwives even water to drink at work was not provided, they were made to pay for damages caused to equipment, no form of motivation or encouragement was given, and no form of reward for the hard work and extra time they put in, to serve as a form of encouragement or motivation. They also reiterated that they lacked the supportive supervision that reinforces good skills and attributes and correction of mistakes in a manner that facilitated learning for the provision of RMC. Rather they were treated as inferior to that of other health professionals as highlighted in the quotes below:

Amanda- if you come to the ward and accidentally something falls down [breaks], you are going to the medical Sup's [medical superintendent] office.
Cindi- yes you are going to pay, breakages are payable, in Hospital C, yes.
(Midwives FGD2 hospital C)

Gyekye- please they should also respect the midwives not the doctors alone. They should respect them no problem, but we are all human beings. How can you treat someone you know….
Afoah- better than
Animwaa- have you considered that the doctors are never in trouble because they always cover their backs
Gyekye - (Twi) yes. And they [doctors] are always insulting us, we are nothing. You come and insult us so much
(Midwives FGD3 hospital A)

The lack of supportive leadership and the subordination led to further frustrations, and they thus became midwives who were easily provoked and unwilling to deliver their best or vented their frustrations on women:

> *that is one of the things that causes the …. Because if you are sick, you are not better, no one was there to ask you oh how are you, take you through anything for you to be ok. You just come to work with it. So, because of that sometimes when you come to work it's not your intention to shout, it's not you want to fight [argue] with the client or anything but because of that (Doyi, midwife, FGD3 hospital B)*

It is possible to explain midwives' assertions as a justification of the mistreatment of women. However, taking this stance would be a lack to recognition of the innate causal structures that power their agency. Therefore, further analysis of these regularities, in addition to those presented in section 5.3. above, using retroduction, leads to the postulation of structural and gender-based violence as mechanisms that supersede midwives' individual choices to shape their agency in a particular way. In addition to the domineering leadership characteristic of structural violence, the evidence illustrates violence against women; women as mothers seeking midwifery care, women as midwives in an unequal health system, and women as midwives seeking maternity healthcare when pregnant. Midwives, therefore, expressed a feeling of learned helplessness, with no one to turn to in difficult times:

> *there are a whole lot of challenges we face but I don't know… but you can't even say it. (Twi) who are you going to tell? (English) who are you going to talk to? (Ivy, midwife FGD1 hospital C).*

In-depth explanation and discussion of this key causal mechanism will be carried out in the discussion chapter. Albeit midwives and stakeholders specifically labour ward managers, therefore, collectively agreed on the importance of establishing an award system where hardworking midwives would be rewarded, to serve as motivation for others. They placed strong emphasis on continuous monitoring, supervision, training, and motivation, not just in monetary terms but in forms that reinforced quality standards and appreciated hard work as highlighted in the quote below:

Otema- continuous monitoring (Twi) that's all, we have finished
Naa- (Twi) yes you see when they come, they keep us on our toes. When you are doing something, you know that people will come and monitor you and trainings and workshops and presentations and things that will make us learn and be on our toes always, yes
(Rotation midwives, FGD6 hospital A)

Cindy- and we should be applauded for the good work that we are also carrying out. […] They should motivate us. Even the little things...sometimes you don't need to bring out the whole world for the person but just say (Twi) oh you've done well. (English) And sometimes tapping on the person's shoulders and encouraging the person alone makes the person feel that you've seen what they are doing not just looking for the wrongs. […] At least if every month they award best midwife for the month koraa …the other midwives too will be motivated
Amanda interrupts- yes
Cindy continues- to get something, like the banks and other institutions they do. Best worker for the month, then it's posted there when everybody comes it's there, it's encouraging, (Twi) it's beautiful.
(Midwives, FGD 2 hospital C)

Although the SSI with high-ranking leaders in nursing and midwifery in and outside of these facilities revealed some monitoring and supervision mechanisms, these were not enough to support midwives to ensure they thrived as professionals and created an environment where RMC was provided. For instance, the NMC had periodic monitory and supervisory visits to all facilities, however, none of the guidelines was geared towards enforcing RMC or supporting midwives for its provision. Though the council had identified the attitudes of staff as problematic, there was no standardised form of training, monitoring, or supervision of midwives in this regard. During supervisory visits there were no structured components of RMC supervisors were to look out for as they were required to use their own discretion as explained in the quote below from a senior NMC official:

So, you as a midwife you use your discretion as a midwife, the ones you know, yes. But there is not structured guideline on respectful maternity care, no it's broad mmm. […] the checklist does not include all that, but it is expected that you the one going

will have your own what… checklist… something that you have learnt already ah haa, so that is how it is. (Joyce, NMC, INT5)

This implied that supervisors who did not have knowledge of these context specific nuances relating to RMC may not have the capacity to correct or provide reinforcement. Furthermore, the NMC stakeholder reported that facilities put their best staff on duty during these visits, thus the best care was observed. There also seemed to be a strong emphasis on the code of conduct for nurses and midwives and the patients' charter of the GHS. According to stakeholders, nurses and midwives were each provided with a copy of the code of conduct during their induction ceremony and the patient's charter was displayed in health facilities. However, merely giving booklets without the necessary structures had yielded no results as there were evidence of mistreatment of women in this study. And the lack of redress mechanisms for service users when these codes were not adhered to impinged on accountability.

All facilities had customer service training for staff, but none was specially aimed at RMC. Though the attitude of staff had been identified as problematic, RMC lacked the needed attention that it required to facilitate a change in practice. Rather, there appeared to be a shifting of responsibility from themselves as leaders and managers to training institutions. Stakeholders expressed specific concern about the type of training midwives received which was not good enough to guarantee attitudinal change as noted in the following quote:

training that you would have from the beginning should change you outright before even you start work but as at now it is not there (Dora, DDNS INT5 hospital A)

These findings illuminated poor leadership within clinical settings leading to poorly mentored, supervised, and motivated midwives in addition to the logistical constraints which have resulted in student midwives being socialised into the culture of normalised mistreatment of women. Furthermore, leaders could neither serve as role models as they did not practice the tenets of RMC either. During the PO they could also be seen shouting at women as well as midwives. In an interview with a stakeholder, she handed over a list of student midwives who

had not reported to work to me to see, breaching confidentiality. The lack of leadership, support, and concern for midwives which had culminated in the mistreatment of women was a manifestation of deeper structures within this social world. Therefore, rather than simply a lack of leadership, support, and concern for midwives, using retroduction, the evidence supports the more innate mechanism of structural and gender-based violence. A CR analysis shows that within the pervading unsupportive culture and the normalised mistreatment of women (both midwives and labouring women), the powers inherent in structural violence manifests in the predominant mistreatment of women during labour and childbirth.

Nonetheless, some measures had been initiated to support midwives. Hospital A had the presence of a clinical psychologist whose services were free of charge for all members of staff, programmes to address stress, and a reward system that encourages the adherence to codes of practice had been planned but not yet implemented. There had also been the development of the employee assistance programme by the GHS but also not yet implemented. This programme will focus on seeking redress for staff who had been mistreated by higher authorities within the organisation and vice versa as indicated by a member of the quality assurance team:

> *yeah they've not ….what do they call it….employee assistance program, yes and it's adopted by the regional health directorate. They are done but it's left with the final one or two. They've constituted a committee and the committee is at the regional level. They have lawyers and other professionals on board, ok, to ensure that…….. so we want to avoid abuse of staff and mostly by their own staff. For instance, by higher authorities, you know their bosses ah haa or vice versa. So, all those things are coming into play now to ensure that they are given the support (QCO INT2, hospital A)*

The implementation of these programmes may contribute to the support midwives require to provide RMC. Nonetheless, motivation; verbal and non-verbal and continuous monitoring were also considered vital for the promotion of RMC and the improvement of the overall quality of care. Not all midwives viewed monetary motivation as a necessity but there was a

consensus that to enforce change in attitude, outstanding performance needed to be rewarded for reinforcement and as an encouragement for others as well as the need for quality supportive leadership that was aimed at mentorship, supportive supervision, and continuous monitoring. These suggestions reiterate the importance of a transformational leadership within the midwifery profession and the health system to model RMC and support midwives towards the provision of RMC.

The causal sequence of these systemic and professional challenges and the innate causative mechanisms identified manifested in a paternalistic approach to care, where women's rights and choices were neglected, and professional power and control exerted on the birthing process to achieve desired outcomes. These resulted in the depression of women's agency and the autonomy intrinsic in midwives' conceptualisation of RMC. Further details of these are provided in the next section.

5.5. Fear of adverse outcome and blame? Paternalistic approaches to care depressing women's autonomy and agency

Women's position as care receivers makes them vulnerable, making the care giver- care receiver balance unequal revealing a relationship of power. The organisation of care, infrastructure, equipment, and policy in all facilities involved in this study were such that both covert and overt exercise of power over the birthing process were widespread. In hospital A where infrastructural changes had been made to improve maternity care, no effort had been made to promote women's autonomy and agency. For instance, there was restriction of women's movement due to continuous foetal monitoring for all women regardless of their conditions, fostering the biomedical principal of safety and this was also perceived by most practitioners as an advancement in technology:

> *Because here we wrap something around your abdomen, and you lie down and do foetal monitoring. […..] to monitor the FH and make sure the baby is fine so we are not ensuring the person's freedom because (Twi) someone will tell you that I want to walk about but we don't let them (Sala, rotation midwife FGD 6 hospital A)*

As discussed in section 4.5, though a policy was in place that enabled companions to be with women during labour, the facility decided the category of person women could have, restricting women's choice. In facility B, it was the hospital's policy to show still-born babies to mothers or their relatives for confirmation of death immediately after birth to avoid the midwife being blamed for the death of the baby. To fulfil this obligation, during a PO, the midwife called in the brother of a woman who had delivered a macerated baby for confirmation of death, disregarding the privacy of other women in labour and without the consent of the woman. This could also hinder the necessary investigation into the cause of death. These practices may have been powered by the fear of blame which was characteristic of midwives' descriptions of their care. Midwives' fear of adverse outcomes was visible in their daily routines and decision-making regarding a woman's care and also shaped by the absence of resources. During a PO in hospital B, a woman requested for CS because of her inability to push during the second stage, after several encouragement and supportive actions from the midwife and the amniotic fluid was meconium stained. After some time of failed effort, the midwife asked the student assisting with the birth to go and check if the theatre was free so that the woman would be prepared for the CS as instrumental birth could not be offered due to the absence of needed equipment. The student came back accompanied by the labour ward manager who told the midwife to make the woman push because the two women they had taken to the theatre earlier had not had their procedures yet. By this time, the liquor was becoming thicker with meconium and the midwife showing signs of panic, changed the tone of her voice, began to shout at the woman telling her that she was not going to let the baby die on her watch, and she was not going to let her loose the baby after 9 months of pregnancy and the woman pushed.

According to midwives, they were blamed for virtually every adverse outcome: breakdown of equipment, maternal mortalities, morbidities, the adverse outcomes from women's choices, and the adverse outcomes from delayed interventions by other health professionals as explained in the quotes below:

Enyo- [….] because if erm you have a case, a foetal distress and you call a doctor, you see it an emergency, the doctor will.... ah how…… how come you knew that it's a foetal distress? He doesn't even see the need for him to come early. Now the baby comes out and the baby becomes asphyxiated, and they will say […] its' the midwife's fault
Love interrupts- […] the relatives will be saying "and then when we came, we told the midwife to take us [for caesarean section]… and the midwife didn't send us; delayed the time at the theatre and we ended up the baby…"
Enyo- but here the midwife has to be doing all the calling…..
Love- you see you have to be doing all the calling whilst maybe there's 10cm pushing, there is….
Adzo interrupts- someone bleeding, a whole lot
Love- it's stressful, it's stressful
Enyo- and at the end of the day, they will blame you the midwife
Love- mmm they will blame the midwife
(Midwives, FGD6 hospital B)

We wanted to do a caesarean section for the client, the husband said we should wait for their pastor, they [health professionals] waited and waited and waited. They [woman and her husband] said they will not do it, I think the following day when they agreed to do the procedure, they went through the procedure, but the baby wasn't there, the baby was dead. And they were now blaming us that we were the cause of the death of the baby. Meanwhile we explained to them the day before they agreed to the thing but… So, it's a problem (Frema, midwife FGD5 hospital B).

Midwives were not only blamed within the hospital premises, but outside which caused concern for their safety. They reported accusations and verbal abuse for being the cause of maternal and neonatal mortalities from within the communities. To avoid being blamed midwives exhibited and verbalised consistently the fear of adverse outcomes and the need to guarantee safety. It could be gathered from midwives' reports of their reasons for becoming midwives, their desire to contribute to the reversal of the high maternal and neonatal mortality and morbidity rates in Ghana. Though it cannot be ascertained from the findings the effect of the high maternal mortality rates on midwives' fear of adverse

outcomes, their desire to reverse this trend may be contributory to their strong emphasis on safe outcomes:

> *Enyo- you don't want to be the cause of someone's death or because of you someone will lose the baby. You have that at the back of your mind, so whenever you come to work, you do your utmost best so that you will not be found any guilty about whatever you did.*
> *Adzo- when we are coming to work, and we are praying we also pray for our clients so that they'll come and deliver safe and sound and take their babies home*
> *All node*
> *Adzo continues- we have their best interest at heart. We will not come from our homes, and we will come and maltreat or be the cause of someone's death or someone losing the baby.*
> *(Midwives FGD6 hospital B)*

Therefore, using retroduction for further analysis of this evidence, I postulate the concept of risk aversion as a causative mechanism influencing RMC. Though the impact of mortality and morbidity was not articulated by midwives, risk aversion appeared to be the ubiquitous mechanism that controlled midwives' actions and inactions. For instance, midwives would not risk giving women information which could result in them refusing a procedure, it resulting in an adverse outcome and the midwife being blamed for it. Or women not pushing when asked to and not having a doctor or theatre available and it resulting in an adverse outcome which they would be blamed for. Risk aversion, could however, be further reduced to a deeper causative mechanism- structural and gender-based violence.

Doing '*your utmost best'* and having women's *'best interest at heart*' as described by midwives was, thus, facilitated through the adoption of a paternalistic approach to care. Paternalism in this study was health professionals assuming the decision-making role for women and using various means and reasons to shift the locus of control from the woman to themselves, thereby neglecting the need for informed choice which is perceived as a component of RMC. The blame, lack of leadership and support, and the powers inherent the paternalistic control of the childbirth process is also characteristic of structural violence. It is,

therefore, postulated that structural violence was the condition required for the professional control over childbirth to become actualised and result in the empirical events observed. Health professionals including midwives exercised control over the birthing process using coercion, withholding information, and physical and verbal abuse to ensure women agreed to the decisions they had made concerning their care.

The paternalistic attitudes of some participants were premised on the assumption that women had low literacy levels, did not know much about labour and childbirth, did not fully understand explanations about procedures given to them, and so could not make the 'right' decisions. Therefore, women did not comply making midwives' work difficult. Health professionals who were literate in maternal health, therefore, knew what was 'best' for women and either coerced or forced decisions upon them:

> *(Twi) As I said because of the history we take we know what is good for you, so when we tell you to lie down you have to lie down. When we have to let you walk a little so that the baby's head will descend (English) we know what we are saying, do you understand? (Akos, rotation midwife FGD4 hospital A)*

The authoritative knowledge of health professionals resulted in the perception that the midwife knew best. Ideologies and knowledge can be an embraced philosophy that can shape the nature of our being and in CR, this can be real and causal and have effects on outcomes. Therefore, the philosophy of care that a midwife knows best which results from their authoritative childbirth knowledge was a causative mechanism that had the dominant capacity to influence midwives' agency during the provision of care. This explained midwives' and other health professionals' position of control over the childbirth process. Whilst some perceived this as paternalistic and a claim of ownership over the woman's body, others asserted that it was a demonstration of their duty of care and force was applied when deemed necessary. In a PO in hospital A, after several attempts to conduct a vaginal examination failed because of the pain the woman feared, the doctor was called. He, without any explanation performed the examination whilst the woman was screaming. Such an abusive approach was criticised by a rotation midwife who perceived it as a claim of

ownership of a woman's body. According to Oparebea, women made the autonomous decision to seek care and this autonomy should be respected by not just, for example, asking women to open their thighs for a vaginal examination, but offering them an explanation of the procedure to enable them make an informed decision as illustrated in the quote below:

> *….that's what sometimes we do, as if we own them. We didn't ask them to come here. (Twi) "maame open your thigh and let me put my hand there". (Oparebea, rotation midwife FGD4 Hospital A)*

During POs, doctors who had diagnosed conditions and prescribed CS as a line of treatment for women were only seen informing women of the procedure and not offering explanations as to why the procedure was needed and what it entailed. Where midwives perceived that the life of the mother or her baby was at risk this paternal approach was deemed justifiable as explained below:

> *Ama- oh we do allow them but sometimes, master [local jargon for friend or boss] we have to take the decision and do it for them. Erm the cord prolapse for instance, (Twi) "my pastor says I shouldn't do CS so madam I don't want the operation" (English) until the cord came out, yet still the client said she won't do the operation so we had to carry [send] the person by force*
> *Ama- because it was twins (Twi) if it had been at least one you think we will leave you? even that we won't leave you, and so we had to carry the woman, remove [deliver] the babies and then…..*
> *Akua interrupts- because you know the babies' lives are in danger ah haa and the CS too she is not going to do it*
> *Ama continues- sometimes we allow them to take decisions but sometimes too when we see they are trying to be difficult we just take our decision, console them, and go on with what we are supposed to do.*
> *(Midwives, FGD1 hospital C)*

These practices contravened midwives' conceptualisation of RMC as woman-centred involving communication, information giving, and informed choice. Withholding information

and forcing women to undergo procedures even when it was in an emergency infringed on women's capacity for informed decision-making and was unsupportive of women's choice. There was also a lack of understanding of women's manifestations of labour pain. Providing the appropriate support for women during their manifestation of pain appeared to be difficult for midwives. According to midwives, as a result of pain and the pushing urge, women pushed when they were not fully dilated or did not push when they were fully dilated for fear of the pain that pushing caused. There was a feeling of frustration and a fear of adverse outcome as a result of these situations as expressed by Akweley:

> *sometimes the person is 4cm (Twi) madam don't push. (English) and she will be there (Twi) "the thing is causing me to push what do I do, I will push". (English) then she will be pushing…. pushing, you end up making the labour prolonged ah haa. And sometimes when you talk to them, you explain….you take the partograph to them and you explain it to them that every 4 hours I'll have to come and insert my hand there, no! She will call you every 5 minutes, so you become….(Twi) "'madam it is coming ooo", when you go and check she will 4cm or 5cm so you become frustrated (Akweley, midwife FGD5 hospital A)*

Such frustrations often led to midwives shouting on women to ensure they did not push. POs revealed several instances where women pushed when they were not fully dilated, and midwives were unable to support women as pharmacological pain reliefs were not routine practice and the only non-pharmacological pain relief which midwives offered (sacral massage) was often rejected by women. During one of such situations in hospital B, the midwife explained the process of cervical dilatation to the woman using a dilation board and encouraged her not to push but to breathe through her mouth, demonstrating the breathing mechanism to her but this was not helpful. A student midwife offered a sacral massage, but this was also rejected.

On the other hand, those who utilised their agency by refusing procedures and medical interventions despite persuasion were classed 'uncooperative'. Though both pharmacological and non-pharmacological pain management was not readily available to

women, some midwives viewed labour pain as an 'excuse' for manifesting pain in a particular way:

> *Cindy interrupts- they are uncooperative*
> *Amanda continues- during labour you will tell them everything still*
> *Cindy interrupts- some of the clients are not cooperative at all*
> *Amanda- yes*
> *Cindy- no matter your explanation, no matter your reassurance, because they are in the pain, they will tell you (Twi) 'it is paining me don't you know that'. (English) Like they….. they blame everything on the pain they are going through*
> *(Midwives, FGD2 hospital C)*

Even in circumstances where information was provided, it appeared that the intention was to obtain informed consent not to offer women the opportunity for informed choice. Hence in situations where midwives sensed the possibility of refusal of procedure from women, this information was withheld.

> *So, they will refuse to understand whatever you want to do. So that is the reason why sometimes we think we do what is right for the client. Because even if I tell you, you will not understand so let me just take the action and then do what is right for you then later on you tell her about it (Akosua, midwife FGD5 hospital B)*

This control was further aggravated by the acute lack of human and material resources, with health professionals in a hurry to move from one woman to the next and unable to offer any support or alternatives when women's choice could not be offered due to unavailable resources. Findings, therefore, suggest that informed choice was more in theory than practice and though midwives conceptualised this as a component of RMC, it had not transformed the fundamental trait of the midwife-woman relationship. Nonetheless, these empirically observable events were considered to have underlying causal mechanisms. Hence, in-depth analysis using retroduction was carried out which revealed an interplay of the structure, agency, and culture with deeper underlying causal mechanisms to produce the outcomes that manifested in these observable events. The causal mechanisms that have been identified are 1) midwives' philosophy of care and ideologies about their role, 2) risk

aversion arising from high maternal and neonatal mortality and morbidity, the absence of resources, and the fear of adverse outcome and blame, and 3) Structural and gender- based violence. Further explanation of the causality of these mechanisms will be provided in the discussion chapter. In section 7.2 figure 10, a conceptual model of factors influencing RMC will also be presented which will summarise the regularities and identified causative mechanisms and provide a visual demonstration of their causal pathway.

5.6. Conclusion

This chapter has presented the systemic and personal factors that have influenced midwives' agency in the provision of RMC. It was apparent that healthcare facilities were not adequately prepared in terms of infrastructure, equipment, skilled human resources, and the leadership that are required to provide the quality and respectful care that hospitals were to offer. The lack of resources resulted in a diminished sense of professionalism and a lack of adherence to professional codes of conduct which had the tenets of RMC enshrined in them. Midwives highlighted that they have had to bear the brunt of the failure of the health system to deliver safe outcomes for women leading to midwives' persistent fear of adverse outcomes and blame. This fear had resulted in a paternalistic approach to childbirth denying women their autonomy and agency.

The evidence obtained has also revealed that professional collaboration with other professionals who play a role in the woman's care had a significant influence on RMC. These professional relationships had been marred by contentions resulting in women being disrespected. This coupled with the notion that their welfare was not a priority to managers further aggravated midwives' frustrations and subsequently their relationship with women because these frustrations were displaced on women. These regularities were a basis for in-depth investigation of causative mechanisms and how they worked to produce these outcomes. Therefore, using the CR principle of retroduction, structures, culture, agency, and causative mechanisms were identified, and a brief explanation given on how they interplayed to manifest in the events observed. Three causative mechanisms which represent the real

deeper level mechanisms that influence RMC were identified. The manifestation of these regularities was also in the fracturing of the relationship between midwives and women which is further illustration in the next chapter.

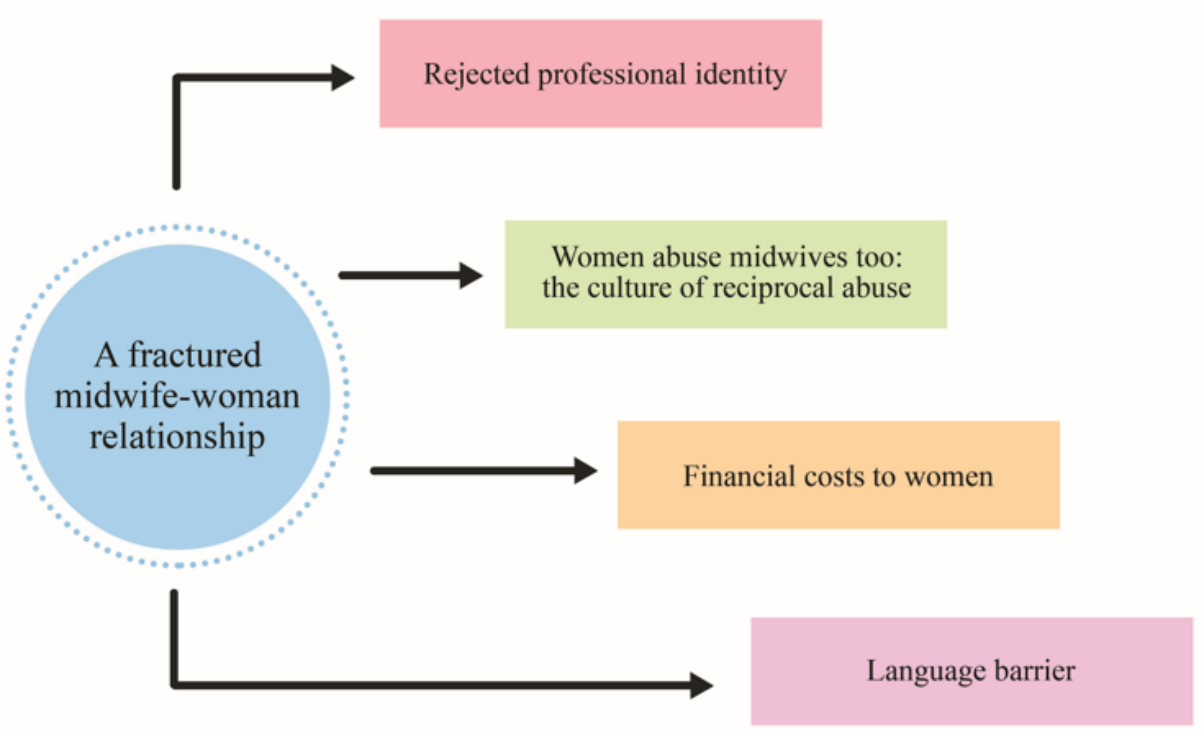
CHAPTER SIX: A FRACTURED MIDWIFE-WOMAN RELATIONSHIP

6.1. Introduction

The previous chapter addressed the systemic and professional issues that had impacted on the provision of RMC including the identification of structures, culture, agency, and causative mechanisms that had resulted in the manifestation of outcomes relating to RMC. This chapter presents findings relating to midwives' account of factors associated with the woman and her companions that had also contributed significantly to the empirically observable events. It was apparent that the midwife-woman relationship was not merely based on midwives' interaction with women or the organisation of maternity care with its inherent structures and processes but also how women interacted with the healthcare system, particularly midwives. How women related to midwives was grounded on the personality of the midwife. In addition, midwives described their experiences of abuse and the rejection of their professional identity because of their age, marital status, or physical stature.

This chapter will explore midwives' description of women's rejection of their professional identity and the pre-existing notion of disrespect that influenced how women related to them. It will also describe the culture of abuse, emphasising on the different forms of abuse that women and midwives experience, one from the other. An explanation will be given on how the socio-economic, cultural dynamics within which the provision of maternity care is situated, and language barrier have also contributed to the fracturing of the midwife-woman relationship. Similar to previous chapters, in-depth analysis will also be carried out using retroduction to facilitate the identification of causative mechanisms. The figure below summarises the themes under which these issues would be discussed.

Figure 8: A fractured midwife woman relationship



6.2. Rejected professional identity

In chapter four, it was highlighted that reciprocal respect and mutual satisfaction with the provision of care were key principles within the midwife-woman relationship. To build on this, evidence from the study also indicates that reciprocity of respect operated in different aspects. The earlier iteration pertained to midwives' need for mutual satisfaction with the outcomes of care and the equal recognition of their rights. In this section, the evidence for reciprocal respect could be seen within midwives feeling of rejection from women or a lack of acceptance of the respectful care offered by midwives (which was a manifestation of women's agency). An act that perhaps impacted on their professional identity as midwives capable of providing skilled and respectful care. Age, physical stature, marital status, and childbirth experience characterised women's preference of who a competent midwife should be, according to midwives.

Prior to the commencement of the direct entry diploma in midwifery programme in Ghana in 2001, midwives had previous education in nursing and several years of practice before pursuing midwifery. They were, therefore, matured in age, had the physical stature of a matured woman, and perhaps had their own children and women were familiar with this cadre of midwives. Contrary to this, the direct entry midwives could begin their midwifery education after their senior secondary (high) school education, usually after the age of 18, they were often unmarried, and without children. Women within this category could generally be considered young (small) within the society and this perhaps reflected in women calling midwives 'small girls', which midwives considered disrespectful. In addition, according to midwives, the small physical stature of some of them was viewed by women as corresponding to age and therefore, they were not respected:

> *Doyi- [..] you know our Ghanaian community….. I don't know they have a problem. They say the diploma midwives we are smaller in nature; the big big ones are like her (points to a colleague Femi)*
> *Femi interrupts- when I go and stand there, ah ha but this one (points to another colleague who looks smaller than her) no!*
> *(Midwives FGD1 hospital B)*

> *Adoley- some also think we are too small to take care of them. They say they want the big big midwives (Twi) we are children*
> *Researcher- when you say too small do you mean? stature or age*
> *Adoley- they don't know our ages so they will use our stature and the look on your face. They say, "you are too small you don't know the work", so they want a bigger person*
> *All laugh*
> *(Midwives, FGD5 hospital A)*

These assertions were confirmed during a POs. In hospital B, a woman asked Adjoa, a physically 'small' looking midwife, if she was the one going to take care of her. The midwife and the senior midwife who was taking care of someone else both answered yes. The senior midwife shouted, *"why do you have a problem with it?"* The woman did not respond but her

facial expression indicated that she probably did. She minimally opened her thighs to be examined, the midwife constantly asked her to do so and there was very little communication between them. There was an indication that my presence as a researcher may have perhaps prevented these midwives from complaining about this to the woman any further. They, however, explained to me later that the woman was acting that way because she thought the midwife was too young.

