ASSESSMENT OF STRUCTURE AND PROCESS FACTORS INFLUENCING DIGNIFIED INTRAPARTUM CARE AMONG MIDWIVES AT KENYATTA NATIONAL HOSPITAL

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DECLARATION

I Alice Wangeci Mathenge hereby declare that this research thesis submitted for the Master of Science in Nursing (Obstetrics Nursing and Midwifery) is my original work and not a duplicate of any other scholar's work.

I have acknowledged the contribution of other scholars in this paper and therefore declare that all materials cited or quoted in this research proposal, which is not mine, are acknowledged through a comprehensive list of references.

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ii

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iii

DEDICATION

I dedicate this thesis to my only and dear sister Jennifer thank you for your support, and unconditional love.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATION

ERC - Ethics Research Committee

FMP - Free Maternity Policy

KNH- Kenyatta National Hospital

UON – University of Nairobi

SDG - Sustainable Development Goals

WHO- World Health Organization

OPERATIONAL DEFINITIONS

Childbirth-it is the expulsion or extraction of a viable foetus and other products of conception out of the womb.

Dignified intrapartum care – organized care provided to all women during labour and childbirth, while maintaining dignity, respect, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support.

Influence: the capacity to have an effect or impact of one factor has over another.

Intrapartum care – care of women and their babies during labour and 2 hours after childbirth.

Labour- the process of childbirth, which starts with uterine contractions ends with the delivery of a baby, placenta, and membranes.

Process factors –these are interpersonal components that meet the individual and social expectations and standard of care.

Structural factors- these are desirable attributes of the setting within which care is provided.

ABSTRACT

Background: Dignified intrapartum care is the basic right for every woman during childbirth. Non- dignified intrapartum care has been reported globally, and recognized as a powerful deterrence to facility-based childbirth. In Kenya, undignified intrapartum care has been frequently reported. Free maternity policy and protecting the woman (*Linda mama*) programs in Kenya have led to increased health facility births. The surge of women seeking health facility childbirth has led to overstretching of health facilities, leading to mistreatment and abuse during labour and delivery.

Objective: To assess the structural and process factors that influence dignified intrapartum care at the Kenyatta National Hospital (KNH).

Methods: This study was conducted at the Kenyatta National, Hospital labour ward. The design was descriptive, cross-sectional employing a quantitative approach through a self-administered questionnaire. Ethical approval was sought from Kenyatta national hospital-University of Nairobi ethics research committee (KNH-UoN ERC). Data were collected within four weeks. The sample size was 79 midwives. A simple random sampling method was used to select the respondents. Data were collected, entered, cleaned, and analysed using SPSS version 24. Descriptive and inferential statistics were reported and presented using tables, figures, and plain text. Association between study variables was estimated using chi-square statistics at a significance level of 5% and a confidence interval of 95%.

Results: Majority of respondents were aged between (24-29) years 45%., with Most of them having worked between 1-3 years at the KNH labour ward, 45.2%. Majority of the respondents, 66.7% had worked in another facility in the labour ward. The majority of respondents were diploma holders 63.5%.

Conclusion: Structure factors were identified as an influence the delivery of dignified intrapartum care which fits in within the Donabedian theory, which states structure has influence quality of care delivered.

CHAPTER ONE: INTRODUCTION

1.1 Background

According to oxford's advanced learner's dictionary (2019), dignity is the act of being given the honour, worth, and respect; worth, decent, humane, and status attached to someone. To dignify means to treat a person with respect and importance. Dignity in health care is defined as understanding, compassion, and empathy at its core. All humans are valuable, irrespective of their status or prevailing condition. Every pregnant woman has the right to the most advanced and attainable standard of health, including the right to dignified and caring with respect throughout childbirth; free from violence and discrimination (WHO, 2018). World health organization (WHO) acknowledges that disrespect and mistreatment violate women's rights, deters women from seeking health care services, resulting in negative health outcomes. (WHO, 2015). Disrespect, mistreatment and abuse of women during childbirth is a violation of human rights (Megui and Sundby, 2018) violates women's dignity (Sudhinaraset *et al.,* 2019). Midwives are crucial position in maintaining, providing, and promoting the dignity of women during intrapartum period (Er *et al.,* 2018, Martin-Ferreres *et al.,* 2019 & Froneman, Wyk, and Mogale, 2017).