Midwives' physical stature was also likened to marital status and childbirth experience. This could be due to the common weight gain after childbirth. Women, therefore, naturally perceived midwives with small stature as having no childbirth experience which was not always the case. According to midwives, women perceived that they did not understand their experiences of labour and childbirth and could not empathise with them. As such women preferred midwives who had previous childbirth experiences:

> *Adzo-Sometimes people will come, and they will tell you (Twi) you haven't given birth before (English) I want someone who has delivered before to attend to me*
> *Researcher- how do they know someone who has delivered before?*
> *Adzo- they see you and they see that.....*
> *Love- one person told a senior colleague here that "you, you haven't delivered before" but she has kids (laughs) she has three kids, but you don't know. "You've not delivered before, so you don't know how painful it is" …*
> *(Midwives, FGD6 hospital B)*

According to midwives, this was not simply an issue of childbirth experience but skill and competence. Women lacked confidence in the skills of young midwives and therefore, refused procedures from them, requesting for older midwives. This perception was, however, not limited to midwives. According to midwives, women also refused care from doctors they perceived to be young:

> *Sala- (Twi) she said if an older person doesn't come, she will not let anyone take care of her, she wants an older person.*
> *Researcher- Panyin [Twi word for older person or a person in higher position] in what sense*
> *Sala- (Twi) she said she wants 'Panyin'*

Researcher- age or what?
Sala- I don't know… (Twi) no, but we are all in scrubs so she can't tell the rank, so she was seeing all of us as children. So, she wanted someone who was older to take care of her. So, this woman lying there till morning. The in-charge [of the shift] even came to take care of her, but she said she still wants an older person, and she was a child. […] Because the in-charge herself has spoken to her a lot and she still wants an older person. Which other older person is there to take care of her? Doctor came she said she wanted an older person. […] Doctor George [medical director also young looking] came she says she wants an older person
(Rotation midwives, FGD6 hospital A)

Midwives purported that this perception resulted not only in women refusing care, but also being rude, and intentionally making caring for them difficult to test how the midwives will react and their negative reactions were used as confirmation for the notion of disrespect:

when I was posted here first, I had problems with a lot of them [difficulties caring for women]. So, once I asked a client 'why were you behaving like that'. And she said that those of us who have not given birth before "when you are taking care of us, like your size, we just feel like misbehaving with you". (Doyi, midwife FGD3 hospital B)

Some midwives, however, resorted to telling lies about their marital status and childbirth experiences in order to gain women's trust and confidence:

So sometimes I even lie and tell them that whatever you are going through I've been through it before ah ha (Doyi, midwife FGD3 hospital B)

These statements suggest a rejection of midwives' professional identity, and this was consequently viewed as disrespectful and reinforced midwives' need for reciprocity of relational respect. In addition, public knowledge of widespread disrespect had also resulted in the pre-existing notion of disrespect which women reported to the labour ward with. The poor attitudes of health professionals generally and particularly the mistreatment of women during maternity care was widely discussed within professional and public spheres especially on various media platforms. According to midwives, women held this dominant perception about them in addition to some misconceptions. For instance, midwives stated

that some women perceived them to be witches who were going to cause harm to them and their babies or destroy the destinies of their children. Some of these misconceptions were also perpetrated by media organisations. For example, a midwife cited reports in the media of midwives having canes at the labour ward, which was false. These are highlighted in the following quotes:

> *You will be the first person to see her baby. And even sometimes they say that eh like the person who will see the baby first will take her destiny or something like that. (Akos, rotation midwife FGD4 hospital A)*

> *the media they were saying that every labour room they have cane that they use to hit the.. the….. the client. Oh chale [local jargon for friend, buddy or mate] how come. Have you seen any cane in our this thing….in our labour ward? (Ivy, midwife FGD1 hospital C)*

To improve the midwife-woman relationship, participants suggested that women should be educated during the antenatal and through the various media outlets on what pertains to labour and childbirth and what was required of them. Midwives stressed that this ought to be carried out by midwives who had daily encounters with women and not by nurses in administrative positions who had no experiential knowledge of the daily occurrences within the maternity units. This was because there had been initiatives by some facilities to educate the public on various health issues and though these were not geared towards RMC, the midwifery aspects had been carried out by nurses and not by midwives:

> *I know that the hospital runs some health programs on the radio, but they should leave the work of the midwife for the midwife. It's enough that the seniors go and sit there and talk plenty …..plenty…. plenty but they should leave the work for us to go and talk. Because we….we know what we go through when the clients come here and the clients know what they go through when they come here. So, sending a nurse to go and …. because (Twi) she is at the administration [in a managerial position] (English) because the person is known by the leaders of ….or the organisers of the radio program, they will send the person there to talk about what she doesn't know or he or she doesn't know that happens here (Abgeze- midwife FGD1 hospital A)*

It was also suggested that for the provision of RMC to be effective, women should be educated on the role of the midwife, the effort some midwives were putting into maternal care regardless of the widespread mistreatment, the need for midwives to be respected, and the role of the NMC. According to some stakeholders educating the public on these roles will enable them identify malpractice and seek the appropriate redress:

> *And then I think the general public should also be educated on the roles of the midwives, so that when they have gotten the knowledge, they can also test the law. Because it is as if things are just relaxed here so people think that they…….. they, you can just do it anyhow, yes. […] by that people will get the information and if they realise that you are not doing things well, they can test the law and sue, yes. (Joyce, NMC INT6)*

Whilst midwives identified the need for them to be involved in the education of women on maternal health issues, they were sceptical about educating women on respecting midwives. According to Ann, this ought to be carried out by the MOH and the GHS as it was not appropriate for midwives to demand respect from women in order for them to be respected:

> *if they want the maternity care, the respectful maternity care to work in Ghana, ministry of health, Ghana health service should also have a team in all the various hospitals. They should have a team, me as a midwife I can't come and tell the client that you have to respect me, and I also respect you. So, it's for that team to do that, that's their job. (Ann, midwife FGD1 hospital B)*

Educating women at the ANC was an already existing aspect of the provision of maternal healthcare which could be intensified to inculcate aspects that promotes RMC. The education being carried at the ANC was beset by challenges, according to midwives. They reported that women were often in hurry so did not pay attention, complained that it was time consuming, did not ask questions or seek clarification, and sometimes some women did not understand the language spoken. Others reported late because they were not interested in the information that was being provided and thus reported to the labour ward unaware of the expectations:

even antenatal services here, they will say that even when I come early ah (Twi) it's just going to be all talk (English) so they will not come early. So they will wait, late and they will come, so they will not even come and then get the chance to er have the talk and even….. even during the education too, they will not even ask questions because (Twi) "I am in a hurry to go home". That is one other major problem hmm (Essuman, Midwife FGD3 hospital A)

Nonetheless ensuring women's satisfaction with care was considered paramount. Thus, suggestions were made for the development of patient satisfaction surveys and exit interviews to inform the development of strategies to improve women's childbirth experiences. These strategies were suggested because midwives believed that the negative perceptions, cultural beliefs, and misconceptions affected women's attitudes towards them. According to midwives, women exhibited negative attitudes such as lack of cooperation, rudeness, defensiveness, lack of appreciation, and hidden aggression. They were easily provoked and did not relate well with midwives regardless of what the midwives did. These negative attitudes towards midwives are explained further in the following section.

6.3. 'Women abuse midwives too'- the culture of abuse

The previous sections have highlighted an enduring abusive culture within the care environment and this section specifically highlights the existence of mistreatment of midwives and women one of the other. Midwives and stakeholders highlighted context specific manifestations of what was described as 'bad attitude' of staff as discussed in the previous chapter. Typologically, these bad attitudes were described as a lack of professionalism. The findings indicated that women were mistreated, and this was more likely to occur during the initial encounter between midwives and the labouring woman. It was highly influenced by whether the woman reported with mandatory items required for birth and the mistreatment at this stage was verbal and often retaliated by women and their companions. Further exposition on these mandatory items and how they impacted on RMC will be highlighted in section 6.4.

The distortion in this encounter had an influence on the provision of care. For instance, in a PO in hospital C, the husband of a woman shouted at the midwife when she requested for the items needed for birth to which the midwife retorted. During examination of the woman, the midwife did not explain procedure and upon examination the woman was fully dilated but the woman had no cot sheet to receive the baby and so the midwife kept complaining. Procedures such as vaginal examinations and offering support during contractions were also avenues during which reciprocal abuse was noted and this was highlighted by midwives. Women were often observed to refuse vaginal examinations, the offer for a sacral massage from midwives or assistance with deep breathing exercises. These were often related to the fact that women felt the vaginal examination was painful and the sacral massages were not helpful in relieving their pain. During these contractions, some women would push prior to full cervical dilation, and this resulted in some midwives shouting at them. On the other hand, midwives also shouted at women with a fully dilated cervix who also did not push when instructed to do so:

> *let's take like someone who is in the second stage of ..... and the person is delivering. There are contractions and the person is supposed to push, and the person will be lying there "maame push". Instead of the person to push…there you have to tell the person like explain the things……the consequences of her actions to her. You have to be firm…. "Madam you have to push". (Ivy, midwife FGD1 hospital B)*

The findings also indicated that midwives may have been socialised into a culture of mistreatment and a paternalistic concept of care where care providers assumed professional authority on all matters and mistreatment was an accepted means of ensuring safety. Though some midwives reported feelings of guilt when they mistreated women to avert adverse outcomes, they were unaware of other alternatives. Words such as lenient were utilised when describing midwives' respectful practices and women who were exercising their right to choose or exhibiting the manifestation of pain were said to be uncooperative or misbehaving. Midwives including students who shared the provision of a woman-centred

care as a reason for becoming midwives also justified the abuse of women on the grounds of safety. For example, Enyo who took joy in providing care for women also legitimised the mistreatment of women to the point of recommending for them to be educated to accept that shouting to ensure cooperation was done in their best interest:

> *Enyo- Because seeing the mothers taking care of them right from the antenatal up to the delivery and after the delivery it's really brought a lot of joy to me*
> *[…]*
> *Enyo continues- to educate them especially in the labour ward and that if the midwife screams on you, it doesn't mean that the person does not respect you, she wants the best for you. So, we have to educate them more on that. Erm erm the side effects of them not cooperating, pushing through undilated cervix and then like heeding to whatever we tell them, the importance of it. They will know that indeed we want the best for it…for them not that we don't respect them*
> *(Midwife FGD6 hospital B)*

Furthermore, the lack of pain reliefs for women and the absence of non-pharmacological pain management posed difficulty in supporting women who could not bear the pain of labour. Thus, midwives were inadequately prepared to manage some manifestations of pain or support women through this as noted in the quote below:

> *we positioned the client, and you know when the baby is coming out because the perineum is expanding, there is that sharp pain. She felt that and she felt her perineum was torn, the client shouted "(Twi) my vagina is tearing, my vagina is tearing". (English) Before we realised the client was off the bed. She got down from the bed, walked out of the labour ward naked and she said she will not deliver again, so she is going home. Everything we were supposed to tell this client failed and eventually she came and delivered at the nurse's station. She was standing whilst the baby was coming so the midwife there has to just catch [deliver] the baby with the bare hands without gloves. (Cindi, midwife FGD2 hospital C)*

Midwives also perceived that sometimes their actions were misinterpreted as abuse and support mechanisms which may not be appropriately explained to women may be misinterpreted. For instance, according to some midwives, attempts to provide diversional

therapy as a means of relieving labour pain, or support women transfer to the second stage room was misinterpreted as either being talkative or pushing women around. Additionally, there was also the perception of neglect by the midwife. Women who were admitted in the latent phase of labour often felt neglected when other women who reported in the active phase gave birth before them and were of the perception that such women were being offered other forms of care to enable them deliver quickly:

> *During a PO in hospital B, a primiparous woman who had been admitted with a 2cm cervical dilatation had progressed to 4cm and had been transferred to the labour ward. At the labour ward three multiparous women who had come in active labour progressed and gave birth before her. When the third woman was being transferred to the second stage room, she began to scream that she was being neglected. She shouted that she wanted to have a caesarean section. All attempts by the midwives to calm her down failed. She walked naked to the midwife's station and laid on the floor, shouting; "take me to the theatre". The labour ward manager and student nurses amidst shouting covered her and assisted her up.*

According to the labour ward manager, reports of women being asked to go home and report later, then giving birth at home without SBA resulted in a government policy where no woman could be refused admission regardless of her stage of labour. This had resulted in women staying longer on the labour ward and the potential for unnecessary medicalisation such as CS, augmentation, and induction of labour. It had also resulted in the perception that other women were cared for in a manner that caused their labour to progress faster whilst others were neglected.

Albeit the organisation and delivery of healthcare reflects the wider societal and political dynamics which had contributed to the mistreatment of women. In a PO in hospital A, the policy of having a husband consent to the provision of vital care such as blood transfusion deprived a woman of this even though she had consented to it. Again, in this same facility where companions were encouraged, the mother of a woman in labour was the one shouting at her and hitting her to push when she was not doing so after several encouragements from midwives. Furthermore, the mother of a teenage girl in hospital C who did not know her

daughter was pregnant until she got into labour would have hit her daughter but for the intervention of midwives and the labour ward manager. Midwives confirmed that companions of women sometimes asked them to mistreat women if they did not push as highlighted in the quote below:

> *At times they their relatives that will rather say (Twi) you should beat her, if she is not pushing beat her. (English) and we will tell them we will not beat her for you to send us to the radio stations. And at times when they are not pushing and we know that second stage maybe she is supposed to push, we do invite the relatives on board to come and talk to them and they… and they rather will want to beat them. (Lena, midwife FGD1 hospital C)*

It could also be noted from the quote above that perhaps attitudinal change has ensued from the public disapproval of the mistreatment of women, but midwives may still be uncertain as to what constituted mistreatment and lacked an understanding of the implications of these practices. Nonetheless, perhaps in response to the mistreatment that women anticipate when reporting to the labour ward, they prepare to retaliate. As such midwives did not only highlight their mistreatment of women, which they legitimised, they also highlighted the mistreatment they also experienced from women which, according to them, women also justified. The mistreatment was either verbal or physical and these were from either women or their companions or both. Physical abuse included, hitting, vomiting on, throwing soiled pad, grabbing the breast, kicking the abdomen or breast with legs, and biting. Midwives reported several instances where they had been kicked in the abdomen by a woman in labour with some midwives miscarrying their pregnancy as a result:

> *Lena continues- Just struggling, throwing the legs, before I realised, she has hit me with the leg, my lower abdomen, early cyesis [midwife was pregnant]. So, in the morning, I started bleeding. […]*
> *Ivy interrupts- by then she [midwife] was bleeding*
> *Lena continues- (a bit teary) […] We also face a lot of challenges*
> *(Midwives FGD1 hospital C)*

Mistreatment also involved verbal abuse which included name calling such as witches, small girls, cursing, shouting, harsh and rude language, and offensive words and according to midwives these were carried out with the premise that they were midwives or nurses who were being paid by the taxpayer and deserved to be treated anyway the care receiver desired to. Midwives were all women who sometimes worked within their own communities and with the current cadre of midwives being relatively young, they experienced a lack of respect or recognition within their communities as illustrated in the quote below:

> *"You are all witches", they even call us witches, yes. "Do you think we don't have like your type in our houses". You know.....they say all sort of things that will provoke you, we ..... it's… hmmm... [looks downcast] it's … it's.... (Gyekye, midwife FGD3 hospital A)*

Midwives asserted that when they complained about these actions of women, they were tagged as uncaring or disrespectful and the actions trivialised. They reiterated that they were also human beings whose privacy and dignity ought to be respected by women, thus, the definition of RMC which was centred on respecting the woman alone was unacceptable to some midwives. They further highlighted the midwife's lack of representation when developing definitions as explained in the quote below:

> *Essuman continues- because if that is how you are going to treat us … because we also have privacy. (Twi) you can come and just because of labour pain you can hold my breast and squeeze it (Twi) so much*
> *All nodding in agreement- hmmm*
> *Essuman continues- (Twi) and if I talk you tell me that I am an uncaring person*
> *Essuman- and so here, here, we also have dignities (Twi) and so the WHO should put it in it. And one other thing is that…*
> *Gyekye interrupts- we will not accept this*
> *Essuman continues- (Twi) one other thing is that when they are setting some definitions they shouldn't sit at ….. abroad and other areas. We down here we are suffering, sometimes what to even work with is a problem.*
> *(Midwives, FGD3 hospital A)*

Shouting on midwives by companions was particularly common in all facilities especially when they had to make payments. The mistreatment of midwives by women was viewed as deliberate. According to midwives, this was a premeditated act of retaliation from women who had the pre-existing notion that midwives were disrespectful. Whilst midwives justified the mistreatment on the grounds of a safe outcome, they indicated that the use of labour pain by women as a justification for mistreating them was unacceptable to them. During PO in hospital A, a woman kicked a midwife in the abdomen with her legs, however, it could not be ascertained if it was intentional. Nonetheless, midwives asserted that it was, as stated in the quote below:

> *So, when they are coming, they've tuned their mind, if I go and this nurse says something, me too I'll just give it to the nurse [insult the nurse]. So even if you are talking to the client in a lower tone, you are explaining yourself, some won't understand you. They'll just be raising their voice and saying a whole lot (Love, midwife FGD6 hospital B)*

These were indications of a fractured relationship caused by a culture of reciprocal abuse within the labour ward, where both care givers and service users abused each other with justification. Both midwives and stakeholders perceived these attitudes as a bottleneck to ensuring quality maternity care, uptake of SBA, and an indictment on their sense of professionalism. But the actualisation of this culture may be powered by real causative mechanisms whose actions may be empirically invisible but with the capacity to influence these observable events. Lack of trust in the health care system as a whole due to its poor quality is postulated as a causative mechanism of women's rejection of midwives' professional identity. This rejection and reciprocal abuse may, in reality, be a rejection of the health care system with its prevailing culture of gendered abuse and structural violence. Similar to previously postulated causative mechanisms, none of the midwives' assertions explicitly denoted lack of trust and rejection of the health system but the postulation of this mechanism emanates from the CR practice of rational judgement to enable the fuller and more adequate interpretation of this causal reality.

This notwithstanding, strategies had been initiated to mitigate these challenges and further actions that were needed to enhance the overall quality of care had been suggested. Strategies that had been implemented and suggested were targeted at the development of human resources, enhancing the delivery of care, and improving women's knowledge on childbirth and maternity services. Human resource strategies were especially focused on the improvement of their interpersonal skills and the development of a sense of accountability. Though they were not specifically focused on RMC, they were expected to have indirect effects on RMC.

In hospital A, the telephone number for the police service and a customer service number were displayed all over the maternity unit for both women and midwives to seek support when incidences occurred. All hospitals involved in this study had implemented some human resource improvement strategies such as the training of all staff members on customer care and the code of conduct of the Ghana Health Service. According to participants, these did not contain the specific components of mistreatment or RMC that had been identified but were generally aimed at improving customer satisfaction in all areas of patient care. For instance, the training on customer care focused on communicating with patients in an empathetic manner which is a component of RMC as explained in the quote below:

> *I'm a doctor I've been asked to do my work, I've done it. It's your head that is paining you, you are having headache, I've given you paracetamol go and take it you'll be Ok. But you know quality and customer satisfaction goes far beyond that. You may give the person the medication but then he or she expected you to examine him or her properly and to her that's ok, she's satisfied with your service and that's quality. Oh, the doctor held my hand, oh he was so nice, the way he touches me, he was so nice. But then what's wrong with you, oh kpa kpa kpa [way of saying someone did things hurriedly] ah haa. And all these things are issues that we ….. so we try to train them in a way that they will empathise with the client [Nathan, QCO hospital A)*

No further details were provided on the content of the training on customer care. It could, however, be noted from the findings that some stakeholders engaged in one-on-one informal

training for midwives on how to communicate with women though no details were provided on how to practically carry this out:

> *erm that one as at now it's not any formal training, we go there we talk to them one on one and then we interact with them, chat with them and we educate them on that. (Mavis, DDNS INT2 Hospital C)*

Providing such generic training, however, may limit the focus on aspects of care that are specifically related to maternal healthcare. The lack of specific attention limits the ability to develop the appropriate skills, and the customer care concept may depersonalise the midwife-woman relationship inherent in RMC as conceptualised by midwives. Additionally, midwives also emphasised that there was a persistent focus on customer care to the detriment of midwives. The principle that 'the customer is always right' resulted in situations where midwives could not seek redress even in situations where they were proven innocent or had been abused themselves:

> *you see … because erm… because erm we are bent on customer care. Everywhere you go, wherever you enter they keep saying the customer is always right. In situations where an incident happens that even from your investigations you prove that the staff at that point in time was correct or was right, they tend to support the customer. Just simply because you will want to keep that client. But keeping that client at the detriment of your staff? (Agbeze, midwife FGD1 hospital A)*

The above quote also highlights the fact that there were disciplinary procedures that were followed and members of staff who were found guilty of offences disciplined. According to participants, disciplinary measures included suspensions, transferring to other facilities, revoking licenses, and working extra shifts. While dismissal was a likely disciplinary measure, it was rarely used as health facilities could not hire or fire because they did not possess the power to do so, limiting their ability to ensure accountability. The details of such investigations could not be ascertained in this study, but it was evident that midwives felt unsupported regardless of the outcome. Some disciplinary measures also appeared to be a punishment rather than a means of enforcing quality standards as there were no measures

to ensure fitness to practice upon a midwife's return to work. In addition, transferring a midwife to another facility may only be a shift of malpractice to another facility and may not necessarily result in change in practice. Nonetheless, this disciplinary procedure was only available in hospital A, and none had focused on the mistreatment of women indicating that mistreatment of women may have been trivialised as noted in the quote below:

> *sometimes you will go to facilities and people will be doing what they are not expected to do and when you try to find out it's as if they have not heard about any code of ethics or anything at all (Joyce, NMC INT5)*

The fracturing of this relationship could also be attributed to some socio-economic and cultural factors as illustrated in the next section.

6.4. Financial costs to women

The financial costs of maternity care to women and the cultural context within which maternal healthcare is situated had influenced the relationship between midwives and women. Under Ghana's NHIS women, have the right to maternal healthcare free of charge. However, 'free' was relative and did not mean 'no-cost' because the insurance policy did not cover items needed for birth such as cot sheets, baby dresses, costs related to blood transfusion, and some medications which the hospital could not provide. This dearth of a comprehensive NHIS meant women would have to contribute to their childbirth costs by buying and bringing these items or paying for them at the point of service.

However, some women's lack of economic and financial independence resulted in them reporting to health facilities without the necessary items that midwives needed to work or the money to pay for them when required. According to both midwives and stakeholders, though women were aware of the nature of the policy, they often reported with the expectation that all supplies and services would be free including soft drinks which women request for after childbirth:

> *Some come their personal things are not here, you ask them she'll tell you "I have insurance". They want water free, they want malt [soft drink] free, they want erm*

sanitary pad free. They want everything to be free for them but at least the hospital is taking charge of all your delivery things so your personal things must be there by you the er er er client. (Linda, LWM INT1 hospital A)

The absence of these items created contentions between midwives, women, and their companions; women and their companions not seeing the need for midwives to be requesting for items when the woman needed to be cared for and midwives insisting on these items because they could not care for women without them. This negatively affected the initial encounter which was an important phase during the establishment of the midwife-woman relationship. This impact was confirmed during POs in all facilities, as these items were requested from women before procedures were carried out and from the quote below:

the person comes and you ask erm the patient or the relatives to bring out a specific item and they might not have it as at that time so you may probe further to ask those things that are not ready and the husband may get angry because they think you… think you people are like that so why are you saying this thing at this point in time so it brings misunderstanding and exchange of words at times and so different interpretations (Manu, midwife FGD4 hospital B)

The contention also emanated from the fact that as part of the birth preparedness and complication readiness plan, women were educated on what would be required of them when they got into labour. According to midwives and stakeholders, women were provided with money saving tips and a list of the items that would be immediately required when they reported in labour, but these were not adhered to by some women. Though midwives demonstrated an understanding of the fact that not all the items could be acquired by all, there was the expectation that the few that were of immediate importance ought to be available. Midwives, therefore, elucidated that it was justified for them to shout or complain because of the pressure the absence of these items put on them, as highlighted in the quote below:

Danny- She will come with nothing ooo so where do you expect the midwife to get cot sheet, rubber… like things that we need to take care of you. We don't...
Doya-hmmm

Danny- […] It's not like we are shouting.... shouting at the.... we don't. But in one way or the other some of them…....
Yomi interrupts- but you cannot pamper someone who comes bare handed, nothing, (Twi) and say "I'm coming to check if I'm in labour", then I will say to her "you have done well by coming".
Danny- yes… yes
Yomi- no! definitely I have to say something to the person, (Twi) because it hurts. (English) because when you come like that you put pressure on us. Because we cannot use our bare hands to receive the baby.
Doya- hmm
Yomi- you [midwife] need to have all these things and from where?
(Midwives FGD3 hospital B)

The pressure midwives felt was the burden to provide for women in the absence of not just items to support the birth of babies but food, water, and other drinks for women during labour and birth. Hospital A was the only facility that provided food for service users, however, women in labour were excluded from this provision. Therefore, in all the facilities women and their companions had the responsibility of ensuring this provision was made. In the absence of this, the financial responsibility was placed on midwives which midwives felt women did not even appreciate as highlighted below:

sometimes we use our own money to buy food for them. […] (English) sometimes the client will come and lie here and then since morning (Twi) she hasn't eaten, so it's also a problem (Frema, midwife FGD5 hospital B)

But some of them come here empty handed so you have to… you have to sacrifice to give out something. We are buying malt [soft drink] for them, we are buying diapers and so forth, but all this comes from our own pocket, and all this disturbs a lot (Linda, LWM INT1 hospital A)

people even come and we have to give our monies out and we have go and buy food for them. They don't appreciate us oohh. They don't appreciate us at all. (Danny, midwife FGD3 hospital B)

This financial responsibility placed on midwives may be humiliating for women and may also have the propensity to elicit the paternal attribute of control and the sense that women owed them. Furthermore, it was noted that the health facilities also placed on midwives the extra responsibility of ensuring that women paid for the provisions that were not covered by the NHIS such as blood and medications and this further worsened the burden on midwives and increased the contentions with women and their companions. During POs in hospital B and C, relatives often got angry with midwives and shouted at them when they asked them to make these payments and midwives retaliated as confirmed in the quote below:

> *this too involves money because the person has to go to the lab and the lab is not free… you pay…. Though insurance will cover some, you will pay a top up. We have to do this and they too they don't understand, and they get frustrated (Twi) then it turns into a misunderstanding between us. (Yomi, midwife FGD3 hospital B)*

Observational data indicated that these situations were extremely frustrating for both midwives and women. In some situations, midwives were made to bear the consequences of the lack of payment. For instance, in hospital B midwives must leave their names at the laboratory so that they can be held directly responsible for the lack of payment. Such midwives were refused blood subsequently until the blood was replaced because non-payment was considered irresponsible on the part of the midwife. Thus, they sometimes had to plead to obtain blood for other women when their names were already on the non-payment list:

> *Doyi- You the midwife you rush to the lab, and you go and take the blood for them, and you go and leave your name……*
> *Femi interrupts- there and they run away [women do not pay before discharge] and leave your name there. […] We went to do blood [laboratory examinations], the HB was 4 or something and she was O negative. The family too are nowhere to be found [to make payment for the blood to be obtained].*
> *Danny interrupts- we can't find them*
> *Femi continues- I had to rush to the lab to go and plead [makes the begging gesture] before they gave us one. Now before they abscond, one, two, three [counting her colleagues] our names are there…..*

These resulted in several misunderstanding and miscommunication between midwives, women, and their companions distorting the midwife-woman relationship. These were further aggravated by the sale of some of these items, e.g., cot sheet, mackintosh etc., by midwives on the ward. Proceeds from these funds were sometimes used to buy equipment like foetal dopplers and blood pressure monitors and as motivation to midwives. However, women and relatives became overburdened with these financial requirements, and the inadequate explanations given led to lack of payment and the misunderstanding and arguments that destroys the relationship. Requesting these items and selling them during that initial encounter between women and midwives also caused delays in providing care to women further confirming the perception of neglect characteristic of the mistreatment of women. Whilst some stakeholders favoured the discontinuation of this practice because it led to the lack of RMC, others were of the view that it could only be discontinued if the government provided these necessary items needed for the provision of care:

> *And sometimes they find it difficult to explain to the patients why they are selling the things and the patient will go round complaining that they are collecting things from them. (Mavis, DDNS INT2 hospital C)*

> *so, if government will supply us with the pad, delivery sheet then we will not sell but for me I cannot sit down for somebody to deliver on the bed and somebody will also come, infection. And we don't have time to disinfect before another person will come and lie down. So that's our problem (Getty, LWM INT1 hospital C)*

It was, therefore, suggested that provision of these items should be made for women instead of them buying these items themselves:

> *Frema- and then they should buy some of the things that we will be needing for the delivery so that those who will come empty handed we will use it for them*
> *Boatemaa- that one is it for free or what*
> *Frema- yes, they should get it for free*
> *Boatemaa- who, the government?*
> *Owusua interrupts- Eiii*

Frema continues- maybe the government should provide us some, some of the delivery mats, rubbers, and all that we need
Boatemaa interrupts- you see that we have those disposable ones so that we can use them for a while
Frema- yes, maybe they can provide erm some for us so that we use it for them. And then food.[…] If they can come and build a canteen or kitchen (giggles) (Twi) so that they can cook food and provide to them.
(Midwives, FGD5 hospital B)

The socio-economic barriers to the utilisation of health care and the pervasive culture that disadvantages women are symbolic of structural violence. These findings are characteristic of these economic barriers, and in addition to the factors described in chapter 5, they provide a causal pathway for postulating structural violence as a causative mechanism influencing the provision of RMC. The explanatory power of this dominant causal mechanism will be explored in section 8.3.4. Furthermore, the fracturing of the midwife-woman relationship emanated from language barrier and tribal associations. These cultural factors contributing to fracturing of this midwife-woman relationship are further explored in the section below

6.5. Language barrier

Most communities in Ghana are multitribal, with very distinct languages and cultural practices. In hospitals A and B, most of the midwives did not speak one of the most predominant languages in these areas making communication with women a major problem. As a result of this midwives felt they could not relate well with women because they spoke different languages as stated in the quote below:

(Twi) we will only speak in Q. When they come, they speak in K and we too we don't speak K. When they come, they speak different languages (English) and some of us we can't speak other languages. So, there is a barrier between us and them (Maya, midwife FGD1 hospital A)

Midwives often had to source the help of other women or their companions as translators which could compromise confidentiality, privacy, and possibly influence the accuracy of the

information given. During an observation in hospital B, midwives had to seek the assistance of a nurse in another ward who spoke the woman's language to translate information before discharge. The woman and her companions had to wait for the nurse to be available to do the translation and were not happy with this because they were in a hurry to go home after being discharged. On further discussions with midwives, they recounted the challenges they encountered during the woman's labour and childbirth because they could not communicate with her. According to midwives, in circumstances where a midwife spoke a non-predominant language with a woman, other women felt the midwife was providing preferential treatment for her based on tribe, further affirming the perception of neglect. Women also responded better to midwives who spoke their language regardless of whether there was a companion to translate for other midwives as explained in the discussion below:

> *Otema (Twi) no matter what you say they don't understand. She will tell you she understands Q but even when you speak it, she will not understand. But let someone who is K come and tell her, and she will push immediately*
> *Yayara interrupts- (Twi) she will push for you immediately. Once she realises that the person speaks her language.*
> *[…]*
> *Yayara- (English) So when I entered, I said ah she is disgracing us, we the Ks we don't do that. When we come and then we push. […] At once this woman pushed just like that*
> *Researcher- did you say it in K*
> *All- yes*
> *Yayara- pushed just like that. First koraa we were thinking that she can't push so we were coming to prepare her for CS. She just pushed like that, so it means she was just there for no reason. Because they [midwives] can't speak the K, she is just lying down, and she is not pushing.*
> *Researcher- but did they use other means of communicating with her so that she will know it's pushing they wanted her to do?*
> *Yayara- the relative is there and the relative was talking to her koraa she didn't listen. The relative was there and the relative understands the Q so at least she was interpreting but still she didn't mind anybody. (Rotation midwives, FGD6 hospital A)*

These tribal affiliations were intrinsic within the wider societal context and influenced the provision of care. Women often had some sense of connection with midwives who were not necessarily of the same tribe but spoke their language and this fostered a better relationship whereas some women did not cooperate with midwives who were not from their tribe as indicated in the following quote:

> *So usually, you get an encounter with a client and the person speaks S and you are speaking Q, as soon as one our in-charges who can speak S comes and talks to them, they calm down and listen to them and they flow with them [relate better with them]. They close from work, and you are left with them, and that issue crops up again it becomes an issue. So, I think adding up to hers, language… language barrier also causes problems. (Ama, midwife FGD4 hospital B)*

Whilst the ability to speak a woman's language may foster a better relationship with her, midwives also emphasised that this may be interpreted differently by other women. Midwives indicated that some women felt neglected when midwives spoke a different language with other women. This makes the culture within the wider society vital in shaping the nature of the midwife-woman relationship, midwives', and women's agency, and subsequently the provision of RMC.

6.6. Conclusion

This chapter has highlighted the extent to which varying factors relating to the woman had contributed to fracturing the midwife-woman relationship which has been the central tenet of the RMC concept referred to by midwives. Evidence has been presented on the culture of abuse within the care environment with midwives abusing women with justification and having the perception that women abuse them as well which they purported that women justified as well. It was notable that whilst some midwives felt their mistreatment of women was justifiable, their mistreatment by women was deemed unacceptable. Midwives, therefore, confirmed their perception of reciprocal respect by citing situations that had resulted in the rejection of their professional identity thereby being disrespected. Though the

unavailability of certain items impeded the provision of care and the financial burden on most women was obvious, there seemed to be an agreement between some midwives and stakeholders that women ought to be financially responsible for some aspects of their care. Some midwives asserted that the provisions under the NHIS were enough effort by government to facilitate maternal healthcare for women. Such perspectives can, however, hinder midwives' ability to advocate for better health policies for childbearing women. Further analysis of these regularities through retroduction resulted in the postulation of women's lack of trust in the health system and structural violence as causal mechanisms. The next chapter will explore how CR facilitated the identification of the causative mechanisms and the development of the conceptual model of RMC. In-depth explanation of the components of this model will also be provided.

CHAPTER SEVEN: UNCOVERING THE REAL: CAUSATIVE MECHANISMS IN RESPECTFUL MATERNITY CARE

7.1. Introduction

The findings presented in the last three chapters have presented a description of observable events and the interpretation of the meanings, beliefs, and views attributed to the provision of RMC. Philosophical positioning and assumptions are an integral aspect of qualitative research, and this study was not an exception. The last three chapters, therefore, presented the implicit identification of themes through reflexive thematic analysis and abduction in critical realism (See section 3.5 and 3.6). Leaving the analysis at this stage characterizes only the empirical and actual realities, however, the central tenet of critical realism is not to investigate regularities at the level of events but to describe the structures and mechanisms that produce them. Hence, the identification of structures, agency, and culture as well as the postulation of causative mechanisms have been carried out using the regularities observed in the empirical data and rational judgement inherent in retroduction. These facilitated the development of a conceptual model of the factors influencing RMC and these will be presented in this chapter. Within the conceptual model, four domains, each presenting an agent within the social environment, will be analysed and their influence on RMC highlighted.

7.2. Causative mechanisms in respectful maternity care

The utilisation of an inductive iterative approach enabled me to draw on participants' voices and my own observations of the provision of care to identify demi-regularities or patterns within the data which informed the development of themes. The main demi-regularities identified which influenced the postulation of causative mechanisms included midwives' ideology about their role (the perception that they knew what was best for women which influenced the use of paternalistic approaches to care). The fear of adverse outcomes and blame, the seemingly competing demands between safety and satisfying birth experience, the psychological impact of high mortality and morbidity rates, the lack of support, resources,

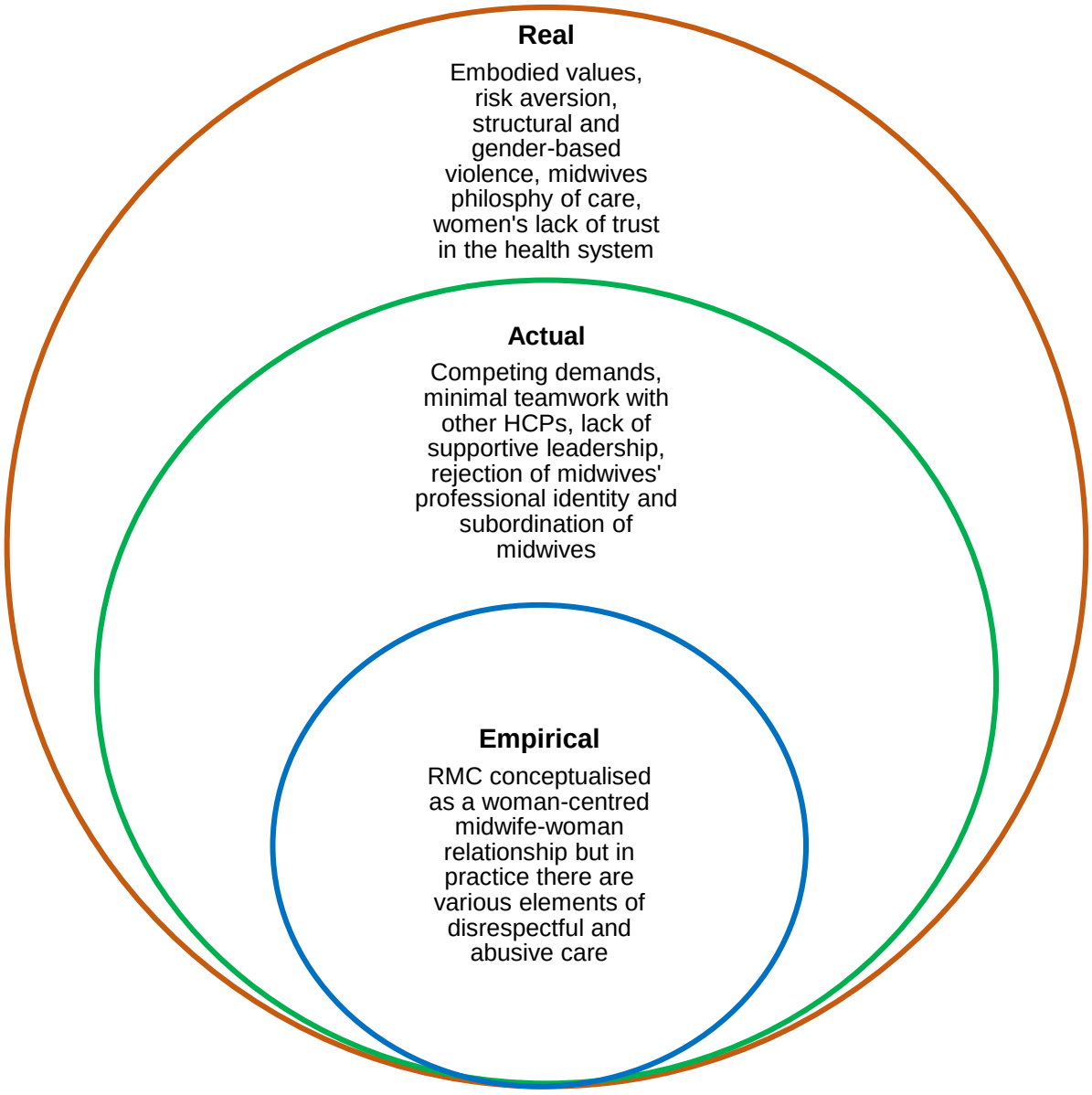
and interprofessional collaboration, rejection of midwives' professional identity and the subordinate role of the midwife also facilitated the postulation of causative mechanisms. These also represented the actual in critical realism.

These regularities manifested in the empirically observable events of the various forms of mistreatment both of women and of midwives. For instance, with regards to midwives' ideology about their role, they were predominately influenced by the perception that they knew what was best for women and needed to do that for them. The strongest motivation for this ideology was the fear of adverse outcomes arising from high maternal and neonatal mortality and morbidity rates, triggering the need to utilize their authoritative childbirth knowledge in paternalistic approaches to care to ensure safe outcomes. Furthermore, within the power structure of the organisations, midwives viewed themselves at the bottom with little or no power and without the support systems needed to perform their roles. This lack of support and power were visible particularly during the provision of emergency care where the midwives' decision-making capacities were superimposed by that of other health professionals, exerting an influence on the midwives' agency and yet blamed when adverse outcomes resulted. This further manifested in various misunderstandings and arguments between midwives and women resulting in the lack of RMC.

In critical realism, however, consistent regularities or succession of events do not mean causality and their explanatory power lie within the identification of causal mechanisms. These regularities, therefore, became the basis for in-depth investigation for candidate causal mechanisms, how they worked, and the discovery of the structures necessary for their activation. Five key causative mechanisms were postulated through the process of retroduction. These were **1) Embodied values, 2) Midwives' philosophy of care and ideologies about their role, 3) Risk aversion arising from high maternal and neonatal mortality and morbidity, the absence of resources, and the fear of adverse outcome and blame, 4) Structural and gender- based violence and 5) Women's lack of trust in the health system.** These causal mechanisms are tendencies which offer explanation of

outcomes and not a prediction of outcome. Stratification of the ontological levels and the emergent components is provided in figure 9 below.

Figure 9: Stratification of the ontological levels of respectful maternity care

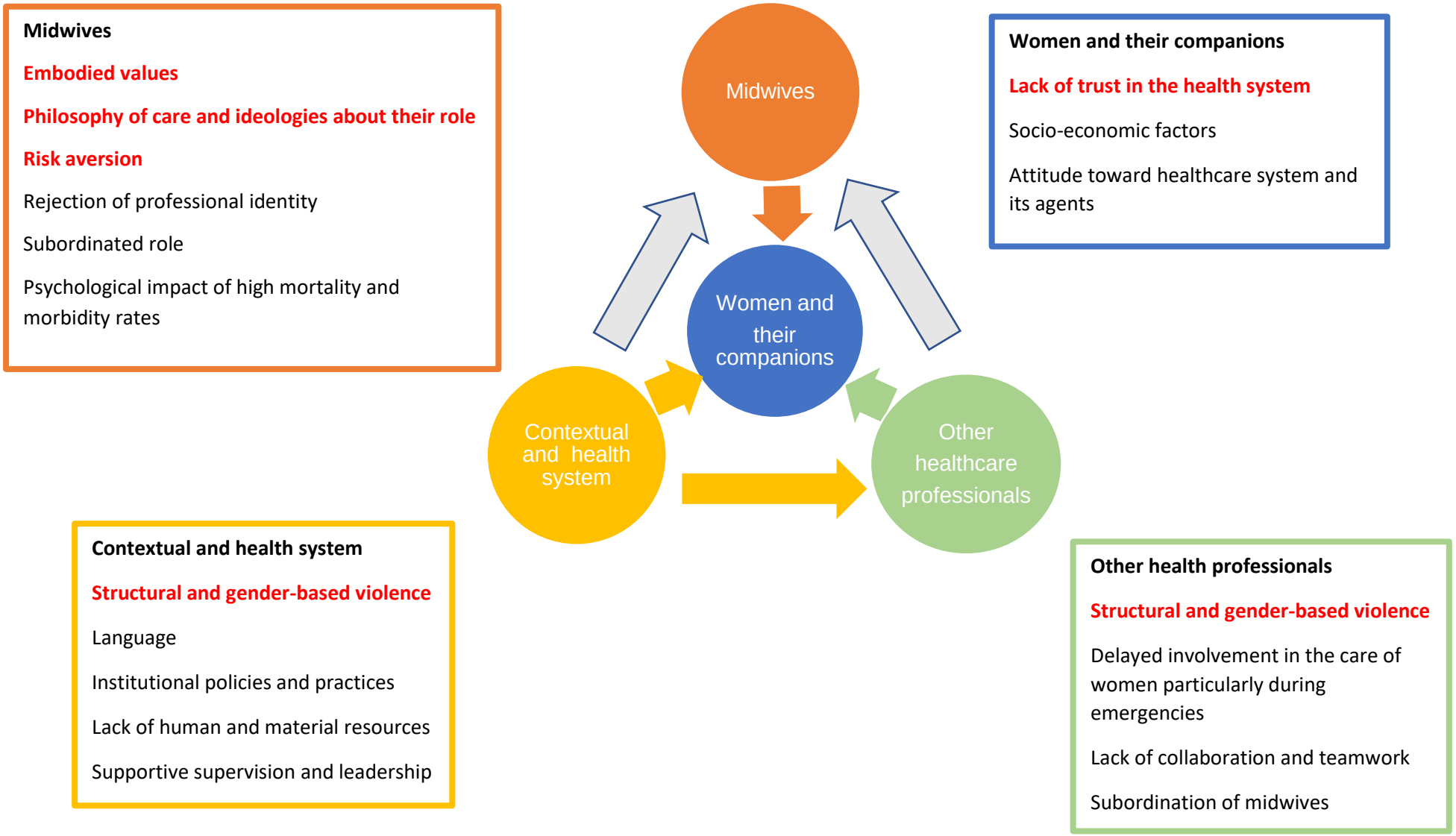


Another key feature of critical realism is the interaction between structure, agency, and causal mechanisms (Archer, 1988). A conceptual model (see figure 10 below) is, therefore, developed to summarise the identified causative mechanisms and regularities obtained from the findings and demonstrate how these mechanisms interacted within the health system structures to influence the agencies of the actors within this context specific work

environment. The model consists of four domains representing agents within the social environment whose agencies are influenced by the identified mechanisms and who in turn influence the provision of RMC. The four domains include midwives, women and their companions, other health care professionals including doctors, and the contextual and health system. The central feature of this model is the woman and where available her companion(s) and the locus of interest is how the midwife, other health professionals, and the context specific health system triad influenced her experience of RMC.

The structures, culture, agency, and causative mechanisms identified are also categorised under these four domains to demonstrate how they interact to influence the various agents with the health system being the underlining structure within which these agents function. It was demonstrated in the sections above that the major causative mechanisms, structural and gender-based violence, were situated within the health system itself and these affected the agency of all the actors in this model. With the midwife being the lead professional in the woman's care, the model also highlights how other health professionals influence her interaction and relationship with the woman and subsequently RMC. This model demonstrates that midwives' agency was highly influenced by powerful structural, political, philosophical, and cultural causative mechanisms. The model further highlights how the woman's interaction with the midwife and the health system also affects the care she receives. For clarity, the causative mechanisms are highlighted in red.

Figure 10: Influences on respectful maternity care: A conceptual model



The interaction between these various agents and the causative mechanisms was visible in the day-to-day occurrences within the maternity units. For instance, in critical realism people's intentions, motives, and reasons have causal power with the potential to influence events and outcomes (Alderson, 2021). Within the clinical environment, midwife's authoritative knowledge, a philosophy of care (causative mechanism) that they knew what was best for women and so they could do whatever was right for them (influence on midwives' agency) coupled with the lack of resources (structural feature), became a means for mistreatment through the withholding of information from women when there was the perceived threat of women refusing procedures (empirically observable event). Furthermore, because of the high maternal and neonatal mortality rates and the fear that they would be blamed if it occurred regardless of the cause, midwives became risk averse and chose safety over RMC. Midwives utilised their power to rid women of their ability to make autonomous decisions about their care especially during emergencies when there was the perceived risk to the life of the mother or baby. During such emergencies, however, the agency of other health professionals took precedence over that of midwives due to their role in the management of such emergencies.

One of the aims of retroduction was to identify the conditions within the specific context necessary for a causative mechanism to result in empirically observable events. Structural and gender-based violence were mechanisms identified which were not articulated in the empirical data but had the propensity to realize the structure's causal powers (Fletcher, 2017). This prevailing mechanism was the key underlying factor influencing not just the mistreatment of women but also of midwives who were all women. The deficiency in resources led to the inability to provide women's choices and the fear of not having the needed resources during emergency, made midwives exercise their power over women to avert adverse outcomes. Women's low economic status also resulted in their inability to afford certain policy requirement making them prone to mistreatment. Thus, agency of all actors within this social environment were shaped to various degrees by these structural features.

Nonetheless, mechanisms explain the causal structure of a phenomenon and in critical realist philosophy, the emphasis on outcomes of causative mechanisms does not mean linear causality but the outcome of a mechanism is contextual and highly dependent on other mechanisms (Bygstad et al., 2016). Thus, given a different context, mechanisms may produce a different outcome. For instance, risk aversion, one of the mechanisms identified through retroduction was as a result of fear of adverse outcome and blame and this mechanism resulted in the mistreatment of women. However, within some high-income contexts, this same mechanism results in overmedicalisation of childbirth which is a different outcome from that identified in the context of this study (see section 8.3.2 for further exploration). Therefore, these mechanisms have explanatory power but are not predictors of outcomes. Thus, in an open social world, these causal powers have the potential to produce different outcomes depending on other contextual conditions.

It is easy to explain midwives' provision of care simply as a lack of RMC, however, to do so would be deemed an epistemic fallacy, that is, a failure to recognise the causal structures that have shaped midwives' practice in a particular way (Bhaskar, 1998a). Therefore, from a critical realist perspective, the evidence presented draws a significant causal connection between midwives' agency and structural features, each of which possess distinct powers (Sayer, 2000) as demonstrated in the conceptual model. Further explanation of the causality of these mechanisms will be provided in the discussion chapter.

7.3. Conclusion

The three levels of analysis within critical realism presents useful evidence for influencing policies and interventions aimed at improving practice. It demonstrates that midwives' agency is highly influenced by powerful structural, political, philosophical, and cultural causative mechanisms. Identifying the various actors within the conceptual model has also facilitated the demonstration of how their agencies interact with causative mechanisms to produce the empirical events. In the next chapter, the themes abstracted will be further reviewed in relation to the wider theoretical literature and the literature on RMC to offer

further explanatory power for the postulated causative mechanisms. The best explanation of these realities is, thus, provided in the discussion chapter below using theories about the realities discovered.

CHAPTER EIGHT: DISCUSSION OF FINDINGS

8.1. Introduction

The findings derived from this study suggest a relationship-based, woman-centred, culturally situated, and systems influenced view and provision of RMC. Participants in this study idealised a concept of RMC that was value-based but also system influenced, and these systemic factors hindered the enactment of this idealised concept. RMC was conceptualised as a reciprocally respectful and mutually satisfying midwife-woman relationship. The values of reciprocal respect and mutual satisfaction were key principles underlying this relational concept of RMC. Midwives adopted professional, cultural, and religious values which became the moral impetus that facilitated the entry into this relationship with women. The initial encounter with the woman when she first reports in labour was deemed a vital phase in the establishment of the relationship and the approach adopted was highly important in determining the quality of the relationship. In addition to these key aspects, midwives also conceptualised RMC as comprising of woman-centred care, supportive care, and ensuring women's dignity, privacy, and confidentiality.

These various components of RMC were idealised because several factors within the health system such as the absence of resources, lack of inter professional collaboration, subordination of midwives, and the fear of adverse outcome and blame had contributed to the utilisation of paternalistic approaches to care and thereby hindered the enactment of this RMC concept in practice. To achieve the objectives of this study, of identifying the 'real' reality that had influenced the provision of RMC, the CR principle of retroduction facilitated an in-depth analysis of the regularities obtained through empirical data. This resulted in the postulation of key structures, culture, agency, and causative mechanisms that had contributed to the nature of RMC empirically observed. These were summarised within the conceptual model of factors influencing RMC shown in figure 10. The key causative mechanisms identified were embodied values, midwives' philosophy of care and ideologies

about their roles, risk aversion, women's lack of trust in the health system, and structural and gender-based violence. The synergy between these causative mechanisms had causal connection with the agency of health providers and this shaped the nature of RMC provided in this context specific social environment.

Novel contributions of this study include the emphasis on a value and relationship-based and woman-centred midwife-woman relationship as the underlying principle of RMC. The values of reciprocity, mutuality, spirituality, and kinship attachment inherent in this concept facilitate the creation of a culturally sensitive and context specific concept of RMC which extends the existing concept beyond the 'absence' of abuse. Another novel contribution to the knowledge on RMC is the impact of IPC on the midwife-woman relationship, RMC, and women's safety. This finding does not only extend the evidence on RMC but also the 'three delays' to accessing maternity care which is vital for discourses on the universal access to healthcare (Thaddeus and Maine, 1994). Finally, the causative mechanisms identified are key findings from this study that not only extend the knowledge on RMC but also the theoretical interpretations of the concept. In this chapter, these novel contributions will be further illuminated in the context of the wider literature.

The first section of this chapter discusses the key concepts of mutuality and reciprocity within the midwife-woman relationship as propounded by midwives and discusses its key features whilst maintaining a 'with woman' philosophy and woman-centred care as the underlying principles of the relationship. Midwives' embodied values i.e., spirituality and the sense of kinship attachment are discussed in relation to the African social value of communitarianism. The section includes further discussion of issues within this relationship such as (dis)trust, and dependence using dependency theories. The impact of the lack of IPC, particularly during emergencies, in addition to other systemic challenges will be expanded upon in this first section and more focus will be given on how they heighten D&A and impact on women's safety. The second section focuses on the systemic issues that have led to the lack of RMC. These include fear, risk aversion, stress, and structural and

gender-based violence. The causative mechanisms will be given explanatory power and an elaboration on how their causal sequence culminates in the mistreatment of women is carried out.

8.2. Relational respect: An approach to respectful maternity care

Midwives' assertions have highlighted that the core feature of RMC is the midwife-woman relationship with principles that are focused on reciprocal respect and mutual satisfaction for both women and midwives but underpinned by woman-centred care. The components of the woman-centred care concept in this study (individualised care, information giving, and informed choice) were congruent with those identified in the scoping review in chapter two. However, the woman-centred care concept identified in the scoping review did not necessarily highlight these components within the context of a midwife-woman relationship. Midwives in this study placed emphasis on the midwife-woman relationship. They utilised embodied values involving spirituality and notions of kinship attachment to develop a supportive relationship with women and ensure the presence of RMC, which was a novel finding from this study. However, midwives' inability to uphold women's trust, autonomy, and choice within this dynamic relationship resulted in paternalistic approaches to care. Additionally, when complications arose, the lack of IPC between the team of professionals required to care for women resulted in the dominant influence of other health professionals on RMC and this was a significant contribution to the knowledge on factors that influence RMC. The scope of the RMC concept is, thus, extended beyond the midwife-woman relationship to include other health care professionals. The following sections provide further discussion of these.

8.2.1. Mutuality and reciprocity

A mutual satisfaction with care and reciprocally respectful relationship between midwives and women were values that characterised midwives' conceptualisation of RMC. The desire for a mutually satisfying experience of care had resulted from the experience of high maternal and neonatal mortalities, the systemic challenges that led to this, and the blame midwives endured as a result. Though there is limited literature on the impact of high maternal mortalities on both women seeking facility-based care and the midwives' providing the care, an important finding and key contribution of this study is that this experience has significant implications on the midwife-woman relationship which may not have been recognised within the RMC literature identified in the scoping review in chapter two. Midwives reiterated that even when adverse outcomes had resulted from women's involvement in the decision-making process or delays from other health professionals, they had been blamed for it, leading to a lack of job satisfaction. As such the outcome of childbirth was important for midwives.

The mutuality affirmed in this study was the midwife's equal satisfaction with the childbearing process and outcomes and this was different to that asserted in other studies. In a secondary analysis of phenomenological and hermeneutic studies, Lundgren and Berg (2007) elucidated six central concepts within the midwife-woman relationship in the Swedish context among which was participation-mutuality. Mutuality was conceptualised by Lundgren and Berg (2007) as the continuous provision of information, openness, dialogue, reciprocal self-giving, and shared responsibility involving the woman's reception of the midwife's personality and professionalism. In this current study, although information giving was perceived as a component of RMC, it was not perceived as an aspect of mutuality but of woman-centred care and the woman's reception of the midwives' personality and professionalism were congruent with reciprocal respect and not mutuality. Midwives' assertions about mutuality in this current study were suggestive of women also taking responsibility for the outcome of labour in situations where women had refused interventions

as highlighted in section 5.5. There were indications that midwives valued their relationship with women because it was the hallmark of job satisfaction. However, they did not wish to go home after work feeling that the woman who lost her asphyxiated baby because she was too tired to push in a setting where emergency CS and newborn care could not be optimally provided was her fault. Thus, mutuality of satisfaction with the outcome of childbirth was an important aspect of the midwife-woman relationship, hence RMC.

Another concept within relational respect is reciprocity. Midwives highlighted the abuse they experienced from women and their companions as well as agents within the healthcare system, and thus cited reciprocal respect within RMC. Midwives expressed dissatisfaction with the concept of RMC that was centralised solely on the woman. This finding shares similarities with those in the scoping review in chapter two where nurse-midwives in the study by De Kok et al. (2020), argued that women misused their rights to insult them and critiqued the emphasis on women's rights over that of midwives without the acknowledgement of the systemic constraints that had resulted in the abuse of women. In addition to the lack of recognition of their rights, midwives in this current study, also emphasised on the rejection of their professional identity and subsequently the care they offered because of qualities that they intimated had no bearing on their midwifery skills.

The nature of reciprocity evidenced in this study extends the theoretical insights from studies like that of Stevens (2002), Hunter (2006), and Berg, Ólafsdóttir, and Lundgren (2012) that explored reciprocity within the midwife-woman relationship. For instance, Hunter (2006)'s ethnographic study in a UK NHS trust utilised reciprocity to highlight midwives' negative and positive exchanges with women within the midwife-woman relationship. The degree of reciprocity in the study ranged from women rejecting support from midwives to being overly reliant with impractical expectations. A model of midwife-woman relationship was devised to provide insight into the emotion work involved in community midwifery. The author identified four key situations within this model among which was 'rejected exchange'. The rejected exchange ensued when 'women seemed to be unresponsive or hostile and unreceptive to

what the midwife had to offer' (p.317). This concept is similar to the 'rejected professional identity' highlighted in chapter six section 6.2 of this current study, where women not only rejected the midwife's professional identity but their offer of care. Berg et al. (2012)'s evidence synthesis, however, offers a contrary opinion by referring to the reciprocal relationship as the midwife getting to know the woman, her needs, and that of her family.

It is worthy of note that studies that have emphasised on mutuality and reciprocity within the midwife-woman relationship have mostly been carried out in high-income countries and within continuity of care models which involve midwives' continuous presence with women throughout the continuum of care (Bradfield, Hauck, Kelly et al., 2019; McAra-Couper, Gilkison, Crowther et al., 2014; McCourt and Stevens, 2009; Walsh, 1999). Contrary to these, this study focused on the intrapartum period within a lower-middle- income country and in this context, care was fragmented because women were often meeting the midwives for the first time. Midwives articulated establishing a midwife-woman relationship and acknowledged the importance of an appropriate approach during the first meeting and the establishment good rapport. However, its practicability was hindered by several factors (discussed in chapter 5 and 6) resulting in midwives' emphasis on reciprocity.

Although midwives conceptualised the mutuality and reciprocity as aspects of RMC, they also alluded to the principles of woman-centred care. In this study, midwives embraced woman-centred care that was individualised in nature with the constant presence of a midwife or birth companion with the woman, and this is central to the 'with woman' philosophy. The midwife-woman relationship is said to be an essential source of fulfilment for the midwife and the childbearing woman and the enhancement of normal reproductive processes (Hunter, Berg, Lundgren et al., 2008; Kirkham, 2010; Leap, Dahlen, Brodie et al., 2011; Renfrew, McFadden, Bastos et al., 2014). This relationship has been the focus of discussions on choice, decision-making, autonomy, continuity of care models, and the medicalisation of childbirth (Noseworthy, Phibbs, and Benn, 2013) and this is also gaining attention within the RMC discourse (De Kok et al., 2020).

Midwives' perception of RMC as woman-centred involved women's participation in decision-making and ensuring supportive care through a friendly relationship and being with women which was similar to the findings in the scoping review in chapter two (Moridi et al., 2020b; Sheferaw et al., 2016). Another similarity with the findings within the scoping review was that, though midwives embraced this philosophy theoretically, this was not the practice in most of the facilities as there were far fewer midwives than women in labour (Dzomeku, Mensah, et al., 2020b; Moyer et al., 2021). Nonetheless, other authors have identified midwifery presence and being with women across the continuum of care as integral for the 'with woman' philosophy (Bradfield, Duggan, Hauck et al., 2018), making it vital for the enhancement of midwifery care and thus RMC. Researchers in high-income countries like the UK, New Zealand, and Australia have asserted that 'being with women' facilitates empowerment of women, enhances their confidence, and provides the foundation for working in partnership with women (Bradfield et al., 2019; Carolan and Hodnett, 2007; McAra-Couper et al., 2014).

Whilst there was an acknowledgement of the value of birth companions, evidence from this study highlighted a defensive approach to practice and to the understanding of RMC based on vigilance and enforcement. In hospital A, care providers insisted rather than encouraged the presence of companions because they served as eyewitnesses of the care that women received. Similarly, findings from the scoping review in chapter two indicated that women with companions were less likely to be mistreated (Adane et al., 2021; Arsenault et al., 2020). This defensive approach to the understanding of RMC and to practice signifies mistrust that may undermine the 'with woman' philosophy. Midwives in this study articulated the feeling of blame for the deficiencies within the health system and a perceived unpleasant impression of their practice had been created within the public sphere without cognisance of these deficiencies. Hence, the need for what one midwife keenly put '*people to come and see what we go through'*. This implies that in the contextual dynamics within which maternity care is placed in Ghana, RMC does not only need to be provided and experienced but also

witnessed to confirm its provision. Though, Shakibazadeh et al. (2018) and other authors of the papers included in the scoping review also alluded to continuous access to support as a component of RMC, an expansion on its contextual nature was not provided. Therefore, the findings from this study present additional knowledge. This finding also revealed a fractured midwife-woman relationship and exposed intrinsic problems such as distrust within this relationship which will be discussed in detail in the section 8.2.3.

This notwithstanding, 'being with women' during the continuum of care (Bradfield et al., 2018) was quite the contrary in this study. Within the Ghanaian context, women were mostly meeting their midwives for the first-time during labour, hence the initial approach utilised during this first encounter was vital. Though midwives demonstrated some ability to establish rapport during this encounter, the condition in which women arrived was often not conducive for this process. The club 36 initiative (see section 4.2.2) implemented in some facilities (though unsuccessfully) offered women the opportunity to meet midwives before they went into labour. This was, however, not in any way similar to the known midwife practiced within models such as the caseload midwifery. This is because women were not assigned any known midwife but could have any midwife on duty attend to them when they reported in labour. As such the same outcomes within the continuity of carer models could not be expected with club 36. The evidence from studies carried out in similar settings (Dzomeku, Mensah, et al., 2020b; Manu et al., 2021; Moyer et al., 2021) identified in the scoping review does not provide any information in this regard. Therefore, this finding also extends the nature of the evidence in relation to companionship and the establishment of rapport as components of RMC.

Furthermore, there is a lack of evidence on approaches that could be utilised to establish rapport when prior relationships are not already established within the broader literature. Albeit the lack of trust in the professional status of midwives makes establishing rapport difficult necessitating the need to address the causative mechanisms influencing RMC. Midwives, however, utilised cultural and religious values to gain an entry into the relationship

with women which enabled them to provide support during the process of childbirth. This is illuminated below.

8.2.2. Relational spirituality and the notion of kinship attachment: embodied values as moral and relational ethics of care

A key causative mechanism and a significant finding in this study with causal connection to the presence of RMC was midwives' embodied values. In this study, midwives used their shared religious backgrounds to develop a supportive relationship with women. Though it was not ascertained if all midwives who entered this sacred space with women had a shared background with them, it enhanced the supportive care provided for women. This was not noted in any of the studies in the scoping review in chapter two. Hence, this finding is vital in extending the evidence on the conceptualisation of RMC in a contextually significant manner. Some midwives sang religious songs with women or for women upon their request, responded to women's prayers, and used religious texts to offer encouragement as a form of coping mechanism as there was no pharmacological pain relief. This was also a form of assurance of the midwife's spiritual presence with women and for women who exhibited signs of fear of unsafe childbirth outcomes, this served as an assurance of safety. Some women who had birth companions, also had this spiritual presence from their companions. These practices were adopted by midwives to establish supportive relationships with women making culture a vital aspect of the midwife-woman relationship and RMC.

Within this specific social environment, safety is not only a justification for mistreatment (as reported in the scoping review in chapter two) but a social construction surrounding birth, though the means to achieving this was sometimes subversive. Childbirth in Ghana is viewed as a dangerous life passage (Wilkinson and Callister, 2010). As such religious practices are integrated into the experience of pregnancy and childbirth, as a coping mechanism, to avert any negative consequences and as an assurance of safety (Aziato, Odai, and Omenyo, 2016). The focus on the fetus is not merely a biomedical issue, but it is

deeply ingrained into the cultural connotations of childbirth where the life of the mother and the fetus are equally important. Hence, childbirth practices are steeped in tradition, spiritual values are an aspect of this tradition and this exerts significant influence on women's decision-making and utilisation of maternal health services (Dapaah and Nachinaab, 2019). In the contextual culture within the study settings, therefore, spirituality and childbirth have an intimate connection and so in including themselves in the woman's inner world, midwives genuinely became responsive to the woman which had positive connotations on RMC, according to evidence from this study.