Globally there is evidence of non- dignified intrapartum care (Galle *et al.,* 2019 & Otis and Brett, 2008a) in high and low income setting. Non-dignified intrapartum care affects the quality maternal care, it is likely to undermine women's trust in the health facilities (Kruk *et al.,* 2018, 2010 & Bohren *et al.,* 2019). Women who face non –dignified intrapartum care have reported shunning away from hospital delivery in future, which hinders World health organization (WHO) goal of having all women giving birth attended to by skilled birth attendant (Afulani *et al.,* 2020 & WHO, 2018). Undignified practices may include but not limited to demeaning words and being scolded, discrimination against, performing examination without consent, failure to provide privacy, neglect and failure to lack of support (Bohren *et al.,* 2020, Dzomeku, van, and Lori, 2017).

A qualitative study conducted in the United states of America, showed evidence of mistreatment during labour and childbirth even in high resource setting, the results pointed that 1 out of 6 women faced some forms of mistreatment and diminished dignity during childbirth (Vedam et al., 2019). In the Latin America and the Caribbean mistreatment during birth was reported especially within low economic settings (Castro and Savage, 2019) where women reported neglect and unconsented procedures. In an observational

study carried out in Uttar Pradesh, India, revealed that 1 out of 5 women were mistreated by the provider during childbirth (Dey *et al.*, 2017). In a comparative study carried out in India revealed the prevalence of abuse and disrespect during childbirth in facility and home based child birth was universal at 97% (Hameed and Avan, 2018).

In sub-Saharan Africa, there is evidence of undignified intrapartum care (Dzomeku *et al.,* 2021). Studies conducted in Nigeria documented a wide range of disrespect and abuse experienced by women during childbirth, (Ishola, Owolabi, & Filippi, 2017 & Okafor, Ugwu, and Obi, 2015). Similar studies conducted in Ghana revealed undignified intrapartum care (Dzomeku *et al.*, 2020a, Dzomeku *et al.*, 2021b). A study carried out in Uganda, revealed cases of undignified care during delivery, women reported being scolded by the midwives (Babigumira *et al.*, 2019). A qualitative study from Ethiopia found women experienced wide range of disrespect and non- dignified care during child birth, which resulted in women experiencing harm, physical and emotional pain (Gebremichael *et al.,* 2018). In studies conducted in Tanzania showed mistreatment during delivery, where women were exposed to non-supportive care (Miltenburg *et al.,* 2018, K *et al.*, 2018, & Shimoda *et al.,* 2020). From South Sudan whereby due to undignified intrapartum care women shun to deliver in health care facilities (Kane *et al.*, 2018).

In Kenya, 1 in 5 women reports humiliation and lack of dignity during labour and delivery, 18% non- dignified care, 14.3% neglect, 8.5% non-confidential care (Abuya *et al.*, 2015). In a study conducted in Kilifi and Kisii counties found evidence women that that women experienced some form of non- dignified care from the midwives (Lusambili *et al.*, 2020). A mixed method study carried out in in Western Kenya revealed evidence of mistreatment during labour and childbirth, women giving description such as; care refusal, abandonment, neglect, unconsented procedures and verbal and physical abuse (Afulani *et al.,* 2017). Some reported being neglected and left alone during childbirth by the health care providers (Lusambili *et al.,* 2020).

Dignified care in the hospital setting protects the patients' rights, ensures provision of the appropriate care, and improves the quality of intrapartum care. Dignified care, provides patient satisfaction, while maintaining respect and patients' autonomy (Henderson et al., 2009). Midwives' actions such as: respecting the patient's privacy, healthy communication, and minimal exposure of the woman's body tend to boost dignified intrapartum care. (Er, *et al.,* 2018). Dignified and Respectful intrapartum care is a key strategy to enhancing

positive maternal experience (Asefa *et al.,* 2020 & Afulani *et al.,* 2017), one of the key domains of WHO's vision for quality of care for birthing women (WHO, 2018). Disrespect, and mistreatment during labour and childbirth are likely to discourage women from delivering in the hospital with a skilled birth attendant (Downe *et al*., 2018 & Kane *et al.*, 2018). Undignified intrapartum care perpetuated by midwives may influence women's decisions in the future (Abuya *et al*., 2015 & Otis and Brett, 2008).