The spiritual tradition was routine in the facilities involved in this study, with morning prayers marking the beginning of a working day. Midwives incorporated this tradition and the nature of this, in this study, was also seen in midwives' view of their profession as a calling to serve, to make a difference in the reduction of MMR, and to provide safe maternal care for women in their communities. In similarity with this study, Lindh, Severinsson, and Berg (2007) reported that student nurses were guided by their inherent values and ideals such as helping others and humaneness in their choice of nursing as a profession. Some midwives in this current study, however, perceived this as a popular view, rather than their personal sentiments and stated that their desire to practice midwifery emanated from the ease in gaining employment and job stability.

Hall (2015) asserts that spirituality and compassion in care are inextricably linked, thus some midwives and stakeholders in this current study perceived that midwives with the fear of God would not disrespect women because the tenets of their belief system did not permit them to act in a particular manner. Rather the depth of care was beyond the professional relationship and the woman was served as a manifestation of service to a deity. However, religious beliefs were also sometimes utilised to justify the absence of support for women especially during pain because pain in childbirth was considered something which was Biblical (Smith, Banay, Zimmerman et al., 2020). In their research conducted in Ghana, Aziato et al. (2016) also indicated that some midwives prevented women from singing because they were not

the only ones on the ward and their singing was disturbing others. Nonetheless, the societal view of safety as intrinsically related to childbirth makes relational spirituality and the spiritual presence of a midwife offer a safe space and an existential meaning for women. This also has the capacity to enhance the midwife-woman relationship, the provision of RMC, and offer hope and assurance of a safe birth. For midwives and stakeholders who embodied this spiritual value, it enabled them to bond with women, it served as a moral impetus, source of strength, and a form of encouragement to spur on with their duties and to do it to the best of their abilities regardless of the challenges they encountered. Establishing a supportive relationship with women was also done using embodied cultural norms- the cultural notion of kinship attachment.

The morality of the midwife-woman relationship did not only include spirituality but also the morality inherent within the sense of communal belonging: regarding women as sisters or relatives. This is characteristic of African communitarianism which is a view that the individual is not an isolated being but is embedded within social relationships and the system of interdependence (Christians, 2004). This ideology presumes that the identity and human dignity of the individual is constructed by the social dimension of their being (Ogunbanjo and Knapp van Bogaert, 2005). Some critics of African communitarianism have argued that community may include patriarchal and other forms of domination which often disadvantages women. Metz (2013), however, argues that the form of morality within communitarianism is a combination of identity and solidarity and the value is placed not just on caring for others but sharing in the way of life of others. For instance, there are cultural practices within the Ghanaian society which humiliates women who are unable to cope with labour pains and manifest behaviours which are deemed culturally inappropriate. Therefore, facilities may be expressing the solidarity that is inherent in African communitarianism with women by ensuring that birth companions are trusted family members who are unlikely to humiliate women if they exhibit such culturally unacceptable behaviours. Thus, deciding the birth companions may not necessarily be to exert control but to express their embodied value of

kinship attachment. Though this does not promote woman-centredness in a liberal sense, it may be an expression of the solidarity characteristic of African communitarianism. These facets of culture were utilised by midwives to ascribe moral value to their caring ethics and may prove valuable to enhancing relational respect when utilised in a woman-centred manner.

Based on this same morality, however, midwives stressed reciprocity which requires women to also treat them as they would treat their sisters or relatives. Gyekye (2011) described a notion of common good within the African societal ethic which emphasises on mutual helpfulness, collective responsibility, cooperation, interdependence, and reciprocal obligations. *Wo yonko da ne wo da* (your neighbour's circumstance is potentially yours), was an Akan (one of the ethnic groups in Ghana) proverb used by Gyekye (2011) to explain the interdependent and reciprocal nature of relationships. This expresses that the African ethic included duty and was not solely rights. This perhaps explains why some midwives in this current study perceived that a woman's rights did not supersede theirs, stating that women who did not respect them should not expect to be respected. It may also confirm the critique of the rights-based approach to RMC in Malawi noted in the scoping review in chapter two, which De Kok et al. (2020) stated had the potential of resulting in challenges rather than promoting respect.

The importance of culture has been emphasised by McFadden et al. (2013) who identified that cultural misunderstanding underpinned a failure to address women's individual needs when providing breastfeeding support for women of Bangladeshi origins in the UK. Contextualisation of constructs is applied to the conceptualisation of RMC in this study which was not the case in the scoping review in chapter two. This study, therefore, presents vital evidence for the adoption of the embodied values inherent within spirituality and African-communitarianism in the conceptualisation of RMC in a manner that facilitates woman-centred care. Robust research is essential to gain deeper insight into how embodied values within the Ghanaian ideal of community and spirituality can be incorporated into care within

the Ghanaian context to facilitate relational respect, promote trust, and enhance the midwife-woman relationship. This notwithstanding, one of the causative mechanisms that was identified in this study was women's lack of trust in the healthcare system and this had negative influences on their relationship with midwives and subsequently on RMC. This is further illuminated in the proceeding section.

8.2.3. Relational (dis)trust

This study revealed elements of distrust between midwives, women, other professionals, and in the health system as a whole. In this study a dual level of distrust was highlighted, firstly at the broader level of the health system or institution and secondly on a more personal level of the care providers. Women's lack of trust in the health system postulated as a causative mechanism for the lack of RMC, was formed by the broader societal poor opinion of the system because of the inherent deficiencies and the poor delivery of care. There was a connection between trust in the health system and trust of the professionals working within it. To exemplify this, evidence from the study affirmed that without any personal knowledge, some women and their companions distrusted not just midwives but health professionals in general. Women formulated their own ideologies about who a competent professional was on grounds of personal identities that may not have bearings on their skills, thus rejecting care from them and exhibiting suboptimal cooperation. There were many misunderstandings, reciprocal blaming, and personalisation of certain situations which occurred during the delivery of care, congruent with findings by De Kok et al. (2020) in the scoping review in chapter two.

Women's lack of trust was linked with reduced cooperation which heightened midwives' frustrations, and this was vented on women resulting in disrespect. This concurs with Gilson (2005) and De Kok et al. (2020) who stated that trust affected the behaviour of people seeking health services, facilitated their collective actions, and the capacity for cooperation amongst people within the health service. Thus, trust and RMC are intricately linked and the

absence of the former, influenced the presence of the latter. Therefore, to gain women's trust and confidence to facilitate the provision of care, midwives were not entirely truthful about who they were and their personal experiences. For example, according to midwives, women felt midwives who did not have childbirth experiences lacked the skill to care for them causing midwives to lie about having had children. Although not in the RMC research, other authors have similarly found in their studies that some characteristics such as age, cultural background, and previous childbirth experience partly had an influence on women's tendency to build trusting relations with midwives and with the wider care system (Huber and Sandall, 2006). On the contrary, Lewis, Jones, and Hunter (2017) found in their study that some of the women who linked empathy with midwives who had experienced childbirth, received it from midwives with no childbirth experience. Though there was no concrete evidence in this current study to confirm or refute any of these assertions, midwives purported that women attributed their physical size with childbirth and so midwives who had had previous childbirth experience were not regarded as such by women because of their size. Furthermore, it was noted that with regards to culture, women usually had some degree of affinity for midwives who were from their tribe or spoke the same language with them and were more inclined towards cooperation when such midwives were caring for them which has not been reported in RMC studies in similar settings.

For the midwives in this study, professional values such as commitment to duty, empathy, being polite, and the friendliness that was created by the occasional jokes within the labour ward fostered an environment where RMC could be provided, and women could freely express themselves and build trust. Inherent within these professional values was also the ability to communicate effectively. These were pervasive in the scoping review in chapter two and in this study. Communication is key to the provision of RMC and enhancing trustful relationships and similar to the scoping review, this was largely problematic in this study. There was firstly the local problem of language barrier and secondly the more global problem of explaining pathophysiology by translating from English to a local language in

order to ensure informed choice and obtain informed consent. Where there was a language barrier, there was limited information giving and suboptimal cooperation from women and a subsequent lack of RMC. Furthermore, whilst women did not trust midwives, midwives also did not trust women to make the right decisions concerning their care when complications arose and so withheld information from them, thus revealing reciprocal distrust and a lack of RMC.

Midwives and women thrive when there is reciprocity of trust (Hunter and Deery, 2009) but for the woman, trusting herself, her care providers, and the wider healthcare system will ensure optimal cooperation with the delivery of care, facilitate the provision of RMC, and the enhancement of the childbirth experience. Midwives' assertions about their rejected professional identity in this study suggests women's need for safety and an expectation of a competent provider. Midwives' share in this need and this has been the dominant reason for the absence of RMC in this study and the scoping review in chapter two. Therefore, whilst there was distrust in women for their inability to make safe decisions, women also distrusted midwives and the impoverished system within which they function for their inability to provide safe care, and this was a hinderance for the provision of RMC. This is congruent with the findings of Lewis et al. (2017) who investigated women's experience of trust within the midwife-woman relationship. They concluded that trust was a fluid phenomenon developed over time and it was interconnected with women's agency. The researchers also indicated that women expected a two-way demonstration of trust where midwives trusted in the capacity of women to make decisions and women trusted in the skill of midwives.

Within the context of this study, women who utilised the facilities were often reliant on the professional knowledge of midwives, however, midwives did not trust women's embodied knowledge as much as women trusted their professional knowledge. Nonetheless, sometimes there may be unrealistic expectations from care receivers within this impoverished system which have the capacity to spur misunderstandings and conflicts and further worsen the vulnerable state of the woman and promote distrust and subsequently a

lack of RMC. I, therefore, concur with De Kok et al. (2020) who identified trust as linked with RMC, that an understanding of the conditions within which midwives work will promote trust. Based on evidence from this current study, I also highlight that a mutual understanding and promotion of the concept of respect will also enhance trust within this reciprocally respectful midwife-woman relationship. The mutual respect and acceptance will enable the evolution of trust over the course of time within the framework of RMC.

The vulnerability of a woman when seeking care makes her dependent on midwives and the optimum delivery of care is based on the professional skills of midwives, revealing a system of interdependence. Within this interdependent relationship, however, women are autonomous recipients of care who have free will and the ability to make autonomous decisions about their care when given the information needed to do so, as epitomised within the RMC concept. These issues which emerged from the study are discussed further below.

8.2.4. Dependence and relational interdependence

The section above highlighted the connection between trust and RMC, reinforced the need for provider trustworthiness, and the importance of a collective understanding of key concepts that promote trust and respect within the midwife-woman relationship. This is carried out with full cognisance of the contextual nuances that adversely affect the optimal provision of care. The nature of vulnerability mentioned in the final paragraph of the previous section does not depict neediness or helplessness but an embodied ontological condition, that is, the unavoidable and intrinsic human need to be dependent on others (Mackenzie, Rogers, and Dodds, 2014; Rogers, Mackenzie, and Dodds, 2012). This ontological condition is, however, exacerbated during situations such as pregnancy, labour, childbirth, and the postnatal period where care is needed, exposing care seekers to the actions of care providers, and increasing their dependence on care providers.

The concept of dependence emerged in this study when the deficits within the healthcare system made women heavily reliant on midwives to provide not just clinical care but sometimes basic needs such as food, clothing for babies (with their own money), ensure that relatives had donated blood in case of an emergency, and facilitate the payment of bills for other services not covered by the NHIS. These deficits were significant structural features that were identified to have adverse impact on RMC. These deficits were also found in a study by Dzomeku, Mensah, et al. (2020b) in the scoping review in chapter two, where midwives reported buying items for women with their own monies. The woman's care, therefore, becomes significantly dependent on the midwife's ability to smoothly negotiate through this fragmented and impoverished system and the woman's needs and ensure a balance between these seemingly competing pressures and demands. This situation could rightly be described as midwifing the facility rather than the woman because the midwife's focus was shifted from the woman's needs to meeting the deficits and demands of the institution.

Van der Weele, Bredewold, Leget et al. (2020) have described dependence as fundamental to caring relationships. Dodds (2014), however, distinguished vulnerability from dependence and defined dependence as a form of vulnerability that makes an individual reliant on others to fulfil the individual's needs and promote and support the individual's autonomy and agency. Dependency has mostly been used by feminist philosophers in areas such as care in disability, aging, and long-term illness where care receivers' conditions limited their degree of personal autonomy (Davy, 2019; Fine and Glendinning, 2005; Kittay, 2011). This concept is relevant in explaining the conditions that result in women's exacerbated dependence on midwives leading to the lack of RMC. However contrary to the assertion by Van der Weele et al. (2020), dependence in this study was not a matter of supporting women's needs and promoting their autonomy and agency. Rather, it was the presence of systemic constraints that had exacerbated women's dependence on midwives and resulted in the exertion of discretionary control over the birthing process. Though these constraints and the power and

control over the birthing process have been identified by previous authors (Bradley, 2018; Moyer et al., 2021) in the scoping review in chapter two, the concept of dependency was not highlighted. This study, therefore, extends the interpretation of the evidence by positing that these deficiencies resulted in dependency by heightening the power differentials between midwives and women and the more powerful, which was the midwife and the institution, exerting control at their discretion. It further promoted the belief that women owed the midwives, and this gave way for conflicts and misunderstandings and objectionably paternalistic and coercive encounters ridding women of their agency and autonomy.

Mackenzie et al. (2014) and Kittay (2011) have argued that dependence and autonomy are not opposing concepts and have discarded the negative notions about dependence that stimulates control from the powerful and rather viewed dependence as an opportunity to promote capacities for autonomy. Mackenzie (2014) further argued that ontological vulnerability which causes dependence is exacerbated by structural and political mechanisms. In confirmation of this assertion, the study revealed that structural deficiencies and institutional policies limited women's capacity to make autonomous decisions or take actions about their births. For instance, even for facilities where there was the capacity for women to have a birth companion, informal hospital policies dictated the type of companion the woman could have, and this was based on societal norms such as having only close relatives witnessing a woman's birth. These norms were, thus, given precedence over women's autonomous choice. Furthermore, dependence of women on midwives and the health system was intensified by the knowledge gap between midwives and women.

Midwives' philosophy of care was based on their view of themselves as the epitome of childbirth knowledge; knowing what was best for the woman and fostering a need for women to do as they were told on the grounds of safety. It has been evidenced that childbirth knowledge constructed by healthcare professionals and used in developing institutional protocols has dominated childbirth discourses (Moore, 2011; Walsh, 2005), disregarding women's embodied knowledge. This has been utilised in the control of women's bodies

during the childbirth process. Similarly, Bradley et al. (2019) used controlling women's bodies and controlling knowledge as overarching themes to describe components of the care provided by midwives. These are forms of paternalism that are incompatible with the woman-centred approach to maternity care which has been affirmed by midwives in this study. To echo the findings in the scoping review in chapter two, midwives in this study purported that, positions of power and control were taken because when outcomes were adverse, women blamed them for it. Several studies in the scoping review described these controlling practices as justification for mistreatment on the grounds of safety (Bradley, 2018; Moyer et al., 2021). However, contrary to these studies, justification is not the only explanation given to these in this study. The identification of causative mechanisms using CR facilitated an exploration of the real reality that resulted in these controlling practices-structural and gender-based violence which will be further discussed in section 8.3.

Nonetheless, in this study, there was reduced autonomy when there were perceived risks to women, lower literacy levels, and the fear of possible refusal of procedures and blame for adverse outcomes and this was similar to the findings in the scoping review in chapter two. Therefore, to ensure that women are adequately supported when navigating through the provision of choice and decision-making within the Ghanaian setting, significant consideration of women's information needs and an assessment of women's capacity to accept outcomes and consequences of decisions should be made. Furthermore, midwives' articulation of the need to bridge the information gap is a recognition of the interdependent nature of the relationship. Interdependence here refers to the reliance on midwives' knowledge for information on childbirth and midwives' reliance on women's ability to utilise this information in their own decision-making about their care and the reciprocal trust that is required during this process to facilitate the co-creation of a safe and respectful experience of care for both women and midwives. Fine and Glendinning (2005) believed that interdependence acknowledges dependency in relationships but also recognises that interdependence arises from reciprocity between partners during an exchange that occurs

over time. Best outcomes are seen when there is harmony between midwives' and women's actions (Fleming, 1998). Interdependence, therefore, reflects a collaborative approach to midwifery care and it is very much woman-centred, focusing on women's autonomy and decision-making capacities.

Therefore, based on the evidence from this study, I propose a concept of relational interdependence that facilitates trust, autonomy, informed choice, and collaboration in decision-making within the value-based woman-centred midwife-woman relationship. Within this concept, midwives are a reliable source of childbirth knowledge which empowers women to become active participants in their care. In that same regard, midwives gain trust in women's embodied knowledge and can support them to utilise both knowledge in their decision-making. In developing this relational interdependence and collaboration, beliefs, values, and cultural practices could play a pivotal role in reshaping practice in a more woman-centred and culturally acceptable way. The facets of culture described in section 8.2.2 would be beneficial in this regard.

Though the study focused on midwives and stakeholders, another key finding was the influence of other health professionals on midwives' relationship with women and subsequently on RMC. A discussion of relational collaboration within the labour ward culture is, therefore, presented in the section below.

8.2.5. Collaborative relations

Though the midwife is the primary care giver for women during maternity care in Ghana, the woman needs other health professionals when emergencies and complications arise and if quality and respectful care is to be provided during these circumstances, a collaborative environment is needed. This is characteristic not just of maternity care in Ghana but of midwifery practice (Downe, Finlayson, and Fleming, 2010). A key finding in this study and a factor that influenced RMC was that IPC was largely absent and this had significant

ramifications not just on the quality of care and women's safety, but on RMC specifically. In a review by Heatley and Kruske (2011 p.55) aimed at clarifying the key elements within IPC in the Australian context, the authors defined interprofessional collaboration as *"a reflexive and dynamic process that involves maternity care professionals from multiple professions working together with the woman to produce quality outcomes. Responsibility and accountability are shared in terms of appropriate level of involvement of a professional with the woman from pregnancy through to the postnatal period".*

This definition suggests a woman-centred approach to decision-making regarding care which was usually not the situation in this study, and which was congruent with the findings in the scoping review in chapter two. On the few occasions where midwives demonstrated support for a woman-centred approach, the doctor's dominant authority took precedence and midwives simply complied to avoid conflict. This may be a result of the emphasis on safe outcomes, the role doctors play in this, and a possible fear that doctors may neglect the woman if she did not comply. Midwifery has historically been positioned as subservient to other groups within maternity care and have been compliant rather than openly challenging of biomedicine (Hunter, 2005). This has been the basis of conflicting encounters observed and reported by midwives during this study. There was conflict between midwives which emanated from the lack of resources and the projection of pressure from higher authorities including pressure from conflicts with doctors which had implications on RMC. This was a consistent finding in all three facilities involved in this study, however, the problem has not been recognised in any RMC related research within similar contexts or within the scoping review in chapter two (Dzomeku, Mensah, et al., 2020b; Moyer et al., 2021). This finding, therefore, presents new knowledge to the existing evidence on RMC. Research that have identified interprofessional conflict within interprofessional relationships, however, identified conflicting ideologies underpinning practice as the main cause (Hunter, 2005; Kennedy and Lyndon, 2008; Vedam, Stoll, Schummers et al., 2014). In the ethnographic study by Hunter (2005) for example, the researcher emphasised that junior midwives whose approach to

care was centred on a ‘with-woman’ philosophy often had conflicting encounters with senior midwives whose position was in allegiance with institutions.

This study significantly emphasised that structural features such as the absence of resources had significantly impacted on collaborative relationships between midwives and between midwives and other health professionals. There often were arguments, misunderstandings, and conflicts between midwives and other health professionals and unfortunately women were caught in the middle. Due to midwives’ lead role in women’s care, other health professionals exerted pressure on them to ensure women and their companions complied with hospital policies and interventions which often led to women being disrespected because the pressure was deflected onto them. For instance, midwives were expected to be the ones to ensure blood transfused were replaced by relatives, ensure women had agreed to procedures like CS, and doctors spoke harshly to midwives when women had not complied within the time frame that doctors deemed appropriate. Whilst the common goal of safety was shared by both doctors and midwives (Hastie and Fahy, 2011), the means of doing this led to disrespect of women and subjected midwives to certain forms of abuse. This indicates that for women who require specialist care during childbirth, RMC is greatly influenced by collaboration between all professionals who will be involved in the care.

The conflict between midwives and doctors, in this study, however, was not based on ideological differences as purported by other researchers (Kennedy and Lyndon, 2008; Vedam et al., 2014), but on the organisation of care and the subservient role of midwives within the organisational hierarchy of authority. Where there were system failures, the midwives who were the ‘face’ of the system bore the brunt and where women and their companions even failed to fulfil their obligations, midwives bore the brunt as well. To exemplify this, when a doctor came to the ward for ward rounds and still met visitors who the midwives had failed on several occasions to persuade to leave the ward after visiting hours, he blamed the midwife, spoke harshly to her in front of women and the visitors, and refused to perform his duties unless the midwives managed the situation. This constitutes neglect

and presents a very detached and impersonal approach to care and as iterated in section 8.2.4, an over dependence of women's care on midwives' ability to negotiate through the challenges of the health system.

Additionally, midwives struggled to put teams of professionals together during emergencies and the delayed response from doctors when called for emergencies put immense pressure from birth companions on midwives which often resulted in conflicts. Unfortunately, women were experiencing the consequences of these conflicts and delays in terms of mortalities and morbidities as well as the disrespect of burnt-out midwives. It is established and evidence continues to indicate that one of the delays that causes significantly high maternal mortality is the delay in receiving care on reaching the facility (Mgawadere, Unkels, Kazembe et al., 2017; Thaddeus and Maine, 1994) and this study is highlighting one of the factors that causes this delay; lack of trust in midwives' decision-making and diagnosis of emergencies and the consequent difficulties they encounter in putting interdisciplinary teams together for these emergencies. Furthermore, similar to the assertions by midwives in the study by Bradley (2018) identified in the scoping review, midwives were blamed for these mortalities and have, therefore, justified their D&A on these high stakes (Dzomeku, Mensah, et al., 2020a; Rominski et al., 2017) especially when emergency care will not be readily available when needed. This also presents a strong connection between safety and RMC. In addition, it extends the RMC discourse beyond how midwives are treating women to include IPC and its effects on RMC and the effect of system challenges on the normalisation of disrespect and accountability. Cooperation, coordination, mutual trust, respect, and a sense of accountability are all essential in ensuring collaborative practice (Keleher, 1998) and based on the discussions above, these are also essential in ensuring RMC. Hence, interpersonal relationships and the discourses needed in the performance of tasks within the healthcare system are vital. The next section offers a discussion of the systemic forces and structures that have influenced the midwife-woman relationship and thus the provision of RMC.

8.3. The provision of care under stress

Evidence derived from this study suggests that the high MMR and the constraints within the system have resulted in a persistent fear of adverse outcomes, the seemingly competitive demand between RMC and optimum maternal health outcomes, and consequently risk aversion; one of the identified causative mechanisms influencing RMC. The trauma associated with the exposure to the high MMRs may have detrimental effects on midwives' interaction with women which may not have been recognised. The following discussion will illuminate the stresses under which midwives provide maternity care. Insights from the findings will be explored by developing an explanatory account of the causative mechanisms identified. Thus, using feminist interpretations to explore violence against women providing care and against women receiving care. In addition, using structural violence as a theoretical framework, exposition will be given on the structures and mechanisms that have resulted in these stressors, consequent mistreatment of both women and midwives, and the hierarchical exertion of power intrinsic to these structures.

8.3.1. Respectful maternity care and gender-based violence using feminist interpretations

The narrative of the findings within this study has exposed the structures and powers within the health system that have resulted not only in the mistreatment of women seeking maternity care but also the mistreatment of the midwives providing the care, who were all women. For this reason, one way of understanding RMC and the structures shaping its provision is in relation to theories of gender-based violence and feminism. At the heart of the mistreatment of women observed in this study are various forms of social inequalities that position women at the bottom of the social ladder. The various forms of violence and subordination exposed in this study and in the scoping review in chapter two are evidence of the low status of women within society and symbolic of the patriarchal power entrenched within the healthcare system. Yodanis (2004) argued that when men dominate the social

structures such as politics, economy, family, health, and policies, violence become a tool that nurtures the subordination of women. Feminist researchers within childbirth discourses have also highlighted the power related issues within the medical models of birth, where care providers are the experts with authoritative knowledge and practices (Chadwick, 2018; Davis-Floyd and Sargent, 1997). Within this framework, the female dominated midwifery profession is subordinated to the male dominated doctors (Walsh and Devane, 2012) particularly when there are perceived risks.

In this study, the evidence of violence was noted in the delays in receiving treatment in health facilities which is highlighted in the 'too little too late' discourse (Miller, Abalos, Chamillard et al., 2016) prevalent in countries like Ghana. In the current study settings, midwives' diagnoses were undermined by doctors leading to delays in interventions and then midwives verbally abused when they were unsuccessful in making women consent to interventions within a time frame appropriate to doctors. Additionally, midwives were blamed for these delays and subsequent adverse outcomes by managers and the public who may be oblivious to the processes inherent in the provision of care. Therefore, within the RMC discourse, violence against women includes midwives who though may be perpetrators of mistreatment of women, are themselves women subjugated within the patriarchal system and reproducers of the domineering powers within it. Recognising gender-based violence as a causative mechanism influencing RMC and thus the gendered nature of RMC focuses its central element not just on its behavioural aspects but equally on the structures within which women are constructed as passive objects with no knowledge, agency, or power. In a scoping review examining how structural violence contributed to violence against women, Montesanti and Thurston (2015) emphasised that the unequal access to the social determinants of health created an environment where interpersonal violence thrived resulting in gendered violence against women in vulnerable situations and the consequent negative impact on their health. Structural violence will be further illuminated in section 8.3.4.

Feminist analyses of violence against women particularly in childbirth have been a central discourse within obstetric violence and the technocratic narratives around childbirth. These feminist analyses have accentuated that the medicalisation of childbirth is carried out within patriarchal power structures that jeopardise women's femininity, embodied capabilities, and bodily autonomy and agency (Sadler, Santos, Ruiz-Berdún et al., 2016; Shabot, 2016). Though research on obstetric violence and the technocratic narratives have their locus of attention on the unnecessary medicalisation of childbirth, unnecessary medicalisation was not documented in this study. Nonetheless, the assertions about violence against women within the technocratic narratives are relevant within the RMC discourse. This is because the patriarchal and paternalistic processes and structures that normalise unnecessary medicalisation are that which normalises other forms of mistreatment of women.

These notwithstanding, with regards to the mistreatment of women in childbirth, midwives through their actions have become complicit with the system which oppresses them. In using their authoritative knowledge and position of power in relation to the birthing women to mistreat them, midwives are actively participating in the production of their own subordination. However, midwives in this study seemed to be defending or protecting themselves rather than gaining power from this patriarchal system. Hence, rather than constructing D&A through the lens of midwives as perpetrators and women as victims as identified in the scoping review in chapter two, it is necessary to recognise violence against women as a causative mechanism for the mistreatment of midwives and women seeking maternity care and the dynamics of power within maternity care deconstructed. Both women and midwives ought to be empowered to establish a system of interdependence (described in section 8.2.4) that enhances trust, collaboration, and a woman-centred approach to care. This can be achieved by redefining the midwife-woman relationship within these contexts, the interactions within this relationship, and recognising the interactions outside of this relationship which have impact on it. However, this cannot be carried out without a full recognition of the realities of care. The following sections will, therefore, provide a discussion

of the systemic realities shaping midwives' agency, the midwife-woman relationship, and subsequently RMC.

8.3.2. Fear, risk aversion, and the exposure to trauma

Participants in this study placed strong emphasis on maternal mortality and morbidities and these sometimes served as a justification for the normalisation of mistreatment. This was consistent in all three sites involved in the study and this is also consistent with reports from other studies described in the scoping review in chapter two (Bradley, 2018; Erlandsson et al., 2014). To both midwives and stakeholders, the reduction in MMRs were an indication of improved quality of care. As such, though midwives embraced a relationship-based and woman-centred approach to care, this was mostly in theory and not in practice as clinical outcomes were prioritised over women's experience of RMC. The responsibility and blame for these adverse outcomes were ascribed to midwives, therefore, ensuring a safe outcome was the priority and the means for achieving this was not a matter of equal concern.

The findings indicate that midwives adopted actions that were intended for the good of women and for the promotion of safe childbirth outcomes which was similarly reported the scoping review in chapter two. Several factors were identified which had influenced the adoption of these and central to these was the fear of blame for adverse outcomes. To move beyond justification, in many ways midwives seemed to be practising 'protective' maternity care – trying to protect women/babies from adverse outcomes but also needing to protect themselves from blame when adverse outcomes arose. This resulted in risk aversion, another causative mechanism influencing RMC identified through CR. Midwives reiterated that they were blamed for practically everything that went wrong during the provision of maternity care, from the breakdown of equipment, the negative consequences of women's involvement in the decision-making and delays from other health professionals to adverse outcomes which occur as a result of the systemic constraints. Therefore, fear was a precursor to the utilisation of approaches which midwives themselves identified as abusive

to women. This fear coupled with the absence of prompt emergency response discussed in earlier sections made midwives risk averse.

The focus on risk prevention in maternity care is a significant aspect of discourses around the midwifery and biomedical models of care in high-income countries and the prevalence of unnecessary interventions intrinsic of the latter (Bryers and Van Teijlingen, 2010; Healy, Humphreys, and Kennedy, 2016; Miller et al., 2016). The perceptions of risk in these settings have resulted in higher rates of CS, instrumental deliveries, psychological morbidity, and a reduced rate of women's satisfaction with care (Walsh and Devane, 2012). Within the Ghanaian setting, however, the perception of risk was shaped by the wider societal culture (discussed in section 8.2.2), the lack of resources, and the lack of prompt emergency response. In this study, midwives' demonstration of compassion and empathy were gravely impacted by this fear of adverse outcome and the avoidance of risk. Therefore, the mistreatment of women appeared to be an act of risk aversion unlike other contexts where unnecessary medical interventions were used and performed the same purpose. This was an important insight derived from the study. To illustrate this, a woman requested CS because of her inability to push during the second stage of labour after several encouragement and supportive actions from the midwife. For fear of losing this asphyxiated baby coupled with the inability to provide the requested CS or other instrumental birth because of resource constraints, the midwife used disrespectful means to get the woman to push.

Several studies in the scoping review in chapter two highlighted health professionals' justification of mistreatment on the premise of achieving safe outcomes, however, there was no emphasis on the effect of high mortalities and the lack of prompt emergency response on midwives' notion of risk and the resultant effect on midwives' agency. While the high MMR may be used as a justification for the lack of RMC as is the ubiquitous explanation, the implications are far more than that. The findings from this study highlight that exposure to traumatic events including mortalities does not only result in risk aversion but may have

psychological implications for midwives and a consequent negative influence on their ability to be empathetic, compassionate, and supportive of women. Similar findings have been reported in a study carried out in the UK that explored midwives' experiences of traumatic perinatal events (Sheen, Spiby, and Slade, 2015). The authors of this study found that 40% of midwives reported high levels of emotional exhaustion and 4% reported high levels of depersonalisation. The traumatic events included unexpected and sudden events such as intrauterine death and events which were highly severe in nature such as severe postpartum haemorrhage (Sheen, Spiby, and Slade, 2016). Midwives' access to support or additional personnel contributed to their perception of the trauma. The researchers argued that such midwives were less likely to be compassionate in their care when they had been exposed to trauma (Sheen et al., 2015).

Some studies have been conducted in some low-middle income countries including Ghana, that investigated midwives' lived experiences of mortality and the psychological impacts it had on them (Dartey, Phetlhu, and Phema-Ngaiyaye, 2017; Dartey, Phuma-Ngaiyaye, and Phletlhu, 2017; Muliira and Bezuidenhout, 2015). Muliira and Bezuidenhout (2015) conducted a descriptive study in Uganda to investigate the psychological impact of the exposure to maternal mortality and the coping mechanisms that midwives used. The researchers reported that of the 238 midwives sampled, 94% had witnessed a maternal death, 93% had moderate to high anxiety, 71% had mild to moderate obsession with death, and 53% had mild death depression. The coping mechanism utilised by midwives included venting, and self-destruction. This reveals an alarming number of midwives who have been subjected to these traumatic experiences and the adverse impact that it may be having on them.

Similarly, Dartey, Phetlhu, et al. (2017) investigated the lived experiences of maternal death in Ghana and the researchers categorised their results as 'fear of recurrence of death, fear of maternal death reviews, fear of stigma from the community, fear of lawsuits and withdrawal of license to practice, and the fear of the reactions of family members of the

deceased woman'. Secondary traumatic stress, a consequent of indirect experience of traumatic events has the capacity to reduce an individual's ability to provide sensitive care and adversely affects the organisational climate (Figley, 1995). Indirect exposure to extreme traumatic events which results in secondary traumatic stress and compassion fatigue, therefore, ought to be considered as similar to that encountered by patients with primary or direct exposure (Beck and Gable, 2012). Midwives in this current study, bore a double trauma because of their direct exposure to traumatic events within the maternity care system during their own pregnancies and childbirth and through the abuse they experience in their line of duty, which may further impact on their ability to be supportive of women. The findings from this study, therefore, provide evidence for the extension of the interpretation of the views of providers on RMC beyond only the justification of abuse to include the psychological impact of traumatic experiences. In this study, midwives' expressed emotions were that of stress and frustration, and this is further discussed below.

8.3.3. Stress

Midwives made emotional expressions such as *stressed up, stressful, frustrated, tired,* and even for stakeholders who are responsible for providing an enabling environment for midwives, stress seemed a normalised justification for midwives' actions. The work environment was physically and emotionally intense which gave rise to physical and emotional distress and the seemingly competing demands between women's expectations for RMC and the need to prevent adverse outcomes. However, the choice made of these demands reflects the dynamics of power and an untenable working environment; thus, where midwives can best exert control without accountability within the resource constrained environment. The system related factors, particularly the absence of beds, policy, guidelines, and inadequate staffing levels have been widely reported by researchers like Dzomeku, Mensah, et al. (2020a), who investigated midwives' understanding of D&A in Ghana. The use of these stressors as justification for D&A was also well documented in the scoping

review in chapter two (Bradley et al., 2019; Erlandsson et al., 2014; Ndwiga et al., 2017). The absence of these resources is a major bottleneck to quality maternal health and the utilisation of services by women (McFadden et al., 2020). Some studies have also documented the influence of stress and burnout on health professionals' wellbeing and consequently the quality of care (Creedy, Sidebotham, Gamble et al., 2017; Hildingsson, Westlund, and Wiklund, 2013).

In spite of this, there is limited attention to interventions focused on supporting midwives, strategies to maximise limited resources, and the political will needed to provide resources. Additionally, these resource constraints are sometimes not acknowledged as a problem by higher level stakeholders. As highlighted in the scoping review in chapter two, although some interventions have been developed using multistakeholder engagement, interventions implemented were predominantly aimed at attitude transformation of health providers through training without equal attention to the systemic concerns raised. This approach reinforces the notion of providers as perpetrators of mistreatment. In some facilities in this study where staffing levels were inadequate, some stakeholders emphasised that they had enough staff and where relatively adequate staffing levels were noticed, and women being supported through the process of labour, this was due to the presence of rotation and student midwives. However, the use of students during their clinical placements to augment staffing levels prevents adequate supervised learning and perpetuates the learning of mistreatment as an approach to care, enabling the socialisation of students into the culture of mistreatment (Rominski et al., 2017). It is, therefore, worth mentioning, that the lack of recognition of the needs of both midwives and women has the propensity for poor interaction from midwives (Patterson, Martin, and Karatzias, 2019) and stress should not be recognised by stakeholders as a justifiable reason for mistreatment but as a clarion call for the transformational leadership and supportive environment needed for the provision of RMC.

There was not only an absence of supportive leadership to provide an enabling environment for RMC but also the presence of an enduring culture of violence within the care system. The

findings suggest a culture of normalised mistreatment not just of women but of midwives who were all women. There were overt and covert forms of violence exerted within the hierarchical structure of power. This could be attributed to the imbalance of power and the intrinsic disparities that characterised the care system. These structural and cultural features were further analysed using retroduction and structural violence was postulated as the concept with deeper powers that was not empirically observable but had significant causal connection with the absence of RMC. In addition to structural violence as a key causal mechanism, horizontal violence is also adopted as an explanation for the intra professional conflict, and these are discussed further in the section below.

8.3.4. Structural and horizontal violence

The poorly resourced and managed facilities and the lack of supportive leadership were passionately discussed by midwives and stakeholders. There seemed to be high expectations from midwives which were not commensurate with the resources, leadership, and supportive structures available to them. The gap between managerial and public expectations and the available resources and support to meet these expectations had culminated in contentious interpersonal conditions and a toxic culture within the labour ward environment that was rife with violence on different hierarchical levels. The interpersonal conflicts and high levels of disorganisation within the work environment can be problematic for professionals, service users, and the organisation alike (Chamberlain and Hodson, 2010). Though the degree of effect remains open, research suggests that toxicity within the work environment has correlations with staff wellbeing which in turn affects work output (Koropets, 2019). The imbalances of power and deep structural inequalities are characteristic of the term structural violence, and this was postulated as the key causative mechanism for the absence of RMC. The term violence within the concept goes beyond the physical nature of it to include the often indirect, subtle, and invisible systemic harm that the social, economic, political, and cultural structures that constitute the healthcare system inflict

on individuals (De Maio, 2015), including women seeking maternity care and the providers who offer the care.

Farmer (2004 p.307) presents structural violence as the *"violence exerted systematically- that is, indirectly by someone who belongs to a certain social order"*. Farmer draws on the example from the health system in Haiti to reveal the persistent effects of colonisation, racism, poverty, and the political economy on health inequalities, marginalisation, and other forms of oppression. This study identified practices, structures, policies, and processes which fostered inequality, and these had been legitimised over time and resulted in the absence of RMC. For instance, making women provide items needed for labour and paying for some services at the point of care, putting the responsibility of ensuring someone had donated blood for emergencies on women, and health facilities built in such a way that women could neither have companions nor their privacy and dignity preserved during their labour and childbirth.

Furthermore, when midwives and stakeholders were asked during FGDs and SSIs what factors affected their interaction with women during the initial encounter, the consistent response was that women often reported "empty handed" (without the necessary items required for the provision of care). Despite this, some midwives and stakeholders were in support of women providing these items at the point of care regardless of the economic hardships which mostly affect women and the impact it had on the initial encounter discussed in section 4.3. These policies make maternal health increasingly reliant on household contributions and shifts the responsibility of providing comprehensive healthcare from government to individuals. The proponents of structural violence, therefore, argue that violence is built into the social structures, ideologies, and institutions and its manifestations are the inequalities in power, resources, access, and opportunities available to those below the social order (De Maio, 2015). Such a system serves to marginalise, disempower, and 'harm' women as well as the professionals who care for them.

The lack of resources and accountability to ensure women's safety when seeking care during childbirth was a fertile ground for women's disempowerment and the deprivation of their agency. Lack of infrastructure, equipment, and personnel to provide care during normal labour and in emergencies have also been well documented in several studies identified in the scoping review in chapter two (Bradley, 2018; Bradley et al., 2019; Ndwiga et al., 2017), however, structural violence has not been as widely identified as a mechanism that shaped the nature of the care provided within these systems. The mechanisms of disempowerment in this study relied on personal responsibility for aspects of care and this triggered a pathway of vulnerability to negative care provider interactions and subsequent disrespect. Solnes Miltenburg, van Pelt, Meguid et al. (2018) emphasised in their study that whilst care providers may be the perpetrators of abuse, this occurs in a deprived social and political system where the broader needs of women when seeking maternal healthcare are undervalued and ignored. Such a system reveals how poverty and economic dependence exacerbates violence against women seeking maternity care.

Therefore, the view of mistreatment through the narrow framework of women as victims of abuse and providers as perpetrators within the recurrent discourse and the partial perspective of RMC as the 'absence' of mistreatment as highlighted in the scoping review in chapter two needs to be broadened. Health providers themselves have become victims of structural violence (Solnes Miltenburg et al., 2018) and the perpetration of violence is not an innate human trait but a result of social formations (Anglin, 1998). Whilst midwives may not be trained to deal with the deficiencies in the system (Bradley, 2018), they are socialised into the scarcity; multi-tasking, management of time, affection, resources, emotional labour, improvisation of equipment, and negative engagements with other burnt out professionals to ensure safe outcomes. Additionally, they are blamed for adverse outcomes without due consideration of the structural limitations inherent in the provision of care. To further aggravate this, their wellbeing is completely neglected by the care system which expects them to care.

Another consequence created by structural violence was horizontal violence. In this study, there were overt and covert forms of violence and tensions which led to intra and interprofessional dissonance and which were mostly because of the lack of resources, and these had ramifications on RMC. This was not identified in other studies in similar settings in the scoping review, therefore, this finding also extends the evidence of factors affecting RMC. Horizontal violence is the negative encounter between individuals at similar hierarchical levels and may be verbal, physical or psychological (Ebrahimi, Hassankhani, Negarandeh et al., 2016). It can also be characterised by bullying, discrimination, and lack of support (Pien, Cheng, and Cheng, 2019). Experienced midwives, rotation midwives, and student midwives were subjected to various forms of violence. For instance, in this study, midwives were exposed to workplace violence such as lack of voice, intimidation, lack of recognition of work output, undermining, and verbal abuse, and this had negative implications on their interactions with women. Similarly, in an Australian study by Catling, Reid, and Hunter (2017), midwives described a culture of bullying within the work place which had resulted in stress, the sense of powerless and fatigue hampering their ability to provide woman-centred care.

For student midwives, in addition to the above, there was unsupervised learning, and midwives' lack of willingness to teach them. McKenna and Boyle (2016) in another study in Australia reported that 30% of students in their study had been verbally abused, 3% physically abused, and 3% sexually harassed. This affects students' emotions and their confidence and the socialisation of students into this culture of abuse could equally be described as violence against them. Rominski et al. (2017) reported that student midwives in Ghana also justified the mistreatment of women indicating not just the normalisation of mistreatment but a socialisation of students into this culture. Midwives in this study made implicit and explicit expressions that they were also human beings who needed to feel cared for, supported, mentored, supervised, and motivated and the lack of these had resulted in the displacement of their frustrations on women.

Midwives recognised that it took strong leadership within the midwifery profession, hospital management, a healthcare system that was dedicated to the needs of both women and midwives, and a political will to provide resources to change the narratives in maternity care. At the beginning of one of the FGDs, some midwives asked me if the central focus of my research was only midwives. According to them, if that was the case, no result would be yielded because they had been complaining about the issues they were going to discuss to no avail. They, therefore, suggested the focus be shifted to professional leaders, hospital managers, and the government. The lack of affirming relationships, supportive leadership and management, the unrecognised and unmet needs of midwives, and the lack of voice for midwives is a bottleneck in the quest for RMC. This should not only be viewed as justification for mistreatment but as a call to action. This is because, according to Patterson et al. (2019), these result in negative effects on the interaction within the midwife-woman relationship. It is unrealistic to leave midwives' needs unmet and have expectations of meeting women's needs fully. The common recommendation has been to train midwives in RMC as highlighted in the scoping review (Afulani, Aborigo, et al., 2019; Asefa, Morgan, Bohren, et al., 2020; Dzomeku, Mensah, et al., 2021) but it is unrealistic to expect that training midwives on RMC will have sustained impact when the realities of working in an impoverished, gendered, and structurally violent care system remains unchanged. Midwives, women, and their families within any maternity care system are inseparable and strategies aimed at ensuring RMC must focus on them as a whole and the system within which they are embedded. Furthermore, the power relations that result in the subversion of midwives and subsequently women, need to be recognised, deconstructed, and strategies developed to balance this, as discussed further below.

8.3.5. The hierarchical exertion of power

In this study, there was a hierarchical exertion of power where the more dominant and powerful oppressed the least powerful; hospital managers, nursing and midwifery managers,

doctors and other health professionals exerted power on experienced midwives and they in turn on student midwives, rotation midwives, and women. Power relations are intrinsic to structural violence and the provision of maternity services. The power dynamics within the delivery of care that subverted people's agency was hierarchical with women at the bottom of this hierarchy. The organisation of care was such that there was medical and managerial dominance. The managers of the facilities involved in this study, who were all male doctors, exerted the highest form of power within the sequence of dominance over the process of childbirth. These were followed by doctors, DDNSs, labour ward managers, and then midwives. Power shaped and determined the actions of these individuals (Schaaf, Kapilashrami, George et al., 2021) and these actions varied but the end result was the depression of women's autonomy and agency.

Foucault (1983) has stressed that power was not an entity but existed in actions: actions upon other actions. Foucault also believed that power was not possessed, was not a disposition or capacity but was exercised and existed in the actions of individuals on the actions of other individuals (Gallagher, 2008). Thus, power exists only when it is actioned and the actions that substantiates power are diverse, encouraging a look at powers not power (Foucault, 2004). According to Foucault (2004), there are different types of power apparatuses that are employed at different levels within the social environment. Therefore, there was no instance where power assumed the same form within the actions of different entities. For instance, the power exercised by heads of health institutions differed from the power exercised by ward managers and this also differed from the power exercised by midwives on women. The powers that were exerted on midwives were in the form of intimation, blame, verbal abuse, humiliation, constant criticism, being made to pay for broken equipment or buying them with their own money, and the undermining of midwives' decision-making regarding women's care.

There was also a gross lack of support and concern for midwives' wellbeing as they were made to offer services when they were either physically or mentally not fit to do so. When

midwives became pregnant, their own experiences of the maternity care system were marred by the managerial failure to recognise their status as pregnant women who needed the same RMC they were being asked to provide. In a similar study in Malawi identified in the scoping review, Bradley (2018) highlighted midwives' lack of voice and how the presence of the researcher was a sign that someone was taking interest in researching their views in addition to that of women. The researcher also highlighted how the lack of institutional support, organisational culture, and oppressed group behaviours had resulted in the lack of care for midwives. Whilst these dominant forces did not directly impact women, midwives' exercise of power over women may be a reproduction of the power exercised over them by the health system and its managers.

Using a Foucauldian understanding, Gallagher (2008) proposed that power could be viewed on different scales: small and large. The exercise of power on a smaller scale is made possible by the strategies of power at a larger scale. In this regard, it suffices to say that midwives' exercise of power fits into the overall power strategies of health facilities and the healthcare system and midwives reproduce the power exercised over them. It also suggests that power is exercised within a network of relationships, that is, the various relationships that exists within the care environment. However, cultural, social, economic, and political norms and the availability of resources determines an individual's ability to exercise power within these relationships (Sriram, Topp, Schaaf et al., 2018). Foucault, therefore, argued that power was not necessarily oppressive but productive. As such to use power as a means of suppression or oppression, an individual with authority had to use what Foucault referred to as disciplinary power (Foucault, 1979).

Though Foucault used prisons to illuminate the use of disciplinary power for constraint, control, surveillance, and disciplinary punishment, this provided hints on how it is utilised in institutions such as hospitals (Foucault, 1979). Within the contexts of this study, authoritative knowledge (Jordan, 1997), which shaped midwives' philosophy of care, and the lack of resources translated into the disciplinary power used in the mistreatment of women and to

maintain dominance over the birthing process. This power also translated into actions such as the lack of time to engage with women in conversation, provide information about their care or to simply be a presence during labour. Furthermore, there was the objectification of women's bodies through actions that ensured cooperation from women; making women do what the midwife perceived to be safe and bringing the woman's body under subjection which were pervasive forms of mistreatment. Hence, in addition to being a mechanism of risk aversion (see 7.3.2), mistreatment was also a power strategy used by midwives to ensure cooperation and Fahy and Parratt (2006) refer to this as a form of power that is disintegrative and undermining of women's self-confidence, embodied knowledge, and power.

This kind of disciplinary and disintegrative power is inculcated into midwives' practice when the focus is placed on what midwives are doing to change mortality trends instead of the systems that are needed to ensure women's safety. For instance, the neglect of structural improvements needed to provide care and the involvement of women in the decision-making process necessary for the provision of medical interventions. Additionally, the focus on RMC has made tremendous strides in areas where strategies have been implemented. However, as noted in the scoping review in chapter two, conceptualisation of RMC based on pre-existing D&A frameworks, the partial view of RMC as the absence of D&A, and the use of training as the dominant strategy to promote RMC risk oversimplifying the nature of contextual, professional, and individual women's needs and problems and the complexities that drive them (Solnes Miltenburg et al., 2018). In this regard, the causative mechanisms influencing RMC that have been identified in this study have facilitated the deconstruction of the systemic structures, culture, processes, powers, and resources and established their causal connection with the agency of midwives. It has, therefore, resulted in the widening of the scope of RMC which will facilitate the development of strategies that address contextual needs.

8.5. Conclusion

This study has extended the RMC concept beyond the 'absence' of D&A, incorporated contextual nuances into the conceptualisation of RMC, and moved RMC beyond the behavioural and ideological, to integrate system related situations and causative mechanisms influencing the provision of RMC. The conceptualised RMC by midwives adopts embodied cultural, professional, and religious values such as reciprocity, mutuality, spirituality, interdependence, and collaboration to offer a woman-centred approach to RMC. Nonetheless, it was notable that the relationship-based, woman-centred approach to RMC theorised by midwives was far from its enactment. The enactment of RMC was that of power, control, risk aversion, stress, and violence within a toxic culture and a patriarchal system underpinned by structural and gendered violence that viewed both women and midwives as passive agents within the maternity care system. The system related causative mechanisms identified through CR were deconstructed and their causal connection with midwives' agency explained. Using theories such as African communitarianism, dependence, feminism, structural violence, and Foucault's theory of power have given explanatory power to these causal mechanisms and facilitated greater insights into the realities that have constructed the nature of RMC. Emphasis have been extended from the midwife as a perpetrator of abuse and women as victims and the view of the systemic concerns raised by midwives only as justification to incorporate the evidence of structural and gendered violence and the impact of the traumatic experiences that midwives are exposed to as well as IPC, and other discourses outside of the midwife-woman relationship. The system, organisational, professional, research, practice, and educational implications of these findings and discussions will be further explored in the next chapter.

CHAPTER NINE: CONCLUSION

9.1. Introduction

The previous chapter discussed findings of the study in relation to the broader literature. The various theories that were adopted provided frameworks to enable further exploration of the findings as well as causative mechanisms identified. This last chapter will provide a summary of these findings, highlighting their novel contribution to the knowledge on RMC within the specific research context and for the extension of global insights into this important topic. The initial scoping review conducted to formulate the research question highlighted a dearth of attention to midwives' views on RMC. However, the updated review carried out to present an up-to-date picture revealed an increased attention to the RMC concept broadly and more specifically to the views of providers including midwives globally and within the Ghanaian context specifically. Despite the increase in attention, the updated scoping review continued to highlight gaps in the evidence on RMC.

The review revealed that findings from studies had mainly been analysed using pre-existing frameworks leading to the partial conceptualisation of RMC as the 'absence' of D&A and the view of D&A mainly as a behavioural problem. There was also the perception of providers as perpetrators and women as victims which culminated in the utilisation of universal rights-based RMC approaches for the promotion of RMC. However, this was critiqued by participants in some studies due to the lack of focus on contextual issues and the rights of providers. Furthermore, though resource constraints were identified as drivers of mistreatment, these constraints were only interpreted as providers' justification of mistreatment without the in-depth identification of causative mechanisms and their causal connection with providers' agency. This partial view was also reflected in the use of training of providers as the dominant form of intervention to promote RMC. However, this had limited

capacity to promote RMC as greater improvement was noted when training was carried out in addition to systemic changes that targeted contextual realities.

The partial conceptualisation of RMC based on existing frameworks, therefore, necessitated an inductive approach to the conceptualising of RMC to facilitate the extension of the concept beyond the 'absence' of D&A and to capture contextual nuances that could facilitate the promotion of RMC within the Ghanaian context. In addition, to problematise the notion of midwives as perpetrators and women as victims and the use of contextual constraints as explanation for the mistreatment of women, a CR philosophical underpinning was adopted which enabled the use of retroduction to identify causative mechanisms and how they influenced midwives' agency. In this chapter, the key contributions of the study to the RMC discourse will be highlighted first followed by recommendations and implications of the findings for policy, practice, leadership, midwifery role, education, training, and future research. The final section will explain the strengths and limitations of the study.

9.2. Summary of key contributions

The aim of the study was to understand midwives' views and beliefs about respectful maternity care in three maternity units in Ghana and how this was enacted, influenced, and experienced in everyday practice. An inductive FE approach enabled the exploration of the aim and objectives of the study. The CR philosophical underpinning facilitated the discovery of the underlying mechanisms that influenced the provision of RMC, and these enabled the achievement of the objectives of the study. Three data collection techniques were employed: PO, FGD, and SSI. The study included three study sites located in one region in Ghana and involved 69 respondents.

The findings of the study revealed a value, relationship-based and woman-centred conceptualisation of RMC with the key elements of reciprocal respect and a mutually satisfying experience for both women and midwives. It also incorporated the embodied

values of spirituality and kinship attachment. A value-based conceptual framework for RMC was, thus, developed which focused on the midwife-woman relationship, woman-centred care and the values incorporated into these. The incorporation of the embodied values of reciprocity, mutuality, spirituality, and kinship attachment represents a novel contribution to the RMC concept. This is because it moves the concept beyond the 'absence' of D&A which was pervasive in the literature to incorporate shared cultural and religious dimensions, making the framework context specific and culturally sensitive. Other components such as privacy, confidentiality, and the provision of supportive care are incorporated into this framework with full consideration of the realities that affect their provision.

This idealised theory of RMC as expressed by midwives, was, however, far from practice as findings revealed the mistreatment of both women and midwives. Using the CR principle of retroduction, structures, culture, agency, and causative mechanisms that had causal connection with midwives' agency were identified. The causative mechanisms identified were embodied values, risk aversion, midwives' philosophy of care and ideologies about their role, women's lack of trust in the healthcare system, and structural and gender-based violence. The interplay of these mechanisms within the pervasive toxic culture of abuse defined midwives' agency and influenced how midwives put into practice this value and relationship-based and woman-centred approach to care. A conceptual model of the influencing factors for RMC was developed and this presented another novel contribution to the RMC literature which often focuses only on midwives' justification of abuse citing structural constraints. The causative mechanisms identified, such as structural and gender-based violence, also extend the theoretical interpretations beyond the notion of midwives as perpetrators of abuse and women as victims. Other novel findings were the lack of collaboration between midwives and other health professionals and how they influenced RMC, resulted in delays, and impacted on women's safety. The identification of this delay also extends the knowledge on the three delays in receiving maternity care propounded by Thaddeus and Maine (1994). Additionally, the impact of exposure to traumatic experiences

such as maternal and infant mortalities resulting in risk aversion is another key contribution that this study makes to the RMC discourse. These key contributions are a wealth of novel contributions from this study, and these are summarised within the sections below. Their implications are highlighted, and recommendations made for further consideration.

9.2.1. Towards a value and relationship-based and woman-centred approach to RMC

As emphasised, research on RMC investigating the views of midwives or health professionals usually focus on describing the presence of D&A, describing RMC as the 'absence' of D&A, and using pre-existing frameworks on D&A to develop the RMC concept. In this study, though descriptions of D&A and the systemic deficiencies that underpin this have been made, an inductive approach has been used and the findings have importantly established a value-based framework for RMC (explained in chapter four). This framework does not merely describe D&A but provides components of RMC that are underpinned by embodied cultural and religious values making it context specific and culturally sensitive. The key values of reciprocity, mutuality, spirituality, and the notion of kinship attachment were used to develop a supportive relationship with the woman. These were conceptualised as key aspects of RMC and these are novel contributions to the RMC concept extending the knowledge on the phenomenon beyond simply the 'absence' of abuse. This research has established that these shared values could facilitate an approach to care that is culturally sensitive and acceptable to both women and midwives.

Although some studies focusing on RMC have highlighted the midwife-woman relationship and woman-centred care, these were not conceptualised as the core tenets of RMC (De Kok et al., 2020; Moridi et al., 2020b). This appears to be the first study in Ghana that has positioned both the midwife-woman relationship and woman-centred care as the core tenets of RMC. The context within which the study was undertaken does not practice the continuity of care models, however, midwives emphasised their interpersonal relationship with women as the underpinning element of RMC. In this regard, emphasis was placed on the initial

approach to the woman when she first reports to the facility in labour, making the establishment of rapport of immense significance. Whilst it was recognised that the condition in which the woman reported and other constraints within the care system had the capacity to mar this process, the utilisation of care ethics and the embodied religious and cultural values had the potential to facilitate a positive approach.

The concepts of reciprocity and mutuality exposed the challenges midwives faced within the health system and their need to not only be accepted by women but also be recognised by the healthcare system within which they functioned. These concepts have also shown that within the current system of practice both the woman's experience of care and midwives experience of service delivery were of significance. This was because the challenges within the system were a bottleneck to the implementation of the ideal concept of RMC. For instance, even though midwives espoused the relationship-based woman-centred concept as the core principle of RMC, for fear of blame, they aligned with the system that disadvantaged them and reproduced the power that was being exerted on them on women. This had led to the fracturing of the midwife-woman relationship. In addition to the inherent systemic and cultural challenges, the smooth establishment of this all-important relationship could not materialise.

In the context of similar systemic challenges in Malawi, De Kok et al. (2020) suggested that the focus should be shifted from woman-centred care to collaborative care and from the focus on women's right to fostering relationships. I, however, argue that with an enabling environment and a supportive and transformational leadership, care can and should be both relationship-based and woman-centred while promoting both the rights of women and midwives. Woman-centred care and collaborative care are not opposing concepts and the promotion of rights can still exist within the midwife-woman relationship. However, based on the evidence from this study, these should be mutual and reciprocal. Midwives within this study recognised the need for partnership with women and the importance of a woman-centred approach to care but lacked the coping mechanisms to deal with the structural

constraints, the culture of blame, and the lack of supportive leadership. The discrepancy between midwives' theorisation of RMC and the reality of day-to-day practice should not lead to a compromise on the standards of midwifery care. Instead, it should draw attention to the need for policy and leadership to model, support, and empower both midwives and women to achieve this approach to care.

9.2.2. Safe outcomes and RMC: the role of lack of interprofessional collaboration and the labour ward culture

The current study has expanded the focus of RMC beyond the immediate interaction between midwives and women to include other health professionals whose interactions with midwives have the ability to influence the utterances within the midwife-woman relationship. The evidence from the study showed not just a lack of teamwork and collaboration between various health professionals but also conflicts, abuse, and subordination of midwives in a manner that had a negative influence on RMC and the safety of women. This was one of the important insights from this study as there was a lack of recognition of this problem in research within similar settings. The evidence showed that there was undermining of midwives' decision-making, interprofessional conflicts, blaming of midwives when women did not consent to procedures recommended by doctors, and the expectation that midwives would ensure that women adhere to hospital policies. These were a consequence of problems relating to resources, trust, competence, and communication. Unfortunately, these resulted in women not receiving only RMC but also delays in the receipt of needed care.

It is notable that whereas the emphasis of RMC is the woman's experience of care, the evidence of delay and the lack of resources needed for prompt emergency response highlighted in this study presents a significant linkage between safety and RMC as reiterated by midwives. Based on this premise there was prioritisation by midwives of safety over RMC because when women's safety was compromised, midwives were blamed. Midwives also felt the psychological effect of the exposure to these adverse events which has not yet been

recognised within the RMC literature, making this an important contribution from this study. This has not only led to the justification of the abuse of women, but the evidence revealed that it has also led to the fear of adverse outcomes and risk aversion. This depicts a seemingly mutual exclusivity between safe childbirth outcomes and RMC. However, RMC and women's safety are not mutually exclusive, necessitating the urgency of improving the quality of interprofessional relationships within maternity care in Ghana and positioning these relationships within RMC and the delays in receiving maternity care discourses. This also makes midwives' emotional and psychological state highly significant in the strive for RMC. It is, therefore, imperative that greater emphasis is made on changing the culture within the labour ward if the relationship-based woman-centred approach to RMC is to be enshrined within midwifery philosophy of care and practice.

9.2.3. Supportive and transformational leadership

This study revealed a lack of supportive leadership and highlighted one that was characterised by blame, bullying, subordination, lack of appreciation, and the limited concern for the wellbeing of midwives and their unfavourable working conditions. Additionally, the research revealed that RMC was not modelled, as leaders and managers themselves abused both women and midwives. This was demoralising for midwives and their paternalistic approaches to care may be a reproduction of the power and control exerted over them. There was the expectation for midwives to care for women when they were not being cared for even when they were pregnant women themselves. There seemed to be the leadership ideology that the improvements within some work environments were enough to keep midwives motivated. However, this current research has emphasised that poor leadership and the unsupportive and untenable work environment shapes midwives' practice in a manner that has ramifications on RMC. This places emphasis on the need for a transformational leadership that emulates the tenets of quality standards and provides the enabling environment for the provision of care.

The study showed that midwives were concerned about the leadership structures and the utilisation of power in shaping the care environment. This study, therefore, positions supportive leadership as a necessity for the promotion and maintenance of RMC within the Ghanaian maternity care system. It has also revealed a significant gap in the strategies aimed at promoting RMC which focuses on training midwives but not leaders who will contribute to the sustenance of the skills acquired in training. This approach may be beneficial but may not have a sustained impact as how care is managed by clinical leaders is also vital in ensuring RMC. The development of supportive clinical leadership, mentorship, and clinical supervision will make RMC holistically integrated into the professional and organisational structures within the clinical setting.

9.2.4. Creating parallels between safety and RMC and between midwives' and women's needs

This study has shown that the provision of maternity care in its current form has elements which appear unethical. Midwives and doctors align with facilities, doctors assume dominant control preventing midwives from supporting women even when they want to, and paternalistic means are used to control women's childbirth experience. There is also absence of leadership and accountability mechanisms as evidenced in this research. The maternity care system was plagued by problems of communication and coordination amongst health professionals, interprofessional conflicts, and lack of cooperation from women and their companions. The study has not only highlighted cases of D&A of women but bullying of midwives, professional subordination, and an impoverished maternal health system that stimulates fear of adverse outcomes and subsequent control of childbirth. The evidence in this study indicates that practice currently creates a false dichotomy; prioritisation of safety over RMC and safety competing with RMC rather than complimenting it. Generally, there seems to be the understanding that preventing adverse outcomes was the highest indicator of quality of care. Thus, safety and RMC appeared, at times, to be

mutually exclusive especially considering the systemic constraints and the high MMRs. Therefore, the lack of RMC was legitimised and normalised even amongst leaders who had the responsibility of ensuring an enabling care environment.

In my experience as a midwife and educator, the complaints and dissatisfaction with maternal healthcare and the health system in general in Ghana was public knowledge well before research evidence established this. Whilst widespread evidence of women's dissatisfaction has led to the increased focus on RMC, it is important that current research including this one is beginning to include emphasis on providers' beliefs and the systemic challenges contributing to the poor quality of care that women receive. This study has, therefore, highlighted the need to create parallels between safety and RMC and between providers' needs and that of women. The study has established that limited attention is paid to ensuring an enabling environment for RMC in terms of resources, leadership, support, supervision, monitoring, teamwork, and collaboration. Most importantly, where attention is being paid to resource improvement, they do not reflect the tenets of woman-centredness and the needs of women or midwives. For instance, in hospital A where infrastructural and resource improvement had been carried out to enable women have companions during childbirth, the hospital decided which companion women could have, and routine electronic foetal monitoring was done for all women regardless of their conditions limiting their desire for mobility during labour.