1.2 Statement of the Problem

Free Maternity Policy (FMP) and protecting the Woman popularly referred to as *Linda Mama* programs in Kenya have seen an increase in hospital utilization during labour and childbirth. (Lusambili *et al.,* 2020, Oluoch-Aridi *et al.*, 2018 & Anderson *et al.,* 2020). The surge of women seeking to deliver in health facilities has led to overstretching of health facilities, leading to neglect and other forms of mistreatment during labour and childbirth (Warren *et al.,* 2018; Oluoch-Aridi *et al.,* 2018). Non- dignified care childbirth and labour results in underutilization of health facilities, with women preferring to deliver at home alone or with relatives or assisted by a traditional birth attendant (Oluoch-Aridi *et al.,* 2018). Various Studies have revealed some of the reasons why some women still shun hospital deliveries, include but not limited to undignified care and mistreatment by health care providers (Oluoch-Aridi *et al.,* 2018; Abuya *et al.,* 2015 & Kane *et al.,* 2018). Births conducted by unskilled birth attendants lead to adverse maternal and neonatal outcomes which rallies against Sustainable Development Goals (SDG) and WHO target (WHO, 2018 & Meguid and Sundby, 2018).

Women from low economic status are at higher risk of encountering disrespect and mistreatment during labour and childbirth (Lusambili *et al.,* 2020 Abuya *et al.*, 2015). A qualitative study conducted in peri-urban facilities in Kenya found that the difference in social-economic status between the health care workers and the clients resulted in mistreatment of women (Oluoch-Aridi *et al.,* 2018 & Anderson *et al.,* 2020). Factors such as lack of enough personnel in the health facilities were attributed to the provision of undignified intrapartum care (Warren *et al.,* 2018 &Kruk *et al.,* 2018). Overcrowding in the labour wards may result to impulsivity of the midwives and thereby turning their aggression towards women (Bohren *et al.,* 2017 & Afulani *et al.*, 2018)

Kenyatta National Hospital (KNH) is a tertiary and national referral hospital in Kenya, with a catchment area of 5 million (Kenya Population and Housing Census Volume, 2019). The

hospital receives a referral from the entire country. This could lead to overstretching the labour ward. The study assessed the influence of structure and process in the provision of dignified intrapartum care. The structural factors in KNH, that were considered in the study included: midwives – women ratio, infrastructure, medical equipment, and departmental policy and audits that promoted dignified intrapartum care. These structures have remained constant even with the surge of women seeking care during child birth. The process factors that were studied were midwives' actual care and humane actions during intrapartum care against the stipulated standard of care. The engagement and commitment of midwives in provision of dignified intrapartum care resulting to maternal satisfaction and quality maternal care. Quality intrapartum care has decreased with introduction of free maternity services not only at Kenyatta national hospital but also in Kenya at large.

1.3 Justification

This study will build upon various results and insight from other researchers, to assess what factors influence provision of dignified care during childbirth. Structure factors that may include limited facilities and equipment, inadequate personnel have been highlighted as negative influencers of dignified intrapartum care (Dzomeku *et al.,* 2021). Institution policies would result in poor quality care resulting in negative maternal experiences (Oluoch-Aridi *et al.,* 2018). The study assessed the influence of the process and structure factors in the provision of dignified intrapartum care. The study assessed the practice of dignified intrapartum care among midwives The study assessed institutional culture and policy and its influence and hindrances towards respectful intrapartum care in labour and delivery, which cultures within the institution are detrimental, and which favour the provision of such care (Oluoch-Aridi *et al.,* 2018, Abuya *et al.,* 2015).

The study aims to assess the structural and process factors that influence the provision of dignified care at Kenyatta National Hospital a teaching and national referral hospital. The research will help in understanding the institutional structures and midwives' care process factors that influence in provision of dignified care. Dignified care is important as it results in positive maternal experiences affecting the decision to seeking facility-based childbirth in the future. Facility-based childbirth is known to reduce maternal therefore midwives' perspectives will be sought to understand the gap in the provision of dignified intrapartum care.

1.4 Significance of the Study

The research study findings would identify the processes and structures that influence dignified intrapartum care. The research findings may be used by policymakers to review policies that promote dignified intrapartum care, in reducing maternal poor outcome and improving the standard of care. The findings may be used to build on existing knowledge on dignified intrapartum care, and form basis for further research work on the perception of dignified care during childbirth from the women's and providers' perception. The study may benefit women seeking care in KNH, by creating awareness and advocacy of dignified intrapartum care among midwives and other service providers at labour ward.