In addition to the emphasis on how midwives will meet the needs of women, supportive structures, inspirational and transformative leadership, and collaborative approaches to work should be emphasised. System-wide supportive leadership to provide role modelling, inter-professional collaboration, and political will to provide resources and remove the structures that disadvantage women are required. These can sustain a model of care which supports the value-based, woman-centred, and relationship-based approach to RMC accentuated in this study. The implications of these and the recommendations for further actions are presented below.

9.3. Implications of research findings and recommendations

Whilst the dominant focus has been on the training of health professionals on RMC and the rights of women as indicated in the scoping review in chapter two, this study has stressed that promoting RMC in settings like the ones involved in this study, goes beyond training and awareness raising on the rights of women. The findings provide beneficial insights into the facilitators, barriers, and the context specific cultural facets for the provision of RMC in Ghana and related settings. The conceptual framework for RMC extends the RMC discourse beyond the identification of D&A to a conceptual model of care that is relationship-based, woman-centred, and incorporates embodied cultural and spiritual values, making it context specific and culturally sensitive. The concept is flexible, and the adoption of CR facilitated the identification of causative mechanisms that influence the provision of RMC. This enabled the exposition of the contextual nuances that influence this ideal approach to RMC and how they interplay to influence midwives' agency. The insight into this causal connection will facilitate the development of strategies to support midwives. RMC is a global phenomenon and area of interest. Therefore, the proposed conceptual framework of RMC and the conceptual model of factors influencing RMC will be of significance to local, national, and international researchers, donors, funders, and other organisations and individuals with an interest in maternal and newborn health, global health and development, and midwifery practice more specifically. The sections below will offer recommendations for policy, clinical leadership, practice, education, the midwifery role, and the identified gaps which require further research.

9.3.1. Recommendations for policy and clinical leadership

The evidence from this study presents useful insights when planning and developing local, national, and international policies, protocols, and guidelines for practice. It has been highlighted that several factors interplay to influence midwives' provision and women's experience of RMC. An important factor highlighted was structural and gender-based

violence. System strengthening strategies must, therefore, address the structural inequalities that disadvantage women. Policies that are recommended include a more comprehensive NHIS that provides complete healthcare coverage from conception to the end of the postnatal period. Necessities for labour and childbirth such as cot sheets and baby clothing that are needed at the point of care must be provided for women, especially those from lower socio-economic backgrounds. This should also include medicines and other emergency services such as blood transfusion. The requirement for women to present someone to donate blood on their behalf prior to labour should be replaced by the national blood donation policy and campaign to acquire blood for use during all health emergencies including those that occur during labour and childbirth. Additionally, infrastructural improvements need to consider enhancing the provision of privacy and confidentiality during labour. These structural and systemic changes that must occur to achieve these recommendations require increasing health system financing.

Birth companions have been shown in this research to have an impact on the assurance of confidentiality. This is because of the exchange of confidential information between women and midwives during the provision of care. Additionally, cultural practices within the wider society such as the humiliation of women who exhibit culturally inappropriate behaviour during labour and childbirth has resulted in policies that determine who a companion should be. Despite these, it is recommended that the type of companion should be determined by the woman and not the facility in order to ensure woman-centred care. However, discussions should be carried out with the woman to enable her to understand the implications of her choice. Women need to be able to make an autonomous decision about the cultural practices that can be integrated into their care and how this is carried out.

Policies and guidelines must recognise and acknowledge contextual issues such as the unavailability of infrastructure, resources, and clinical leadership and how they influence the implementation of standards. In the absence of needed resources, there should be guidelines to support midwives with alternate means of navigating through the care system

to ensure women achieve their desired childbirth experience. For instance, in the absence of beds for women to lie on during labour, childbirth, or the immediate post-partum period, there should be guidelines to support midwives in communicating these to women and their companions. Women should be able to consent to sleeping on the floor or be able to opt for another facility that has available resources. This will limit the contentions between women and midwives and the resultant impact on the midwife-woman relationship and RMC. Priority should again be given to the midwife-woman relationship by developing guidelines for the request of vital lifesaving products such as blood for transfusion to avoid challenges that negatively impact on midwives' relationship with women, their companions, and other health professionals.

Clinical leadership development is a vital strategy that will not only facilitate the promotion of RMC but will ensure midwives are supported, inspired, and facilitate the transformation of the culture within the care environment. Clinical leadership needs should be assessed, and core competencies developed in reference to priority areas in need of improvement such as the development of accountability mechanisms and supportive tools to facilitate the support of both midwives and clinical leaders. A clinical leadership development programme should be created, competencies implemented, and outcomes measured in terms of impact on service delivery. Strategies developed should be tested through robust research to ensure they are context specific and acceptable. Although leadership has been shown to be important in shaping the practice of midwives in this study, the taking up of leadership roles does not necessarily ensure effectiveness. Midwifery leaders must be role models, knowledgeable, emulate high standards of care and women's safety, inspire, and innovate, and these must be stipulated in job descriptions.

9.3.2. Recommendations for the role of the midwife, practice, and interprofessionalism

Research from high-income countries has highlighted that building positive relationships between women and their midwives promote sustainability of the midwifery model of care and midwifery practice (Leap et al., 2011; McAra-Couper et al., 2014). An important aspect of this model is the personal attention given to women, to the midwife-woman relationship, and the time available for midwives to understand women and their needs. The midwife-woman relationship has again been demonstrated in this study to be the locus of interest with regards to RMC. There is, therefore, the need to focus attention on strategies to mitigate the challenges within this relationship to enhance the provision of RMC.

Some midwives in Ghana provide continuity of care in some rural areas, where they offer care 24 hours a day, 7 days a week, and 365 days a year. This is because of the acute shortage of midwifery workforce and the inaccurate distribution of the available professionals. These services can be evaluated, reorganised, modified, and resourced to facilitate the creation of a context specific model of care that prioritises the midwife-woman relationship and woman-centred care. It has widely been evidenced in this study that a a value and relationship-based and woman-centred approach to care is a concept of midwifery care that has been theoretically embraced but lacks a practical application. A strategy to translate this theory into practice whilst navigating through the ongoing challenges is, therefore, required. This strategy must include communication tools to facilitate and improve the interaction between midwives, women, and their companions, and with other health professionals. Thus, there is the need to consider the creation of a context specific model of care that recognises and acknowledges the realities of care yet integrates the tenets of a woman-centred approach to care and the cultural facets that are important to women's childbirth experience. The value-based conceptual framework for RMC developed in this study would be helpful in this regard.

The role of the midwife especially in relation to RMC has been evidenced to be significantly impacted by other professional relationships. The lack of IPC highlighted in this study was found to negatively impact on both women's safety and RMC. Teamwork and collaboration has been documented to have an impact on patient safety (Lillebo and Faxvaag, 2015) and the problems within IPC have been linked to imbalances in authority, lack of understanding of the roles of others within the professional team and ineffective communication (Courtenay, Nancarrow, and Dawson, 2013). Although this necessitates robust interventions to promote IPC, Reeves, Pelone, Harrison et al. (2017) in a Cochrane review found low certainty of the evidence from the included studies to indicate that interventions had positive impact on IPC. Campbell, Layne, Scott et al. (2020) also found similar results when they reviewed literature on interventions to promote teamwork and communication among registered nurses and nurse assistants. While this is a developing field, due to the impact of IPC on both health outcomes and RMC, robust research to determine effective interventions to promote IPC is required.

Attention ought to be given to mechanisms of IPC such as interprofessional learning and the use of professional communication and shared decision-making tools to enhance communication between health professionals and to facilitate decision-making regarding women's care particularly in Ghana where resources are scarce and health outcomes are poor. Modalities of trust, competence, decision-making, and communication within the multi-disciplinary care team should be integrated into strategies aimed at improving IPC. Other professionals must recognise the midwife as the lead professional in the provision of normal childbirth services and recognise the importance of their response in ensuring women' safety when complications arise. Additionally, midwives themselves ought to be empowered as lead professionals in maternity care to enable them support and advocate for women when required.

9.3.3. Recommendations for education and training

Though midwives in this study highlighted an absence of training, RMC has been an aspect of the midwifery curriculum in Ghana since 2015. However, evidence from this study and the wider RMC literature highlight that there is a justification for the mistreatment of women even amongst student midwives. This indicates that the normalised mistreatment and the structural and horizontal violence within the labour ward culture is being passed on to students. This suggests that teaching RMC in the classroom or training for service providers, which is the predominant strategy for the promotion of RMC, is not enough to shape students' clinical learning or is insufficient to ground students and qualified midwives in appropriate clinical behaviour. The lack of mentorship and the toxic culture are necessary considerations for students' clinical education and mentorship. RMC needs to be modelled and not just taught and an enabling environment is required to facilitate the provision of RMC. Preceptorship programs must integrate the components of RMC and supportive tools for students to develop the appropriate skills. Preceptors must be assessed on their RMC competencies to ensure the appropriate skills are being passed on to students. Mistreatment of women, though normalised, was not a shared culture, therefore, midwives should also be given advocacy training to equip them with the skills needed to intervene when a woman is being mistreated.

Additionally, the midwifery curriculum and thus practice in Ghana is not underpinned by any professional philosophies. Philosophical underpinnings of midwifery such the 'with woman' and woman-centred care are generally missing in the curriculum and in my anecdotal experience, missing in midwifery discourses in Ghana. It is, therefore, not surprising that the practice does not inculcate such approaches. It is expedient that steps be taken to embed these theories and philosophical underpinnings into the curriculum and into midwifery discourses and practice. It is, however, necessary to recognise and knowledge the specific contextual truths and models and theories developed, tested, and translated into practice in

a manner that suits the Ghanaian context, the needs of women, and the evolving role of midwives in Ghana.

The reciprocal and mutual nature of midwives' conceptualisation of RMC also necessitates a dual approach to education on RMC. To achieve the reciprocally respectful and relationship-based approach, women ought to be empowered to not just challenge the status quo but to recognise the role of midwives and other healthcare professionals in their care. There needs to be education about rights but also decision-making concerning their births as well as the accompanying responsibilities. There are several context specific factors that affect women's decision-making regarding care that may have ramifications on their health. For instance, as evidenced in this study, the incorporation of religious and cultural beliefs into the utilisation of healthcare sometimes prevents women from consenting to interventions but blame providers for adverse outcomes that result from the refusal of these interventions, especially in a system where optimum emergency response is not a guarantee. Additionally, the low literacy levels and the lack of time to educate women can affect their capacity to make informed decisions about their care. Therefore, women's information needs should be critically assessed, and programmes implemented to empower them to become autonomous decision-makers in their care and also recognise their responsibilities in that regard. Based on the needs identified, educational programmes should be developed and integrated into the various stages of pregnancy, labour, childbirth, and the post-partum period to suit women's level of need to facilitate their empowerment. Strategies for promoting RMC can only be woman-centred if they are designed to increase women's knowledge about their birth and create a supportive environment for women's involvement in their care.

9.3.4. Recommendations for research

This research generated an important context-specific framework for RMC; however, the current practice is not modelled after this ideal concept. The study showed that the initial approach to the midwife-woman relationship when she reports to the facility in labour was

highly significant. Approaches needed to establish rapport and initiate this relationship require research attention. Models of care that promote this relationship have been explored and adopted in various countries. However, in resource scarce settings like Ghana where these models are not immediately attainable, context specific models can be developed and tested through robust research to enhance this initial approach to the midwife-woman relationship where the midwife is not previously known. An example might be a clustered midwifery model of care where midwives and women are put into groups and midwives provide periodic supportive ANC to women in their groups. This will facilitate the establishment of the midwife-woman relationship prior to labour and help meet women's information needs regarding labour and childbirth. Strategies should be tested through research to ensure their feasibility within the specific context. For instance, there is no data on Club 36 (see section 4.2.2.) but have been widely recommended by midwives in this study. Evidence from the study, however, indicates that this initiative is not well integrated into care, may not be enhancing the midwife-woman relationship in any way, and may also be negatively affecting RMC components such as privacy. Therefore, this needs to be further investigated and its capacity to promote RMC, enhance the midwife-woman relationship, and promote women's trust in maternity care established.

A significant contribution to the RMC concept is the incorporation of embodied values into the provision of care. These values include aspects of culture and spirituality which facilitate the creation of a supportive relationship with women. However, due to the diverse nature of the Ghanaian population, there may be other aspects of these embodied values that were not captured during this study. This study involved only one region out of sixteen regions in Ghana and though findings are transferable due to similarities in models of care and professional cadres, the cultural and spiritual values may not be transferable due to ethnic diversity. Therefore, further research is required to verify and extend the embodied values to integrate other aspects which may not have been captured in this study.

RMC studies have mostly involved women and healthcare providers and the power and control mechanisms employed by providers have been widely evidenced. This study illustrated how the exertion of power by leaders and managers within the care environment also impacts on RMC. Therefore, a study to target these stakeholders is required to gain insight into how the dynamics of power is contributing to creating the culture within the health care system and how RMC is enacted. The impact of midwives' exposure to traumatic experiences and their linkages with RMC also merits in-depth exploration. Further research into Interprofessionalism and shared decision-making in maternity care within the Ghanaian context will be necessary to test best practice approaches to determine models for practice that will promote IPC, teamwork, and subsequently RMC. Determining women's information needs also merits greater attention and appropriate interventions developed to enhance their involvement in the decision-making process. Finally, the study suggests that the culture within which care is provided is one that does not facilitate the provision of RMC. As such it is necessary to apply cultural change models such as Johnson's cultural change model (Freemantle, 2013) to facilitate the process of change within the labour ward culture.

9.4. Strengths and limitations of the study

9.4.1. Strengths

The conceptual framework for RMC presented in this study provides an approach to RMC which is not focused solely on the identification of D&A or the absence of D&A but incorporates embodied values that have the capacity to positively influence the provision of RMC. The embodied values which include cultural and religious elements can facilitate the creation of an ethic of care that is culturally sensitive. These findings reflect the importance of context and cultural sensitivity and represent a foundation on which larger research to potentially extend the framework for RMC can be built, and to test and translate the framework into practice. The study also provided insights into other factors influencing RMC that have not yet been discovered in similar settings such as the lack of IPC and the

influence of the exposure to traumatic experiences on midwives' risk aversion, fear of adverse outcomes and their subsequent influence on RMC. The use of the CR was beneficial for the identification of causative mechanisms. This was achieved through the adaptation of the thematic method of analysis to incorporate the CR key principle of retroduction. The causative mechanisms identified which were grounded in the data have causal connection with the nature of RMC observed, they have explanatory power, and help in understanding the observable events within the social world and extending the theoretical interpretations of RMC.

The adoption of the three different methods of data collection offered an avenue for triangulation. The capacity for triangulation was further augmented by involving distinct groups of respondents from differing research sites. The use of participant observation was helpful in authenticating data collected through other methods and facilitated the acquisition of important data which were not achieved through the other methods. It also facilitated the discovery of the structural and contextual realities associated with the provision of maternity care which were vital in the postulation of causative mechanisms.

Another significant strength of the study was the flexibility for participants to speak in their preferred language. Some participants were not comfortable expressing themselves in English, which could have potentially prompted the need for a translator. However, my ability to speak a common language with the participants made it possible for them to express themselves in their preferred language and thus providing a rich source of data. Additionally, the settings and participants involved in this study shared similarities with other settings in Ghana and other Lower-middle income countries. Therefore, findings are potentially transferable to such settings. Finally, my ability to immense myself into the culture without influencing it facilitated the collection of a rich source of data.

9.4.2. Limitations

The focus on the intrapartum period limits the spectrum of insight into the midwife-woman relationship, though other aspects of care were not the focus of the study. Nonetheless, understanding into the mechanisms influencing the midwife-woman relationship was gained which could be a foundation for investigating other aspects of care.

When people are observed, there is always the possibility of Hawthorne effect and the likelihood of underestimation due to familiarity with the practice. As a practicing midwife and educator in Ghana, though I had not practiced in the specific research settings before, they had similarities with other settings I was familiar with. Additionally, as a result of the limited availability of health professionals in some of the facilities involved, I had to sometimes support with the provision of care. Therefore, the possibility of overlooking some aspects of practice that were familiar was high and this may contribute to some aspects of the care being unreported. However, the writing of field notes was a tool used to avoid the possibility of this happening. Additionally, I discussed all aspects of data collection and analysis with supervisors whose comments and advice facilitated the avoidance of the Hawthorne effect.

For student midwives participating in this study, my role as an educator presented a potential for the influence of power. Furthermore, some experienced midwives at the beginning of the study practiced as though they were being supervised, preventing the observance of actual practice. In-depth explanation was provided to all the categories of participants for them to gain a better understanding of my role as a researcher and the purpose of the study. In addition, I engaged with participants during their breaks to gain entrance and immerse myself into their social world and this proved beneficial.

9.5. Summary of chapter

The study has facilitated the development of a framework for RMC, a conceptual model of the factors influencing RMC, and how the various domains and mechanisms within the model contribute to shaping the observable events related to RMC. The study has exposed the contextual dynamics and complexities associated with the provision of RMC. It has also revealed the structural and systemic realities that influence the interpersonal relationships functioning within the context specific social world and how these influence women's experience of RMC and maternity care as a whole. RMC is a universal concept and a multistakeholder effort is required to ensure its promotion and provision. Therefore, the dissemination of the findings and recommendations of the study through publications, presentations at conferences and workshops, and the development of policy briefs is expedient. This will inform policies, standards and protocols, and hence maternity care practices on the strategic interventions to enhance the promotion of RMC, the improvement in the quality of care, and strengthening of the health system.

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APPENDICES

Appendix 1: Summary of studies identified in the scoping review

Summary of empirical studies conceptualising RMC

Author(s) and date	Aim and objectives	Research setting	Study population	Methodology and methods	Findings
Ackers, Webster, Mugahi et al. (2018)	To understand what respectful care means to mothers and midwives in Uganda and what hinders them from providing it.	Kabarole District, Uganda.	52 Mothers, midwives and a cohort of midwives registered for a degree programme	The study involved a combination of 64 in-depth qualitative interviews together with three focus group discussions.	Communication (verbal) and being welcomed influenced women's perception of RMC Abuse was not observed within the facility researched. Midwives justified the lack of RMC attributing it to various reasons such as work load
Adane, Bante, and Wassihun (2021)	To assess respectful focused antenatal care and associated factors among pregnant women	Shashemene town public hospitals, Oromia region, Ethiopia	420 women	Cross-sectional study	About 63% of women received respectful care during focused antenatal care. Factors that were significantly associated with the lack of respectful focused antenatal care were having no formal education, low average monthly income, having unplanned pregnancy, and being multigravida.
Afulani, Sayi, and Montagu (2018)	To examine factors associated with PCMC, particularly the role of household wealth, personal empowerment, and type of facility	Western Kenya	1052 women aged 15 to 49 years who delivered in the 9 weeks preceding the survey	Survey	Wealthier, employed, literate, and married women reported higher PCMC than poorer, unemployed, illiterate, and unmarried women respectively. Also, women who had never experienced domestic violence and women who delivered in health centers and private facilities reported higher PCMC than those who have experienced domestic violence and those who had delivered in public hospitals.
Andru, Olwit, Osingada et al. (2020)	To explore midwives' understanding of respectful maternity care and observe how their practice conforms to this concept	Referral hospital in central Uganda	17 midwives were interviwed and 20 midwives were observed	Qualitative study combining one-on-one interviews and observation	RMC was conceptualised by midwives as treating women with respect, dignity, politeness, providing information, and ensuring privacy and confidentiality. There was a lack of in-depth understanding of the domains of RMC and leading to a disconnection between what the participant mentioned and the observed practice.

Arsenault, English, Gathara et al. (2020)	To describe the levels of competent and respectful care and explore potential determinants of variation in quality	Kenya and Malawi	A total of 1100 women were observed in 392 facilities across Kenya and Malawi	Service Provision Assessment (SPA) surveys conducted in Kenya in 2010 and in Malawi in 2013–2014 and observations.	Only 61–66% of basic elements of competent and respectful care were performed. Quality differed between countrires and between regions in the same country. Facilitites with better staffing, private hpspitals and delivering in the morning were associated with higher competent and respectful care
Bante, Teji, Seyoum et al. (2020)	To assess respectful maternity care and associated factors	Harar hospitals, Eastern Ethiopia.	425 women	Cross-sectional study using interviewer administered questionaires	Only 38.4% of women received respectful maternity care. Fcators that were significantly associated with respectful maternity care were delivering in private hospitals, having ANC follow-up, planned pregnancy, labor attended by male provider, and normal maternal outcome.
Bradley (2018) (Thesis)	To investigate how Malawian midwives conceptualise, practice and value RMC and to assess the constraints and enablers they face in providing RMC	Three Ministry of Helath and three Christian Health Association of Malawi facilities	70 practising midwives currently working in the labour ward and stakeholders	Qualitative critical realist approach using narrative interviews, critical incident technique and key informant interviews	The findings were focused on the challenges of providing RMC particularly the broader post colonial health system context, the professional midwifery system (qualification, identity, ethos, practice and recruitment of students), midwives' relatioship with women, and the challenging work environment for midwives.
Butler, Fullerton, and Aman (2020)	Research conducted on behalf of the ICM to identify essential competencies for midwifery practice also identified the knowledge, skills, and professional behaviors that should be hallmarks of respectful maternity care practices	The global community of midwives	A total of 895 individuals from 90 of the then-current 105 ICM member with good representation across English, French, and Spanish speakers, high-income, medium-income, and low-income countries, and educators and clinicians.	A three-round, online, modified Delphi survey was conducted between April 2016 and October 2016.	115 RMC-related items were endorsed by participants which were compared with the 12 domains of RMC identified by Shakibazadeh, Namadian, Bohren et al. (2018). The related items provide a framework for a comprehensive set of knowledge, skills, and professional behaviors that should be expected of all midwives.

Bulto, Demissie, and Tulu (2020)	To assess RMC during Labor and Childbirth and associated factors	West Shewa zone, Central, Ethiopia	567 women	Cross-sectional study using exit-interviews	Only 35.8% received RMC and factors that significantly associated with RMC included giving birth at health center, daytime delivery, longer duration of stay (≥13 h), involvement in decision-making, asking for consent before the procedure, current pregnancy unintended, the presence of < 3 health-workers during childbirth, and satisfied on waiting-time to be seen
Christe and Padmanaban (2021)	To assess the available standard of RMC	A Public Referral and Teaching Hospital, Chennai, India.	130 women	A Questionnaire was used for data collection	Five domains of RMC were assessed and most women reported receiving RMC. No woman expressed dissatisfaction with the privacy provided and 95% of women received dignity and respect from their providers. 5.1% of women expressed dissatisfaction with the care received.
Currie, Natiq, Anwari et al. (2021)	To reflect on international efforts including the examination of both providers' and clients' experiences and to share lessons learned for future efforts to measure and promote RMC in Afghanistan and similar fragile settings.	Afghanistan	Skilled birth attendants in 40 district hospitals, 27 provincial hospitals, 5 regional hospitals and 5 specialized hospitals	Cross-sectional assessment of the 2016 Afghanistan Maternal and Newborn Health Quality of Care using semi-structured interviews and direct observation	Effective communication, respect and dignity, and emotional support were critical elements of RMC, however, this was mostly lacking. Structural and political constraints and workload were contributing factors for the mistreatment of women
Declercq, Sakala, and Belanoff (2020)	To analyse the self-reported experiences of women with Medicaid versus commercial insurance relating to autonomy, control and respectful treatment in maternity care	California birth certificate files for births between September 1 and December 15, 2016	2,318 women	Survey using the Listening to Mothers in California survey questionnaire	Women with Medi-Cal reported less control over their maternity care experience than women with commercial insurance. They had less choice of prenatal provider and a vaginal birth after cesarean. They were also less likely to be consulted before having an episiotomy and more likely to report feeling pressure to have a primary cesarean and less likely to be encouraged by staff to make their own decisions

De Kok, Uny, Immamura et al. (2020)	To explore how international standards translate into local realities	Malawi	13 women, ranging in age from 21 to 40 who had given birth at a health facility between 1 week and 7 months ago. 23 midwives, aged 26 to 46, with varying levels of experience, from a few months to 12years. This included two students. 61 guardians.	Team ethnography approach involving semi-structured interviews, focus Group discussions, and ethnographic observations	The importance of being with women and talking in a loving manner were within the concept of RMC. However, there was a dual disconnection between, first, universal RMC principles and local notions of good care and, second, between midwives and women and guardians. The disconnection between midwives, women, and guardians related to fraught relationships reproduced by and manifested in mechanistic care, mutual responsibilities for trouble, and misunderstandings and distrust.
Deki and Choden (2018)	To gain in-depth understanding on knowledge, attitude and practices of nurse midwives	Three referral hospitals in Bhutan	83 nurse midwives working in birthing units	Cross sectional descriptive study involving self administered structure questionnaire with both open and closed ended questions	Most respondents had the knowledge and practiced women's rght to information, confidentilaity, privacy, and communication during childbirth. Some aspects of RMC relating to the respect of choice and rights of woen were lacking in knowledge and practice. Workload, infrasture and equipment were inadequate and were determinants of the provision of RMC
Deki and Wangmo (2020)	To explore the attitudes, views, behaviors and emotional experienced by women related to labour and childbirth and to describe women's satisfaction with RMC	3 facilities in Bhutan	426 women	Cross-sectional study using structured questionnaire with both open and closed ended questions	Satisfaction rate the services provided ranged from excellent to unsatisfactory, 37.10% women rated the services excellent, 31.20% very good, and 20.20% Good. Overall 41.8% decribed their experience as dreadful.
Dynes, Twentyman, Kelly et al. (2018)	To help fill these gaps through collection and analysis of interviews linked between clients and providers, allowing for description of both patient	61 facilities (6 hospitals, 25 health centres, and 30 dispensaries) in Kigoma Region, Tanzania	249 providers categorised into clinicians (Assistant MedicalOfficers/ ClinicalOfficers/ Assistant Clinical Officers), Nurses/midwives	Cross- sectional surveys consisting of facility-based client post-delivery exit interview questionnaire and provider interview	The outcome variables of interest included the continuous variables of: RMC-D1 score defined by the domains of Friendliness, Comfort, and Attention, RMC-D2 score defined by the domains of Information and Consent. RMC-D3 score defined by Non-abuse and Kindness. These represented the receipt of three dimensions of RMC. Significant client-level determinants for

	and provider characteristics and their association with receipt of RMC.		(Nurse Officers/ Assistant Nurse Officers/Registered Nurses/Midwives/Enrolled Nurses), and other staff (Medical Attendants/Maternal and Child Health Aides). 935 post-delivery clients between 15 to 49 years	questionnaire and self-administered knowledge test	perceived Friendliness/Comfort/ Attention RMC domain included age and self-reported complications. Significant provider-level determinants included perception of fair pay (Perceives fair pay versus unfair pay: Coef 0.46), cadre (Nurses/midwives versus Clinicians: Coef −0.46), and number of deliveries in the last month
Dzomeku, Mensah, Nakua et al. (2020b)	To explore the views of midwives on respectful maternity care	Tertiary health facility in Kumasi, Ghana	15 midwives working on the labour wards for at least one year	Exploratory descriptive qualitative research design using an interpretative approach with data collected through individual in-depth interviews	Midwives' understanding of RMC were focused on the domains of non-abusive care, consented care, confidential care, non-violation of childbearing woman's basic human rights, and non-discriminatory care. there were also elements of woman-centredness and evidenced-based pactice. This was however, not the practice as midives supported
Erlandsson, Sayami, and Sapkota (2014)	To explore how the concept of RMC was perceived by SBAs in practice	Two tertiary level maternity hospitals in Nepal	24 SBAs (physicians, certified nurses, auxiliary nurse-midwives or degree-trained nurses)	Focus group discussions	SBAs understood that respectful care at birth was important, but argued that 'safety comes before comfort'
Hajizadeh, Vaezi, Meedya et al. (2020)	To determine the status of respectful maternity care and its relationship with childbirth experience	Two public and four private hospitals in Tabriz, Iran	334 postpartum women in postpartum wards	Prospective cohort study using questionaires	The was a direct relationship between respectful maternity care and positive childbirth experience. Four respectful maternity care subdomain scores were: (a) friendly care 63.57 (19.28), (b) abuse-free care 65.28 (17.74), (c) timely care 57.76 (13.93), and (d) discrimination-free care 65.89 (16.98). The mean (SD) respectful maternity care score was 62.58 (12.1) with a range of 15 to 75.
Ige and Cele (2021)	To explore provision of respectful maternity care	Two health facilities in Lagos State, Nigeria	20 midwives	Exploratory descriptive research design using semi-	There was adequate provision of confidentiality, availability of showers and water, availability

	by midwives during childbirth			structured individual interviews	of meals and drinks to women, and pain relief in labour and delivery. Other aspects of RMC such as privacy, use of dignified tone/language, and obtaining consent for procedures during labour and delivery were poorly provided
John, Duke, and Esienumoh (2020)	To determine clients' experience of respectful maternity care and midwives' caring behaviour		83 postnatal women who had spontaneous vaginal delivery, and 51 midwives	Descriptive study using a Structured Clinical Observation Checklist with 18 items for direct observation and a Reporting Checklist for the identification of RMC and non-RMC	Fifty eight clients (69.9%) reported receiving respectful maternity care, while 25 clients (30.1%) reported experiencing or witnessing lack of respectful maternity. Midwives' caring behaviour identified include, motivating positive behaviour during labour and childbirth, informing clients about progress of labour, and being generally supportive.
Jolly, Aminu, Mgawadere et al. (2019)	To explore knowledge and understanding of the seven domains of the RMC Charter among healthcare providers and to explore women's perceptions regarding respectful maternity care.	Maternity Unit of Bwaila Hospital in Lilongwe, Malawi.	64 women 9 health care providers	Qualitative study involving the use of in-depth interviews, focus group discussions, and key informant interviews	The findings highlight importance the patient-provider relationship, the need for more education of women regarding the stages of pregnancy and labour, the importance of a woman's involvement in decision-making, the need to maintain confidentiality when required and the lack of human resources
Manu, Zaka, Bianchessi et al. (2021)	To assess respectful maternity care in health facilities.	Forty-three facilities across 15 districts in Bangladesh, 16 in Ghana and 12 in Tanzania.	Facility managers; 325 providers (nurses/ midwives/ doctors). Bangladesh (158), Ghana (86) and Tanzania (81). 849 recently delivered women. Bangladesh (295), Ghana (381) and Tanzania (173). Observation of 641 client–provider-Interactions. Bangladesh (387),	Cross-sectional study nested within the quasi experimental pre–post evaluation of the Every Mother Every Newborn Quality Improvement (EMEN-QI) intervention.	20% of facilities in Bangladesh, 25% in Ghana and 25% in Tanzania had no maternity clients' toilets and one-half had no handwashing facilities. Policies for RMC such as identification of client abuses were available: 81% (Ghana), 73% (Bangladesh) and 50% (Tanzania), but response was poor. They provided emotional support during labour care to 80% of women in Ghana, 79% in Tanzania and 48.5% in Bangladesh, and were often courteous with them—61% in Bangladesh, 89% in Ghana and 90% in Tanzania.

			Ghana (134) and Tanzania (120).		
Miltenburg, Lambermon, Hamelink et al. (2016)	To explore women's perspectives and experiences of maternal health services through a human rights perspective	Four different geographical locations Magu District, Tanzania.	17 women between the ages of 31 and 63, fluent in Kiswahili, and with a history of 3 or more facility based childbirth experiences.	Qualitative exploratory study involving in-depth interviews	Women' experiences reflected poor quality of care which violated their human rights. Women coneptualised the principles of their human rights to include 'being treated well and equal', 'being respected' and 'being given the appropriate information and medical treatment'.
Montoya, Fritz, Labora et al. (2020)	To describe the performance frequency of elements of care deemed essential for high-quality, compassionate obstetric care and its associated factors	15 referral hospitals in Mexico	401 births attended to by 191 providers in fifteen Mexican public hospitals	Observation and secondary analysis of woman, provider, and hospital characteristics and their association with the performance of 14 evidence-based and 15 respectful birth practices via descriptive statistics and multiple logistic regression models.	Only in four births were all the analysed evidence-based and respectful-birth practices performed. Professionals who were trained in respectful birth care were more likely to address women by their name, allow consumption of liquids during labour, encourage skin-to-skin contact, and examine the placenta after birth and were less likely to perform episiotomies.
Moridi, Pazandeh, Hajian et al. (2020b)	To provide insight into Iranian midwives' perspectives on RMC during labor and childbirth	Two non-teaching public hospitals in Tehran, Iran	24 midwives with at least a bachelor's degree of midwifery, work experience for one year or more in labor and birth units, and having complete responsibility of labor and childbirth care.	Qualitative study using Semi-structured, indepth, face to face interviews	Findings were discussed under three themes "showing empathy", "women-centered care" and "protecting rights". RMC was considered a broader than the mere prevention of mistreatment
Mousa and Turingan (2018)	To provide a descriptive overview of the quality of care in the delivery room focused on respectful maternity care as	Maternity and child health department at Minia university hospital in Minia, Egypt	501 postpartum women	Cross-sectional retrospective study using questionnaires containing 15-item RMC Scale	Majority of the postpartum mothers felt that they received friendly care, abuse-free care and a timely care on a moderate degree during childbirth. There was a high degree of discrimination free care during childbirth. However, 50% of the postpartum mothers

	perceived by women during labor and delivery				experienced being shouted at by healthcare workers, more than half did not receive prompt care
Moyer, McNally, Aborigo et al. (2021)	To explore providers' perspectives and behavior regarding respectful maternity care, including knowledge, attitudes, and practices	Government health facilities in rural northern Ghana	43 front-line maternity care providers	Mixed-methods cross-sectional study combining quantitative survey data, qualitative interviews, and observations of labour	Quantitative survey results indicate most providers report explaining procedures to women (89.5%), involving women and families in care decisions (84.1%), and covering or screening women for privacy (81.5%). At the same time, 38.9% reported mistreating women. The reports of RMC during the survery were contrary to observations
Ogbuabor and Nwankwor (2021)	To validated a person-centred maternity care scale and assess the perception of PCMC and its associated factors among post-partum women	Two districts of Enugu State, South-east Nigeria	450 post-partum women aged 15–49 years, who delivered in 9 weeks preceding the study constituted the study population.	Cross- ectional survey design using an interviewer administered questionnaire	Twenty-two items were retained in the PCMC scale with high internal reliability and goodness-of-fit indices. Factor that influenced RMC included age, employment status, gestational age at which ANC began and delivery by non-skilled birth attendant.
Pathak and Ghimire (2020)	To determine women's perception of RMC during facility-based childbirth	Nepal Medical College and Teaching Hospital	150 mothers admitted to the maternity ward	Descriptive cross-sectional study involving face-to-face interview technique using a validated tool containing 15 items each measured on a scale of 5	Perceptions were measured on the four main dimensions of RMC: friendly care, abusefree care, timely care, and discrimination-free care. 84.7% of the women reported that they have experienced overall RMC services with a mean score ± SD (61.70 ± 12.12). Some women reported various forms of disrespectful care such as being shouted on (30.0%), being slapped (18.7%), delayed service provision (22.7%), and not talking positively about pain and relief during childbirth (28.0%).
Raval, Puwar, Vaghela et al. (2021)	To assess the level of RMC practices in three public health care facilities	A district in Gujarat, India.	41 pregnant women	Cross-sectional study using the RMC charter as a tool for data collection during observation	RMC was observed across seven domains. Most women experienced disrespectful intrapartum care provided at the public health care facilities; however, at-least two performance standards of the RMC charter were met during intrapartum care at each public health care facility

Rosen, Lynam, Carr et al. (2015)	To guide quality improvement activities for facility-based maternal and new-born care by determining the frequency and quality of key interventions through direct observation of care	Five countries: Ethiopia, Kenya, Madagascar, Rwanda, and the United Republic of Tanzania	Doctors, nurses, midwives and unskilled assistants	Structured, standardized clinical observation checklists were used to directly observe quality of care	Insufficient communication and information sharing by providers as well as delays in care and abandonment of labouring women were identified as deficiencies in respectful care. Failure to adopt a patient-centred approach and a lack of health system resources are contributing structural factors.
Rubashkin, Baji, Szebik et al. (2021)	To examine the associations between incentivized continuity care models and obstetric procedures and respectful care.	Hungary	589 Hungarian women between the ages of 18 and 45 who also had children under the age of 5	Cross-sectional survey	Informal payment continuity models predicted increased autonomy scores (doctor: 3.97, 95% CI 2.39-5.55; midwife: 7.37, 95% CI 5.36-9.34) and reduced odds of disrespectful care. the chosen doctor model predicted a lower odds of disrespctful care whiles the chosen midwife did not significantly predict a reduction in disrespectful care. there was a higher rate of RMC amonst women with a chosen care provider.
Sheferaw, Bazant, Gibson et al. (2017)	To measure the prevalence of RMC and mistreatment of women in hospitals and health centres and to identify factors associated with the observed RMC and mistreatment of women in Ethiopia, including facility- and provider-related factors	Four regions in Ethopia namely, Tigray, Amhara, Oromia and SNNP regions involving a total of 28 urban and peri-urban health facilities, six referral hospitals, and 22 health centers	240 women were observed and deliveries were managed by 117 providers in 28 facilities	Cross sectional study design using structured RMC observation checklist	Health centres demonstrated higher RMC performance than hospitals. Male providers were more likely to provide RMC than females. As compared with others cadres of providers, midwives were more likely to implement quality improvement standards. The most frequently practiced RMC element was ensuring that women take light food, occurring in 83% (n =193) observations. The least practiced item was asking women's preference of birth position, observed in only 29% (n = 68) of the observations.
Shimoda, Horiuchi, Leshabari et al. (2018)	To describe from actual observations the respectful and disrespectful care received by women from midwives during their labour period	Two hospitals in urban Tanzania	Midwives	Descriptive qualitative study using naturalistic observation. Observations were analysed using content analysis	Midwives showed both respectful and disrespectful care and some practices that have not been explicated in previous reports of women's experiences. Five categories of RMC were identified: 1)positive interactions between midwives and women, 2) respect for women's privacy, 3) provision of safe and timely midwifery care, 4) active engagement in women's labor

					process, and 5) encouragement of the mother-baby relationship.
Stein (2019) (Thesis)	To explore what women who have recently given birth consider respectful care by maternity workers to be, what their experiences of respectful care were during childbirth and the immediate postpartum period, and how important respectful care was to them in terms of their ongoing health-seeking behaviours	Santa Cruz County, California	10 women who had given birth within the six months	Qualitative descriptive study design	The findings were discussed under Five themes 1) needs were met in a timely manner; 2) care is patient centered; 3) overall feelings of kindness; 4) caregivers are experts; and 5) the environment is safe
Uwamahoro, Sengoma, Ndagijimana et al. (2021)	To investigate the perceptions and attitudes of midwives towards the provision of respectful maternity care during childbirth	3 district hospitals in Kigali city	28 midwives	qualitative cross sectional study using in-depth interviews	Majority of midwives were knowledgeable about RMC and understanding on the seven rights of the childbearing woman. They also were aware of the presence of mistreatment during childbirth and the challenges that resulted in these
Wilson-Mitchell, Marowitz, and Lori (2018)	To explore the opinions and perspectives of Jamaican midwives and perinatal nurses regarding barriers to provision of respectful, quality maternity care of Jamaican adolescents.	All parishes in Jamaica	12 Nurse-midwives from all Jamaican parishes attended the Caribbean School of Nursing, University of Technology, Jamaica 2nd Biennial Nursing and Midwifery Research Conference, August 13–14	Semistructured focus groups and interviews	Restrictive public and institutional policies culture, personal beliefs, and the location of care delivery hindered midwives from providing respectful care which allows for shared decision-making, informed consent, and allowing for a desired labour companion
Wubetu, Sharew, and	To assess the proportion of respectful delivery care and factors	Debre Berhan town public health facilities	413 mothers	Cross-sectional study using interviewer-	Nearly one-third 147 (35.7%) of women reported receiving respectful delivery care. The most commonly violated component of respectful

Mohammed (2020)	associated with respectful delivery care			administered structured questionnaire	delivery care was receiving informed care 197 (47.8%) and the most protected category was discrimination-free care 403(97.8%)
Yosef, Kebede, and Worku (2020)	To assess respectful maternity care and associated factors among women	4 Northwest Amhara, referral hospitals, Ethiopia	410 women	Cross-sectional study	The overall magnitude of women who have received respectful maternity care was 56.3%. The capacty to receive RMC was negatively influenced by the number of antenatal care visits, previous history of facility delivery, and delivery time.

Summary of Reviews conceptualising RMC

Author(s) and date	Aim and objectives	Type of review	Types of studies included	Findings
Bradley, McCourt, Rayment et al. (2019)	To synthesise literature, using midwives' voices and perspectives to explore the broader drivers of (dis)respectful care during facility-based delivery	Qualitative systematic review and meta-synthesis	Primary qualitative studies or mixed-methods studies with a relevant qualitative element	A conceptual framwork was uilised to describe how micro-level interactions in the labour ward are influenced by meso and macro-level factors. Micro-level interactions were mapped to the themes powere and control and maintaining midwives' status. The work environment was a dorminant theme at the meso level in addition to toher factors such as the midwives' position in th ehierachy os the heath system and the midwives' conceptualisation of RMC. There was no data on the macro-level.
Mgawadere and Shuaibu (2021)	To explore enablers and barriers to respectful maternity care in low and middle-income countries	Literature Review of	Qualitative Research	The enablers and barriers were synthesised under two main themes: interpersonal relationship and support, and privacy and confidential
Shakibazadeh, Namadian, Bohren et al. (2017)	To develop a conceptualisation of RMC	Qualitative evidence synthesis	Studies using qualitative methods	The twelve domains of RMC that were synthesised demonstrates that the concept is broader than a reduction of disrespectful care or mistreatment of women during childbirth.
Wilson-Mitchell, Eustace, Robinson et al. (2018)	To provide a broad overview of RMC as an emerging field, current research, and applications to experience in Tanzania	Literature review	16 studies that had relevance to Tanzania	The conceptualisation of RMC to as the widely accepted domains of universal right of the childbearing woman. The identification of factors that plague the work-life conditions of midwives in the global south such as poor infrasture and and low resources which inhibit the provision of respectful care

Summary of empirical intervention studies

Author(s) and date	Aim and objectives	Research setting	Study population	Methodology and methods	Intervention	Findings
Afulani, Aborigo, Walker et al. (2019)	To evaluate the effect of an integrated simulation-based training on provision of RMC	Five highest volume delivery facilities in East Mamprusi District in Northern Ghana	43 providers including midwives, doctors, anaesthetists and nurses	Integration of specific components of RMC into a simulation training to improve identification and management of obstetric and neonatal emergencies. Evaluation was conducted through surveys at baseline and endline	Integration of specific components of RMC, emphasizing dignity and respect, communication and autonomy, and supportive care, into a simulation training to improve identification and management of obstetric and neonatal emergencies	Statistically significant differences were found in the characteristics of women interviewed in the baseline and endline
Asefa, Morgan, Bohren et al. (2020)	To describe lessons learned in RMC training and its implementation from the perspectives of service providers' perceptions and experiences.	Ethiopia	64 service providers (midwives, integrated emergency surgical officers, nurses, general practitioners, and health officers)	Interventional Mixed methods study employing a pre- and post-intervention quantitative survey and focus group discussions, two months following the intervention	three-day RMC training	Improvedment in the participants' awareness of the rights of women during childbirth and their perceptions and attitudes about RMC were positively influenced.
Asefa, Morgan, Gebremedhin et al. (2020)	To compare the experiences of mistreatment reported by childbearing women before and after implementation of a respectful maternity care intervention	Three hospitals in southern Ethiopia	388 women and a total of 64 health service providers participated in the training including 52 midwives	A mixed methods pre–post study design	Training of service providers, placement of wall posters in labour rooms and post-training supportive visits for quality improvement.	The number of mistreatment components experienced by women was reduced by 18%. Women who had a complication during pregnancy and childbirth experienced a greater number of mistreatment components.

Dzomeku, Boamah Mensah, Nakua et al. (2021)	To evaluate the impact of the training by exploring midwives' experiences of implementing RMC knowledge in their daily maternity care practices 4 months after the training workshop.	A tertiary health facility in Kumasi, Ghana	14 midwives who participated in RMC training	Descriptive qualitative research design usingn in-depth interviews	A four-day RMC training workshop	The application of newly acquired RMC knowledge positively improved midwives' relationship with childbearing women, assisted them to effectively communicate with women, and positioned them to recognize the autonomy of women
Geddes, Humphrey, and Wallace (2017)	To design and pilot a training module for clinical midwives in the promotion of respectful maternity care, and to demonstrate to participants the link between human rights and maternal health care, showing how a human rights based approach may improve the experiences of patients and care providers.	Malawi	40 Midwives, managers and lecturers who were involved in training and delivering care in health facilities.	Training programme devised jointly by an interdisciplinary team from midwifery and law.	Human rights approach with training materials designed by human rights experts within the team who were familiar with how a human rights-based approach can be tailored to various settings.	At the conclusion of the training, a qualitative evaluation was undertaken and the participants mainly found the content engaging, educational and appropriate for practice
Green, Perez, Walker et al. (2021)	To create an actionable framework for the practice of respectful maternity care based on the experiences of Black birthing people.	United States	50 Black mothers	Cultural humility Reproductive Justice and Research Justice were used as guiding framework and data collected through FGI	Actionable framework for black birthing people	A cycle of respectful maternity care was created and the core values included: Value blackness, birth equity, reproductive justice, professional oath, holistic maternity care, humanity and love.

Hall and Mitchell (2017)	To describe an educational workshop that enables learning to promote dignity and respect in maternity care	United Kingdom	BSc (Hons) Midwifery Undergraduate students over 5years Evaluation data from around 50 students	Theories of transformational learning was the underpinning philosophy which guided the development of the workshop	Workshops were conducted in the first year of the midwifery program and after the students had undertaken a variety of placements in both community and hospital settings.	The use of creative teaching approaches in a workshop setting appears to provide an effective learning opportunity around dignified and respectful care.
Kujawski, Freedman, Ramsey et al. (2017)	To reduce the prevalence of disrespect and abuse during childbirth in Tanzania.	Two hospitals in Tanga Region, Tanzania	2,085 at baseline and ,680endline women who had been discharged from the maternity ward after delivery	Comparative before-and-after evaluation design	A client service charter and a facility-based, quality-improvement process aimed to redefine norms and practices for respectful maternity care	The intervention was associated with a 66% reduced odds of a woman experiencing disrespect and abuse during childbirth
Mengistu, Alemu, Kassa et al. (2021)	Study describes the development, implementation and results of interventions to improve respectful maternity care.	17 health centers and three hospitals in three Districts in Ethiopia	Institute for Healthcare Improvement senior project officers who had first-hand experiences as HCPs in rural settings, multidisciplinary health professionals, including facility leadership, MNH clinical providers, data managers and health extension workers	Quantitative and qualitative methodologies using FGDs	Actresses were trained to perform the scripts obtained from FGDs in video testimonials and videos were shown to participants in a training module followed by participatory reflection and discussion.	Even though RMC training addressed all seven categories of mistreatment, only births with privacy and birth companion offered were documented in the database. There was a significant increase in percentage of births with companion and privacy during the project period, which was maintained in the long-term, a year after the end of the direct project support.
Ndwiga, Warren,	To describe providers' perceptions,	13 facilities in Kenya	89 indepth interviews and 142 quantitative	Interviewed using a two-part quantitative questionnaire: an	Heshima project used a participatory process for developing and	Behaviour change interventions, central to promoting respectful care

Ritter et al. (2017)	attitudes, knowledge, and practices for both their work environment and clients' rights after a behaviour change intervention package aimed at promoting RMC in Kenya		interviews with health care providers (nurse-midwives and doctors) facility managers, senior reproductive health program managers (at national, county, and sub-county levels), and civil society representatives.	interviewer-guided section on knowledge and practice, and a self-administered section focusing on intrinsic value systems and perceptions	implementing a package of interventions at facility, policy, and community levels. Workshops utilizing materials adapted from the values clarification and attitude transformation (VCAT) curricula developed by IPAS	are feasible to implement but require sustained interaction with health systems where providers practice
O'Connor, McGowan, and Jolivet (2019)	The purpose of this case study is to learn from the experiences and successes of the RMC Global Council to inform the development of a validated, empirically-grounded strategic framework that outlines the critical success factors for effectively raising awareness of a policy- and human rights-related issue.	Members of the RMC Global Council	28 participants categorized into "influencers"—or those who implemented the awareness-raising efforts—and the "influenced"—those who were affected by the efforts.	Case study approach beginning with a literature review to identify theoretical models on awareness raising, development of a new, draft framework using components of the Framework for Effective Campaigns, the SpitFire SmartChart 3.0, and Network Theory and semi-structured interviews	Review of lietrature for theoretical models of awareness raising which culminated in the development of a new model and semi-structured interviews	The validated awareness-raising framework includes five strategies that characterize a successful awareness raising effort: 1. The effort utilizes elements of strategic planning 2. The effort aims to capture the attention of key stakeholders 3. The effort delivers a consistent persuasive message 4. The effort creates a receptive environment 5. The effort maximizes all existing and potential resources
Ouédraogo, Kiemtoré, Zamané et al. (2014)	To reinforce skills in RMC among its members of the society of Obstetricians and	3 health facilities in Burkina Faso; a primary rural	A total of 46 health workers, including obstetricians, obstetricians in training, health	A project to reinforce skills in respectful maternity care	Interventions (presentations, group work, role play, and case studies) to reinforce skills in	Participative approach to learning interpersonal skills contributes to improved quality of care

	Gynaecologists, Burkina Faso and health workers at three facilities	district hospital, secondary urban regional hospital and an urban university hospital	assistants (nurses specialized in surgery and anaesthesia) and midwives		respectful maternity care). The training also included study visit to observe interactions between providers and pregnant women in health facilities	and motivation of the workforce. A suboptimum working environment negatively impacts on quality of care.
Ratcliffe, Sando, Lyatuu et al. (2016)	To describe an exploratory study conducted in a large referral hospital in Dar es Salaam, Tanzania that sought to measure D&A, introduce a package of interventions to reduce its incidence, and evaluate their effectiveness.	Tanzania	2000 women and 55 providers	Extensive consultation with critical constituencies. Pre -post questionnaires, structured interviews, and direct observation	(1) Open Birth Days (OBD), a birth preparedness and antenatal care education program, and (2) a workshop for healthcare providers based on the Health Workers for Change curriculum.	Comparisons before and after the interventions showed an increase in patient and provider knowledge of user rights across multiple dimensions, as well as women's knowledge of the labor and delivery process. Patients and providers reported improved communication, which direct observations confirmed.
Reis et al. (2012)	To collect information from key stakeholders about their experience implementing interventions to promote RMC	19 countries	48 individual stakeholders	A survey instrument was developed to collect information from country and project stakeholders	Interventions to promote RMC included Strengthening training, Developing clinical guidelines and protocols, Implementing community activities, including campaigns	Interventions include Strengthening training, Implementing quality improvement approaches, Developing clinical guidelines and protocols, Implementing community activities, including campaigns, Strengthening local laws and regulations, Advocacy, including initiatives and clients' rights charter

Smith, Schachter, Banay et al. (2020)	To highlight the effectiveness of the solution package on provider provision of better care and client satisfaction, as well as intermediary outcomes and behavioral mechanisms	Chipata District, Eastern Province, Zambia	220 surveys of providers and clients were completed between baseline and endline.[	A quasi-experimental evaluation using Datta & Mullainathan's (6) behavioral design approach to systematically design interventions. Baseline and endline interviewsm	5-component solution package: BETTER (Breathe, Encourage, Turn, Think, and Rub) Pain Management Toolkit, Feedback Box, Provider–Client Promise, Fresh Start Funds, Reflection Workshop	The solutions were simple for providers to implement and were easily integrated into existing services by providers during labor and delivery. pain management toolkit as helpful in expanding the types of pain management techniques used during labor
Warren, Ndwiga, Sripad et al. (2017)	To capture and explain the complexity and interconnectedness of the elements of Heshima (an evidence-based participatory implementation research)	13 facilities in five regions in Central and Western Kenya	A range of communities, facilities and policy stakeholders	Consolidated framework for implementation research	Policy dialogue, VCAT workshops, maternity open days, counselling for porviders, mediation training for society leaders, and community education and male involvement	A participatory approach to the implementation of interventions to promote RMC has the capacity to reduce disrespect and abuse and promote a more respectful care
Webber, Chirangi, and Magatti (2018)	reports on the experiences of nurses in a series of workshops based on the "Health Workers for Change" curriculum	Rorya District, Mara, Tanzania.	60 nurses	Workshops, survey and focus groups	"Health Workers for Change" curriculum which includes six workshops covering the following topics titled: "Why I am a health worker", How do our clients see us?", "Women's status in society", "Unmet needs", "Overcoming obstacles at work", and "Solutions".	The participants appreciated the training, reflected on the poor quality of health care services they were providing, and recognized that their attitudes towards their women patients were problematic.
Wilson-Mitchell, Robinson,	To develop and deliver a two-day RMC workshop for	Rural Tanzania	Over 170 Midwives	Cocreation of solutions intellectual partnership model	Teaching RMC using an intellectual partnership model	The implementation revealed that midwife learners were creative,

and Sharpe (2018)	midwives using principles of Intellectual Partnership Model	innovative, context specific in their social innovation creations related to RMC when supported by respectful facilitators. 2-year certificate learners were less prepared for critical thinking work and social innovations than midwives who had 3 or 4 year formal training

Summary of reviews of RMC interventions

Author(s) and date	Aim and objectives	Research setting	Methodology and methods	Intervention	Findings
Downe, Lawrie, Finlayson et al. (2018)	To assess the effectiveness of introducing RMC policies into health facilities providing intrapartum services	Kenya, Tanzania, Sudan, South Africa	Systematic review including 2 Cluster RCTs, 3 before and after studies	Introducing RMC policies into health facilities.	Moderate certainty evidence suggested that RMC interventions increases women's experiences of respectful care
Namusonge and Ngachra (2021)	To find out the factors contributing to disrespect and abuse during childbirth, to identify strategies for addressing issues affecting respectful maternity care.	60 studies on Respectful Maternity Care interventions/ approaches were selected for analysis	Systematic Literature Review	Interventions were focused on capacity building of health workers on RMC and clinical quality, clinical audits and feedback, improvement of health workers' performance, and supportive supervision, community engagement.	Studies focused on capacity building of health workers on RMC and clinical quality, clinical audits and feedback, improvement of health workers performance, and supportive supervision, and community engagement
Ratcliffe (2013)	1)To identify risk factors for disrespect and abuse during childbirth and place them into a framework which takes into account the various sub-systems that impact the provision of RMC. 2) To develop an evidence base of interventions which have the potential to be successful in promoting RMC. 3) To use the framework and catalogue of interventions identified to make recommendations for the Hansen Project on Maternal and Child Health	Ethriopia and Tanzania	Extensive structured literature review and key-informant interviews	Twenty two interventions were identified to address these risk factors and were categorized by the framework level that they affect and at which they would be implemented	Sixteen risk factors for D&A were identified and categorized into a framework that includes four levels: Individual and Community, Provider, Facility, and National Systems. Identified interventions addressed risk factors. The efficacy of interventions is dependent on coordination and synergy between levels of stakeholders.
Rubashkin, Warnock, and Diamond-Smith (2018)	To map the PCC objectives of past interventions using a current definition of PCC delivery care and to explore the impact of PCC objectives on PCC and clinical outcomes.	51 studies were from multiple locations	Systematic review	Interventions were categorised into 5 primary person-centred care objectives: automy, supportive care, social support, the health facility environment, and dignity	52 studies were identified and synthesised.. Autonomy was the most intervention and interventions generally either imporved or made no difference to the person-centred care outcomes. Relationship between person-centred care objectives and clinical outcomes were unclear

Commentaries on RMC interventions

Author(s) and date	Aim and objectives	Research setting	Intervention	Findings
Austad, Chary, Martinez et al. (2017)	To describe an ongoing obstetric care navigator pilot program employing rapid-cycle quality improvement methods to quickly identify implementation successes and failures	Rural Guatemala	Care navigators	Care navigation is a promising strategy to overcome the "humanistic barrier" to hospital delivery by mitigating D&A.

Summary of empirical studies focusing on tools to measure RMC

Author(s) and date	Aim and objectives	Research setting	Study population	Methodology and methods	Findings
Afulani, Feeser, Sudhinaraset et al. (2019)	To develop a shorter, more simplified PCMC tool that could be applied by program implementers across multiple settings	Kenya, Ghana, and India.	Women	Application of the 30-item PCMC scale in four studies in three LMICs— Kenya, Ghana, and India.	Thirteen items were retained for a potential multi-setting short PCMC scale, incorporating the domains of dignity and respect, communication and autonomy, and supportive care.
Afulani, Diamond-Smith, Phillips et al. (2018)	To present the results of the psychometric analysis of the PCMC tool that was previously validated in Kenya using data from India, to assess the validity and reliability of the PCMC scale in India, and to compare the results to those found in the Kenyan validation	Uttar Pradesh, India	Women who delivered in 40 government facilities	Data from a previous cross-sectional survey was used to validate the scale	A 27-item PCMC scale was developed for India with a possible score range from 0 to 81, compared to the 30-item PCMC scale in Kenya with a 0 to 90 possible score range. The items were grouped into three conceptual domains similar to Kenya
Afulani, Diamond-Smith, Golub et al. (2017)	To extend the literature by developing and validating a person-centered maternity care scale.	Rural and urban settings in Kenya	6 post partum women	Literature review to define construct and identify domains, and develop items to measure each domain. Expert reviews to assess content validity. Cognitive interviews with potential respondents to assess clarity, appropriateness, and relevance of the questions. Surveys to assess construct and criterion validity and reliability.	A 30-item PCMC scale with three sub-scales to measure person-centered maternity care was developed. The subscales were dignified and respectful care, communication and autonomy, and supportive care.
Ayoubi, Pazandeh,	To report on construction and validation of such new	Tehran, Iran	400 eligible postpartum women	This was a mixed method study that was designed in two phases: item generation through three	The Women's Perception-RMC questionaire has 19 items that loaded

Simbar et al. (2020)	assessment tool which was developed in Iran from labouring women's point of views.			focus groups with post- partum women and a literature review study, the items and questionnaire were finalized through an expert review; and (II) evaluating psychometric properties using face, content, construct validity and reliability.	in three factors: Providing comfort, Participatory care and Mistreatment.
Dzomeku, Boamah Mensah, Nakua et al. (2020)	To construct a scale that measures childbearing women's experiences of RMC during childbirth and the immediate postpartum period in the study setting	Tertiary healthcare facility in Kumasi, Ghana	263 postpartum women	Authors reviewed of a 60-items draft RMC scale from Ethiopia. 42 items that were contextually applicable to Ghana were selected	23 items RMC scale (23i-RMC) was developed with three main factors: Verbal abuse-free, Discriminatory-free and Dignified care (VADDC), Physical and Psychological Abuse-free care (PPAC), and Compassionate Care (CC).
Esmkhani, Namadian, Nooroozy et al. (2021)	To determine the psychometric properties and localization of the RMC Respectful Care questionnaire in Iran.	Zanjan city, Iran	150 postpartum women	This cross-sectional analytical study (Psychometric Analysis) was conducted to determine the psychometric properties of the Persian version of the RMC Respectful Care questionnaire which was developed by Sheferaw et al.	The original RMC tool achieved an overall high internal reliability. Only friendly care had a good internal consistency score in the target population
Feijen-de Jong, van der Pijl, Vedam et al. (2020)	To reports on results of a study to evaluate applicability, including the psychometric properties of a translated and adapted version of the MORi and MADM in a Dutch population of pregnant women living in different areas in the Netherlands.	Netherlands	557women	Cross-sectional study	Both the MORi and MADM showed feasibility, internal consistency, and with respect to construct validity, both measures discriminated between type of care provision. women with a healthy pregnancy reported statistically higher MORi-scores in comparison to those with pregnancy complications.

Hajizadeh, Asghari Jafarabadi, Vaezi et al. (2020)	To adapt RMC to the Iraniancculture and determine its psychometric properties.	Iran	265 postpartum women	Quantitative study	All items achieved an acceptable content valaidity. RMC questionnaire showed that item 12 had a low factor loading and was eliminated from the Persian version.
Jenkinson, Kearney, Kynn et al. (2021)	To validate two pre-existing scales in the Australian context, and to determine the extent to which Queensland women currently ex-perience respectful maternity care and autonomy in decision making.	Queensland, Australia	Ten women for FGDs and 161 completed	A sequential two-phase study was designed to 1) determine the con-tent validity of the MORi and MADM scales in Australia, and 2) to un- dertake a cross sectional survey to capture women's recent maternity care experiences.	Item content validity (ie. i-CVI 0.78) was established for all but one item, and scale content validity (ie. s-CVI 0.9) was established for both scales, with s-CVIs of 0.92 and 0.99 Respectively.
Moridi, Pazandeh, Hajian et al. (2020a)	To develop a scale for evaluating knowledge and practice of midwives on Respectful Maternity Care	Tehran, Iran	20 experts in midwifery and reproductive health and 250 midwives	Exploratory sequential mixed method study undertaken in five phases: 1. Item generation, 2. Content and face validity, 3. A pilot study for item analysis, 4. Construct validation and 5. Reliability assessment.	The Midwives Knowledge and Practice-RMC scale has 23-item in the knowledge and 23-item in the practice section that loaded in three factors: Giving emotional support, providing safe care, and preventing mistreatment.
Rubashkin, Szebik, Baji et al. (2017)	To validate and test an online questionnaire to study maternity care experiences among Hungarian women.	Hungary	1,257 women	Literature, collation of validated items and scales from two previous English-language surveys and adapting them to the Hungarian context and an expert panel review	Pre-xisting English-language items were rated as clear and relaevant to the Hungarian context. 9 new cash payment questions were added to the questionaire
Scott, Gharai, Sharma et al. (2020)	To conduct cognitive testing of an RMC measurement tool for use in rural northern India.	Madhya Pradesh, India	21 rural women	Cognitive interviews which involved asking the respondent the survey question, recording her response, then interviewing her about what the question and response options meant to her.	Although women tended to provide initial answers to the survey questions, cognitive interviews revealed widespread mismatch between respondent interpretation and question's intent. Many key terms and concepts from the international RMC literature did not translate well and showed low resonance with respondents, including consent and being involved in decisions about one's

					care.
Singh, Gogoi, Caleb-Varkey et al. (2021)	To describe the development process of the study tool to assess respectful maternity care in health facilities of India.	20 tertiary care across India	85 stakeholders	The tool development process comprised of four steps: 1) literature review and meeting with Technical Advisory Group; 2) the national stakeholders workshop and development of the initial tool; 3) feedback on the tool from twenty tertiary care public health facilities from various regions of India; 4) the final tool and its validity approval by Technical Advisory Group.	A new tool was developed to document RMC deficits in labor room settings. Deficits inclue: physical harm or ill-treatment, withholding a patients' right to information, informed consent, and choice/preferences, Gaps in confidentiality and privacy, Gaps in dignity and respect, Non-provision of equitable care, free of discrimination, Abandonment or being left without care, Detained or confined against will
Sheferaw, Mengesha, and Wase (2016)	To construct and validate a scale that measures women's perception of RMC provided in health facilities.	Ethiopia	Labour and delivery clients	A mixed approach of qualitative and quantitative methods. Inductive item generation process that included a literature review and in-depth interviews	Extracted components were labelled as friendly care, abuse-free care, timely care, and discrimination-free care. The final 15-item scale generated showed an adequate reliability and correlated strongly with the global satisfaction measures
Sheferaw, Bakker, Taddele et al. (2021)	To assess the availability of an institutional-level respectful maternity care (RMC) index, its components, and associated factors.	Ethiopia	3804 health facilities	A cross-sectional study design	Three components of the institutional-level RMC index were identified: "RMC policy," "RMC experience," and "facility for provision of RMC."
Taavoni, Goldani, Rostami Gooran et al. (2018)	To develop and pretest a new instrument, the Quality of Respectful Maternity Care Questionnaire in Iran (QRMCQI), with an ensured validity and reliability to evaluate and measure Respectful Maternity Care (RMC) in three sections of labor,	Iran	20 experts and 453 mothers	Mixed sequential exploratory design. The questionaire design was in five phases: questions generation, face validation, content validity assessment, confirmatory factor analysis and reliability assurance of the questionnaire.	59-item QRMCQI for evaluating respectful maternity care in Iran with 41 questions in labor, 10 in delivery and 8 in post-partum

	delivery and post-partum				
Vedam, Stoll, Martin et al. (2017)	To develop and validate a new instrument that assesses women's autonomy and role in decision making during maternity care.	British Columbia, Canada	1672 women	Community-based participatory research	Women who were cared for by midwives had the highest median MADM scores, and for those who saw physicians had 10 or more lower points. Midwifery care was associated with higher MADM scores, even during short prenatal appointments (<15 minutes).
Vedam, Stoll, Rubashkin et al. (2017)	To develop a survey tool that assesses women's experiences of maternity care, including disrespect and discrimination	British Columbia, Canada	Women of childbearing age from diverse communities	Community led participatory action research using cross-sectional survey	Items in scale assess the nature of respectful patient-provider interactions and their impact on a person's sense of comfort, behaviour, and perceptions of racism or discrimination The Mothers on respect index (MORi) is a reliable, patient-informed quality and safety indicator that can be applied across jurisdictions to assess the nature of provider-patient relationships.
Vedam, Stoll, McRae et al. (2019)	To report on quantitative findings of the Changing Childbirth in British Columbia study	British Columbia, Canada	2051 women	Cross-sectional online survey	Most women (95.2%) preferred to be the lead decision-maker during care. women cared for by physicians had significantly lower autonomy (MADM) scores than midwifery clients as did women who felt pressured to accept interventions. Women who had a difference in opinion with their provider, and those who felt their provider seemed rushed reported the lowest MADM scores.

Summary of systematic reviews focusing on tools to measure RMC

Author(s) and date	Aim and objectives	Research setting	Methodology and methods	Findings
Afulani, Buback, McNally et al. (2020)	To provide practical evidence-based recommendations on indicators that may be used for routine measurement of RMC in programs.	Not applicable	A rapid review	49 indicators were identified. These included several domains of RMC and mistreatment including dignified/nondignified care, verbal and physical abuse, privacy/ confidentiality, autonomy/loss of autonomy, supportive care/ lack thereof, communication, stigma, discrimination, trust, facility environment/culture, responsiveness, and nonevidence-based care.
Dhakal, Gamble, Creedy et al. (2021)	To critique the process of development and psychometric properties of tools that measure respectful or disrespectful care experienced by women during labor and birth in lowand middle-income countries.	Low and middle-income countries	A systematic review	The review could not identify any measures of disrespectful care even though most included measures focused on disrespect and abuse. No measure was of sufficient quality to determine women's experiences of disrespectful and respectful maternity care in low- and middle-income countries.

Appendix 2: Participant information sheets

Study Title: Respectful maternity care among midwives in three maternity units in Ghana: A focused ethnography

PARTICIPANT INFORMATION SHEET FOR FOCUS GROUP DISCUSSION

Research Ethics Reference: 154-1811
Version 1.0 Date: 16/01/2019

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. One of our team will go through the information sheet with you and answer any questions you have. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The purpose of this study is to investigate Ghanaian midwives' understanding of respectful maternity care and how this affects their practice. The study also seeks to determine what prevents or promotes midwives' ability to provide this care in Ghana.

Why have I been invited to take part?

You have been invited to take part in this study because you are a midwife at one of the three sites hosting this research and your contribution will be vital for this study. We will be recruiting up to 60 participants in this study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This does not affect your legal rights.

What will happen to me if I take part?

A researcher will contact you to go over the information sheet. If you agree to take part in the study, you will be asked to attend a focus group discussion involving three to five other midwives from the labour ward, which will take place at the hospital's conference room. Upon arrival for the discussion, we will talk you through the study procedures and give you chance to ask any questions.
The group discussion will be facilitated by one member of the team. There will also be a trained co-facilitator will take notes during the discussion. The themes and questions will focus on how midwives

provide respectful care to women on the labour ward. It will also focus on the barriers and facilitators to the provision of this care. The discussion will be audio recorded by the researcher using an audio recorder. This should take approximately one hour.
If you are happy to take part, then you will then be asked to sign a consent form.

What is a focus group discussion?

A focus group discussion is a data collection method that involves four or more participants who discuss a particular topic facilitated by the researcher with assistance from a co-facilitator.

Are there any risks in taking part?

There is the possibility that you may find discussing some aspects of your experience distressing. All participants will be encouraged to pause or stop if they find such circumstances stressful for them.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research. Your contribution will ensure that the perspectives of midwives are included in this research. The research may ultimately inform the development of strategies and policies to improve maternity care in Ghana.

Will my time/travel costs be reimbursed?

Travel expenses will be offered if you have to travel to the study site for focus group discussions when you are off duty. At the end of the focus group discussion, you will receive some light refreshments as a way of saying thank you for your time.

What happens to the data provided?

The research data will be stored confidentially using an encrypted laptop. To help ensure your privacy, you will be assigned a false name, and it will be used instead of your name. We will save all the recordings and research data using that pseudo name so that none of the data will have your real name or other individual identifiers associated with them. Your name and any personal information about you on consent forms will not be disclosed.

Personal / sensitive data such as your consent form would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

We would like to use fully anonymised direct quotes in research publications.

All research data and records will be stored for a minimum of 7 years after publication.

Data sharing in this way is usually anonymised (so that you could not be identified)

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study at any time without giving any reason and without your legal rights being affected. Any personal data will be destroyed.

If you withdraw, we will no longer collect any information about you or from you, but we will keep the anonymous research data that has already been collected and stored as we are not allowed to tamper with study records. This information may have already been used in some analyses and may

still be used in the final study analyses. To safeguard your rights, no personally identifiable information will be used.

Who will know that I am taking part in this research?

All information collected about you during this research would be kept strictly confidential. Any audio digital recordings and electronic data will be anonymised with false names as detailed above. All such data are kept on password-protected computer sitting on a secure restricted access server and any paper information (such as your consent form, contact details and any research questionnaires) would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

Anything you say during a focus group discussion will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the midwife in-charge of the labour ward.

What will happen to the results of the research?

The research will be written up as a thesis for the degree of Doctor of Philosophy in Midwifery. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

The research will be published in peer reviewed journals.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS 154-1811) at the University of Nottingham and the Ghana Health Service Ethics Review Committee (Reference number: GHS-ERC013/10/18)

Who is organising and funding the research?

This research is being carried out as part of a PhD programme in the School of Health Sciences, University of Nottingham, UK and the tuition fees for the primary researcher are funded by the University of Nottingham Vice Chancellor's Scholarship for research excellence (international).

What if something goes wrong?

If you have a concern about any aspect of this project, please speak to the researcher [Jennifer Akuamoah-Boateng] or the Principal Investigator [Professor Helen Spiby], who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

Contact Details

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Alternatively, contact

Professor Helen Spiby, Lead Research Supervisor

Email: helen.spiby@nottingham.ac.uk

Telephone: +44 (0) 115 82 30820

Dr Catrin Evans, Research Supervisor

Email: catrin.evans@nottingham.ac.uk

Telephone: +44 (0) 115 82 30894

Dr Phoebe Pallotti, Research Supervisor

Email: phoebe.pallotti1@nottingham.ac.uk

Telephone: +44 (0)115 74 86500

For Clarification on Ethical Issues and your right as a participant, contact the administrator of the Ghana Health Service Ethics and Review Committee, Hannah Frimpong, Research and Development Division, Ghana Health Service, Accra. Tel: 0507041223

Study Title: Respectful maternity care among midwives in three maternity units in Ghana: A focused ethnography

PARTICIPANT INFORMATION SHEET FOR SEMI STRUCTURED INTERVIEW

Research Ethics Reference: 154-1811
Version 1.0 Date: 16/01/2019

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. One of our team will go through the information sheet with you and answer any questions you have. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The purpose of this study is to investigate Ghanaian midwives' understanding of respectful maternity care and how this affects their practice. The study also seeks to determine what prevents or promotes midwives' ability to provide this care in Ghana.

Why have I been invited to take part?

You have been invited to take part in this study because you are in charge of the labour ward, a nurse/midwifery manager or a stakeholder in the provision of maternity care and your contribution will be vital for this study. We will be recruiting up to 15 participants in this study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This does not affect your legal rights.

What will happen to me if I take part?

A researcher will contact you to go over the information sheet. If you agree to take part in the study, you will be asked to attend an interview at a location (not your home) convenient for you. Upon arrival for the interview, we will talk you through the study procedures and give you chance to ask any questions.

The interview will be conducted by one member of the team. The themes and questions will focus on how midwives provide respectful care to women on the labour ward. It will also focus on the barriers and facilitators to the provision of this care. The interview will be audio recorded by the researcher using an audio recorder. This should take approximately one hour.

If you are happy to take part, then you will then be asked to sign a consent form.

What is a semi-structured interview?

A semi-structured interview is a data collection method that involves a researcher asking a research participant some questions on a particular topic to seek the opinion of the participant. This process is guided by an interview guide but also flows according to the information provided by the participant.

Are there any risks in taking part?

There is the possibility that you may find discussing some aspects of your experience distressing. All participants will be encouraged to pause or stop if they find such circumstances stressful for them.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research. Your contribution will ensure that the perspectives of midwives are included in this research. The research may ultimately inform the development of strategies and policies to improve maternity care in Ghana.

Will my time/travel costs be reimbursed?

Travel expenses will be offered if you have to travel to the venue for the interview. At the end of the interview, you will receive some light refreshments as a way of saying thank you for your time.

What happens to the data provided?

The research data will be stored confidentially using an encrypted laptop. To help ensure your privacy, you will be assigned a false name, and it will be used instead of your name. We will save all the recordings and research data using that pseudo name so that none of the data will have your real name or other individual identifiers associated with them. Your name and any personal information about you on consent forms will not be disclosed.

Personal / sensitive data such as your consent form would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

We would like to use fully anonymised direct quotes in research publications.

All research data and records will be stored for a minimum of 7 years after publication.

Data sharing in this way is usually anonymised (so that you could not be identified)

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study at any time without giving any reason and without your legal rights being affected. Any personal data will be destroyed.

If you withdraw, we will no longer collect any information about you or from you, but we will keep the anonymous research data that has already been collected and stored as we are not allowed to tamper with study records. This information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, no personally identifiable information will be used.

Who will know that I am taking part in this research?

All information collected about you during this research would be kept strictly confidential. Any audio digital recordings and electronic data will be anonymised with false names as detailed above. All such data are kept on password-protected computer sitting on a secure restricted access server and any paper information (such as your consent form, contact details and any research questionnaires) would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

Anything you say during a focus group discussion will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the midwife in-charge of the labour ward.

What will happen to the results of the research?

The research will be written up as a thesis for the degree of Doctor of Philosophy in Midwifery. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

The research will be published in peer reviewed journals.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS 154-1811) at the University of Nottingham and the Ghana Health Service Ethics Review Committee (Reference number: GHS-ERC013/10/18)

Who is organising and funding the research?

This research is being carried out as part of a PhD programme in the School of Health Sciences, University of Nottingham, UK, and the tuition fees for the primary researcher are funded by the University of Nottingham Vice Chancellor's Scholarship for research excellence (international).

What if something goes wrong?

If you have a concern about any aspect of this project, please speak to the researcher [Jennifer Akuamoah-Boateng] or the Principal Investigator [Professor Helen Spiby], who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and

give you an indication of how she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

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Study Title: Respectful maternity care among midwives in three maternity units in Ghana: A focused ethnography

PARTICIPANT INFORMATION SHEET FOR OBSERVATION

Research Ethics Reference: 154-1811
Version 1.0 Date: 16/01/2019

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. One of our team will go through the information sheet with you and answer any questions you have. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The purpose of this study is to investigate Ghanaian midwives' understanding of respectful maternity care and how this affects their practice. The study also seeks to determine what prevents or promotes midwives' ability to provide this care in Ghana.

Why have I been invited to take part?

You have been invited to take part in this study because you are a midwife at one of the three sites hosting this research and your contribution will be vital for this study. We will be recruiting up to 60 participants in this study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This does not affect your legal rights.

What will happen to me if I take part?

A researcher will contact you to go over the information sheet. If you agree to take part in the study, the researcher will observe your day-to-day activities at the labour ward. This should take approximately four hours during a shift over a period of one week.
If you are happy to take part, then you will then be asked to sign a consent form.

What is a participant observation?

Participant observation is a data collection method that involves a researcher observes the day-to-day activities of research participants. The researcher takes notes at the end of each observation

Are there any risks in taking part?

We do not anticipate any risks to you from your participation in this study.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research. Your contribution will ensure that the perspectives of midwives are included in this research. The research may ultimately inform the development of strategies and policies to improve maternity care in Ghana.

Will my time/travel costs be reimbursed?

You will not incur any additional expenses as this part of the research will take place during your usual work patterns.

What happens to the data provided?

The research data will be stored confidentially using an encrypted laptop. To help ensure your privacy, you will be assigned a false name, and it will be used instead of your name. We will save all the recordings and research data using that pseudo name so that none of the data will have your real name or other individual identifiers associated with them. Your name and any personal information about you on consent forms will not be disclosed.

Personal / sensitive data such as your consent form would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.

We would like to use fully anonymised direct quotes in research publications.

All research data and records will be stored for a minimum of 7 years after publication.

Data sharing in this way is usually anonymised (so that you could not be identified)

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study at any time without giving any reason and without your legal rights being affected. Any personal data will be destroyed.

If you withdraw, we will no longer collect any information about you or from you, but we will keep the anonymous research data that has already been collected and stored as we are not allowed to tamper with study records. This information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, no personally identifiable information will be used.

Who will know that I am taking part in this research?

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Anything you say during a focus group discussion will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the midwife in-charge of the labour ward.

What will happen to the results of the research?

The research will be written up as a thesis for the degree of Doctor of Philosophy in Midwifery. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

The research will be published in peer reviewed journals.

Who has reviewed this study?

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If you have a concern about any aspect of this project, please speak to the researcher [Jennifer Akuamoah-Boateng] or the Principal Investigator [Professor Helen Spiby], who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

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For Clarification on Ethical Issues and your right as a participant, contact the administrator of the Ghana Health Service Ethics and Review Committee, Hannah Frimpong, Research and Development Division, Ghana Health Service, Accra. Tel: 0507041223

Appendix 3: Informed consent

Faculty of Medicine and health Sciences

Scholl of Health Sciences

Room B33, B Floor

Queens medical Centre Campus

University of Nottingham

NG7 2UH

Consent form (focused group discussion)

(Final version 1.0 date 10/01/19)

Title of Study: A focused ethnographic study of the provision of respectful maternity care by midwives in a labour ward

Names of researchers: Jennifer Akuamoah-Boateng, Professor Helen Spiby, Dr Catrin Evans, Dr Phoebe Pallotti

Name of participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the focused group discussion will be audio recorded using an audio recorder and that anonymous direct quotes from the discussion may be used in the study reports. ☐
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself. ☐

6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred, it will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐

7. I agree that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers ☐

8. I agree to take part in the above study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Faculty of Medicine and health Sciences

Scholl of Health Sciences

Room B33, B Floor

Queens medical Centre Campus

University of Nottingham

NG7 2UH

Consent form (Interview)

(Final version 1.0 date 10/01/19)

Title of Study: A focused ethnographic study of the provision of respectful maternity care by midwives in a labour ward

Names of researchers: Jennifer Akuamoah-Boateng, Professor Helen Spiby, Dr Catrin Evans, Dr Phoebe Pallotti

Name of participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded using an audio recorder and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reported i.e., potential risks to another person or to myself. ☐
6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred it will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐
7. I agree that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers ☐

8. I agree to take part in the above study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Faculty of Medicine and health Sciences

Scholl of Health Sciences

Room B33, B Floor

Queens medical Centre Campus

University of Nottingham

NG7 2UH

Consent form (Observation)

(Final version 1.0 date 10/01/19)

Title of Study: A focused ethnographic study of the provision of respectful maternity care by midwives in a labour ward

Names of researchers: Jennifer Akuamoah-Boateng, Professor Helen Spiby, Dr Catrin Evans, Dr Phoebe Pallotti

Name of participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the focused group discussion will be audio recorded using an audio recorder and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself. ☐

6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred, it will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐

7. I agree that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers ☐

8. I agree to take part in the above study ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix 4: Interview and observation guides

Interview guide (stakeholders)

Stakeholders (facility level) –Labour ward in charges, deputy director of nursing and midwifery services, quality control officer, medical director/superintendent

District level (DHMT)/regional level – director of medical services, deputy director/regional director of nursing and midwifery services, principal nursing and midwifery officers, quality control officers, representatives of the NMC.

National level- director of nursing and midwifery (MOH/GHS), head of midwifery regulation NMC, registrar/deputy registrar NMC, quality control officers (MOH/GHS)

Introduction

I would first of all like to thank you for participating in this study in-spite of your busy schedule and for the opportunity to interview you. My name is Jennifer Akuamoah-Boateng, a registered midwife and Midwifery Tutor at the Nursing and Midwifery Training College Atibie-Kwahu and currently a PhD student at the University of Nottingham, UK.

As part of my PhD I am conducting a study on the provision of respectful maternity care by midwives at the labour ward. The interview will take approximately 60 to 90minutes. Our conversation will be audio recorded using a tape recorder. If you wish to pause or stop the interview, please notify me and I would do so. You can withdraw from this study at any stage without giving any reason.

I would now like to know if you have understood the information given now and in the information sheet and your consent for this study is voluntary. If you have any further questions or concerns regarding this study or the interview, please do not hesitate to ask and they will be addressed appropriately.

Interview questions

Note: questions will not be asked in the particular order presented. The participants will be encouraged to discuss issues in greater depth and to provide clarification where necessary.

Topic one: Explore respectful maternity care

- What will you consider as the good quality maternal healthcare which you expect from service providers (probe: is respectful care a part of it?, what do you consider respectful care, what are the components)
- How do you ensure the provision of respectful maternity care (probe: what are the factors that influence the provision of this care, what are the facilitators and challenges for the provision, how are the capacity of providers being built to ensure the provision of such care, in what ways do you involve women/families/community in the delivery of care, how do you assess the quality of care that the facility provides)

Topic two: policy on the provision of respectful care

- How are policies been implemented and enforced and who are the target audience(s) in care (probe: what are some of the policies being used, are there policies on RMC, are policies international, national or local, how are they being disseminated, what has been the facilitators and barriers for the dissemination, implementation and enforcement of policies on respectful care

- Have you been involved in the development of policies concerning respectful care (Probe: How accessible are these policies at all levels? Managerial, provider level and community level, have there been inputs from the public in the development of policies? If yes how was it facilitated

- In the absence of policies on respectful care, how are you ensuring that care that is provided is respectful? (Probe: What informs these strategies that have been adopted, have there been difficulty in enforcing these strategies, what has been or would be the role of research and the involvement of other stakeholders (e.g. providers, community members and opinion leaders) in the development and implementation of these strategies?

Topic three: Promoting respectful maternity care

Probes

- How do the facility address the concerns and expectations of women and their families (Probe: How does government, regulatory bodies and health facilities' rules and procedures influence the maternity care specifically respectful care
- What are the factors that exists within your institution that facilitates or prevents the provision of such care (supervision, work environment, job satisfaction, managerial capacity, human resource, role of professional association, burnout) (probe the reasons for these)
- What in your opinion are some of the strategies that can be improved or implemented to provide better quality maternity care (probe: are these feasible, who or which organisation will be involved in it)

Please is there anything you want to add to what you have already told me?

Guide for focus group discussion

Topic one: Client provider interaction

- Why did you choose to become a midwife? you started training as a midwife and then started practicing, have things changed in any way, better or worse? (What are some of the perceptions women and the general public have about midwives in Ghana (Probe: Are these speculations or they are really true) (break the ice and establish rapport,
- Talk about a particular time when you felt really good or unsatisfied about the services you have provided for your client or your interaction with the client (Probe: what influenced it. In situations where you felt unsatisfied given a similar situation at a different time what will you do differently, what do you consider a healthy/good client interaction, what other factors enhances the client provider interaction, do instances like this affect your satisfaction with the job)
- What are the factors that influence client provider relationship (Probe facility, community, personal, societal factors)
- What in your opinion is good quality maternity care? (Probe: Is that the service being provided? If NO what prevents us from providing it. If YES what facilitates your ability to provide it)

Topic two: Understanding of respectful maternity care

- How would you define care that is respectful maternity care (Probe: what are the factors that will affect the provision of the respectful maternity care you are referring to)

(Facilitator provides WHO definition of respectful maternity care and the components are discussed)

Respectful maternity care 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.

- In your opinion how does the maternity services do in the various components of the definition (Probe facilitators and barriers for the provision of any of the components)

Topic three: facilitators and challenges for the implementation of already existing Standards

- Do you follow the recommendations of the NMC for the management of labour as stated in the procedure manual for the management of labour? (Probe specific aspects such as welcoming, greeting, establishing rapport, introducing yourself, explaining procedure, communicating findings effectively, allowing clients to ask questions, referring to clients by name or madam to show respect, providing support and encouragement (what particular things do you do to provide support and encouragement)
- If yes what are some of the things that influenced your ability to do so, of NO what are the challenges
- **Facilitator provides a scenario of a client in a challenging situation who requires support and encouragement** (Probe: Do you think you have been provided with adequate training to deal with such situations? (Probe why)**,** in what ways are you supported to provide the care that is required of you? (Monitoring, supervision, rewards for good work, remunerations. In your opinion, what will it take midwives to provide the care that is recommended by the NMC and government?

- Is there anything you want to add?

Scenario (adapted to suit the nature of the labour ward)

While sitting at the nurse's station doing your documentation, a woman walks in with her relatives holding her by both hands. Just when she arrived in the nurses' station, she laid on the floor and started screaming. What will you do? (Probe: How will you attend to the woman? what will enable you provide RMC according to the manner you have described it? What will prevent you from providing RMC according to the way you have described it?)

Guide for participant observation

Site:……Date:……Shift:……

Topic	Observation	Comments
The physical environment	Key features in the environment, number of beds, provision of privacy, cleanliness, availability of equipment	
Initial assessment when client comes in labour	Welcoming client and accompanying person(s), greeting, introducing themselves,	
Care during labour (1st, 2nd and 3rd stages of labour)	Provision of privacy during assessments, use of partograph in monitoring the first stage, pain relief (pharmacological and non-pharmacological), providing food and drinks, explain procedures and communicating findings after procedure, allowing client to ask questions, allowing companions where appropriate, encourage client to ambulate and assume preferred position, effective communication and general interaction with client (e.g. are they called by name?, communicates progress of labour in an effective manner), explaining what will happen in labour, drapes client, support client in a friendly way, congratulating client after the birth of the baby, showing baby to client	
Care during the 4th stage of labour (first 6hours after birth)	Monitoring according to guidelines, provision of pain relief, support to initiate breastfeeding, monitoring of vital signs,	
Organisational culture	Staff interactions (among midwives and midwives with other staff) and approach to care, norms, rules, events,	
Handing over between shifts	What information goes into the handing over process, how do they refer to clients,	

Appendix 5: Ethics approval from the University of Nottingham

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

4 December 2018

Jennifer Akuamoah-Boateng
PhD Student
c/o Professor Helen Spiby
Professor of Midwifery
Division of Midwifery
School of Health Sciences
12th Floor Tower Building
University of Nottingham
University Park
NG7 2RD

Dear Ms Akuamaoh-Boateng

Ethics Reference No: 154-1811 – please always quote	
Study Title: Respectful maternity care among midwives in three maternity units in Ghana: A focused ethnography.	
Location of Study: Eastern Regional Hospital, Akuapim South District Hospital & Tetteh Quarshie Memorial Hospital, Eastern region of Ghana	
Chief Investigator/Supervisor: Professor Helen Spiby, Professor of Midwifery, School of Health Sciences	
Lead Investigators/student: Jennifer Akuamoah-Boateng, PhD Midwifery, School of Health Sciences	
Other Key Investigators/Collaborators: Dr Catrin Evans, Associate Professor, Nursing Dr Phoebe Pallotti, Associate Professor, Midwifery, School of Health Sciences.	
Proposed Start Date: 01.12.2018	**Proposed End Date:** 30.06.2019 7 mths

The Committee considered this application at its meeting on 16 November 2018 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 02.11.2018

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion has been given on the understanding that:

1. Copies of approval from the Eastern Regional Hospital, Akuapim South District Hospital & Tetteh Quarshie Memorial Hospital in the Eastern region of Ghana are submitted.
2. All appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.
3. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
4. The Chair is informed of any serious or unexpected event.
5. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 6: Ethics approval from the Ghana Health Service Ethics Review Committee

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: 233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
20th November, 2018

MyRef: GHS/RDD/ERC/Admin/App 18/1445
Your Ref. No.

Jennifer Akuamoah-Boateng
Cavendish Hall
University of Nottingham
NG7 2QL.

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC013/10/18**
Project Title	Respectful Maternity Care amongst Midwives in a Maternity Unit: A Focus Ethnography
Approval Date	20th November, 2018
Expiry Date	19th November, 2019
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
PROFESSOR MOSES AIKINS
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Appendix 7: Amendment approval from the Ghana Health Service Ethics Review Committee

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

MyRef:ghs/rdd/erc/Admin/Approval/18/435
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: −233-0302-681109
Fax 1 233-0302-685424
Email: ghserc@gmail.com
19th January, 2019

Jennifer Akuamoah-Boateng
Cavendish Hall
University of Nottingham
NG7 2QL

Re: Application for Amendments of Participants Information Sheet and Stakeholders' Interview Guides

Reference is made to your letter dated 17th January, 2019 on the above subject matter.

The Ghana Health Service Ethics Review Committee (GHS-ERC) has reviewed the documents submitted, and the rationale for the request for amendment of the named documents. The GHS-ERC has given approval for the amendments to be implemented.

GHS-ERC Number	GHS-ERC:013/10/2018
Project title	Respectful maternity care amongst midwives in three maternity units in Ghana: A focused Ethnography
Effective Date for Approval of Amendment	18th January, 2019
GHS-ERC Decision	Amendment Approved

This approval covers the following only:

1. Changes to Participants Information Sheet:
Rewording of information sheet old version to new version accepted by the University of Nottingham

Appendix 8: Permission letter from the Region

OUR CORE VALUES
- People-Centered
- Professionalism
- Team work
- Innovation
- Discipline
- Integrity

Ref. ERHD/465/18
Your Ref. No.

Regional Health Directorate
Ghana Health Service
P. O. Box 175
Koforidua, ER
GHANA

20th December, 2018

Email: erhdgeneraloffice@gmail.com

THE MEDICAL DIRECTOR, REGIONAL HOSPITAL,
THE MEDICAL SUPERINTENDEDNTS,
TETTEH QUARSHIE MEMORIAL HOSPITAL,
NSAWAM GOVERNMENT HOSPITAL,
EASTERN REGION.

RE: PERMISSION TO CONDUCT RESEARCH

Permission has been granted Ms. Jennifer Akuamoah-Boateng, a PhD in Midwifery student of the University of Nottingham, to conduct her research for her Thesis in your hospital.

Please accord her the needed assistance to enable her complete her research work.

Attached please find her personal application and ethical clearance from the Ghana Health Service Ethics Review Committee for your reference.

Thank you.

DR. (MRS) ALBERTA A. BIRITWUM-NYARKO
REGIONAL DIRECTOR OF HEALTH SERVICE (ER).

Cc: Ms Jennifer Akuamoah-Boateng

Appendix 9: Letters of Introduction from the University of Nottingham

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine and Health Sciences
School of Health Sciences
Division of Midwifery
Floor 12, Tower Building
University of Nottingham
University Park
Nottingham
NG7 2RD

12/06/2018

Dr Kofi Ablorh
Medical Superintendent
Akuapim South Municipal Hospital
Nsawam
Ghana

Dear Dr Ablorh

Letter of introduction: Jennifer Akuamoah- Boateng

I am pleased to introduce the above in her capacity as a doctoral student registered in the School of Health Sciences at the University of Nottingham, UK.

I am providing this Letter of Introduction in my capacity as one of the academic supervisory team for Ms Akuamoah-Boateng who is carrying out research entitled *'A focused ethnography of the provision of respectful maternity care in the labour ward'*.

Ms Boateng is approaching the end of her first year of a three-year doctoral programme and is seeking to identify sites that are willing to support her data collection.

We would be most grateful for any assistance that could be provided to Ms Boateng to facilitate her doctoral studies.

Yours sincerely

Helen Spiby

Helen Spiby
Professor in Midwifery

+44 (0)115 8230820
Helen.spiby@nottingham.ac.uk
nottingham.ac.uk/healthsciences

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine and Health Sciences
School of Health Sciences
Division of Midwifery
Floor 12, Tower Building
University of Nottingham
University Park
Nottingham
NG7 2RD

12/06/2018

Dr Isaac Adu-Poku Antwi
Medical Superintendent
Holy family Hospital
Nkawkaw
Ghana

Dear Dr Adu-Poku Antwi

Letter of introduction: Jennifer Akuamoah- Boateng

I am pleased to introduce the above in her capacity as a doctoral student registered in the School of Health Sciences at the University of Nottingham, UK.

I am providing this Letter of Introduction in my capacity as one of the academic supervisory team for Ms Akuamoah-Boateng who is carrying out research entitled *'A focused ethnography of the provision of respectful maternity care in the labour ward'*.

Ms Boateng is approaching the end of her first year of a three-year doctoral programme and is seeking to identify sites that are willing to support her data collection.

We would be most grateful for any assistance that could be provided to Ms Boateng to facilitate her doctoral studies.

Yours sincerely

Helen Spiby

Helen Spiby
Professor in Midwifery

+44 (0)115 8230820
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nottingham.ac.uk/healthsciences

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine and Health Sciences
School of Health Sciences
Division of Midwifery
Floor 12, Tower Building
University of Nottingham
University Park
Nottingham
NG7 2RD

12/06/2018

Dr Kwame Anim-Boamah
Medical Director
Eastern Regional Hospital
Koforidua
Ghana

Dear Dr Anim-Boamah

Letter of introduction: Jennifer Akuamoah- Boateng

I am pleased to introduce the above in her capacity as a doctoral student registered in the School of Health Sciences at the University of Nottingham, UK.

I am providing this Letter of Introduction in my capacity as one of the academic supervisory team for Ms Akuamoah-Boateng who is carrying out research entitled *'A focused ethnography of the provision of respectful maternity care in the labour ward'*.

Ms Boateng is approaching the end of her first year of a three-year doctoral programme and is seeking to identify sites that are willing to support her data collection.

We would be most grateful for any assistance that could be provided to Ms Boateng to facilitate her doctoral studies.

Yours sincerely

Helen Spiby

Helen Spiby
Professor in Midwifery

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