1.5 Research Questions

The study will be achieved by answering the following research questions:

1. What is the practice of dignified intrapartum care practiced at Kenyatta National Hospital?
2. What are the structural factors that influence dignified intrapartum care at Kenyatta National Hospital?
3. What are the process factors that influence dignified intrapartum care at Kenyatta national hospital?

1.5.1 Broad Objective

To establish the structural and process factors that influence the delivery of dignified intrapartum care among midwives at Kenyatta National Hospital in the labour ward.

1.5.2 Specific Objectives

1. To assess the practice of dignified intrapartum care among midwives at Kenyatta National Hospital, labour ward.
2. To determine structure factors that influence dignified intrapartum care among midwives at Kenyatta National Hospital, labour ward.
3. To identify process factors in influencing dignified intrapartum care among midwives at Kenyatta National Hospital, labour ward.

1.6 Theoretical Framework

Avedis Donabedian's model (2005), measures the outcome of health care using structure and process as the components. Quality care the degree to which health care services

increases the possibility of desired health outcomes, consistent with current professional knowledge. According to the model structure is defined as the organizational aspects of the care setting; where healthcare takes place; focusing on the provider, equipment, and facilities. The process are the components of actual care being delivered, looking at what is going on in the particular setting; reflects the way the system and processes work to deliver the desired outcome. The process factors are described as the intervention that provides the patient with the outcome, these are the actual provision of care.

The Donabedian (1966) model provides an evaluation of a framework that supports systemic inquiry into health services in a linear pathway with structure, process, and outcome criteria.

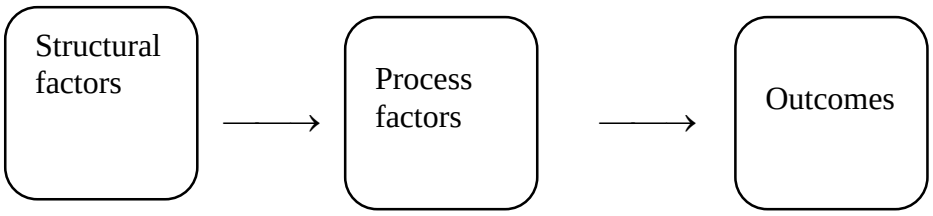

Figure 1. 1: Donabedian Model Unidirectional Path

Donabedian Avedis, 2005

The structural measures reflect the attributes of the service providers; midwives - to – patient ratio, the size of the facility (Wagoro, 2006), and highest attained professional qualification and experience of the health care providers. The influence of the size or capacity of the unit on the provision of dignified intrapartum care, the number of delivery beds in the facility, the bed capacity if the patients share beds, and its implication. The level of education or experiences of the midwives would also influence in provision of dignified intrapartum care; the level of education should not be equated to the competency level. While considering dignified intrapartum care in the labour ward, it should be demonstrated that the setting supports caring for a woman in labour in a humane way. The facility has facilities appropriate accommodating for the woman who is in labour. Areas such as the

waiting bay, procedure room, childbirth room, and availability of bed that can accommodate a woman in labour.

The process is described as the intervention or service that midwives provide to the women, the actual provision of care (Hay, Lamrini & Rai, 2013). The provider's attitude and biases which enables midwives to provide high-quality care that is widely accepted and validated in the literature in intrapartum care (Wagoro, 2016). The process factors refer to clinical processes for the childbirth of care. The clinical practice is the use of best practice guidelines and the development and implementation of care, based on the appropriate standard of care.

The model evaluates the health care outcomes, as an inquiry into the health services. This model helped in assessing dignified care intrapartum care as an outcome from the structure and processes from the midwives' perspective. The outcome is influenced by the setting of care and the services provided by the midwives. Donabedian suggested that these components are interdependent, their relationship impacts the next dimension either positively or negatively. The model provides a road map to improving quality as the ultimate indicator of the care provided. In the context of the study quality denoted dignified intrapartum care. The structure and the process were independent variables which influence the outcome; dignified intrapartum care. When healthcare is deficient in structural components, it risks compromising the process which in turn, compromises the potential quality outcomes (Gardner, Gardner & O'Connell, 2012).

1.7 Conceptual Framework

The conceptual framework follows the Donabedian model, a conceptual model on the causal pathway with structural factors and process factors, with the outcome as dignified intrapartum care.

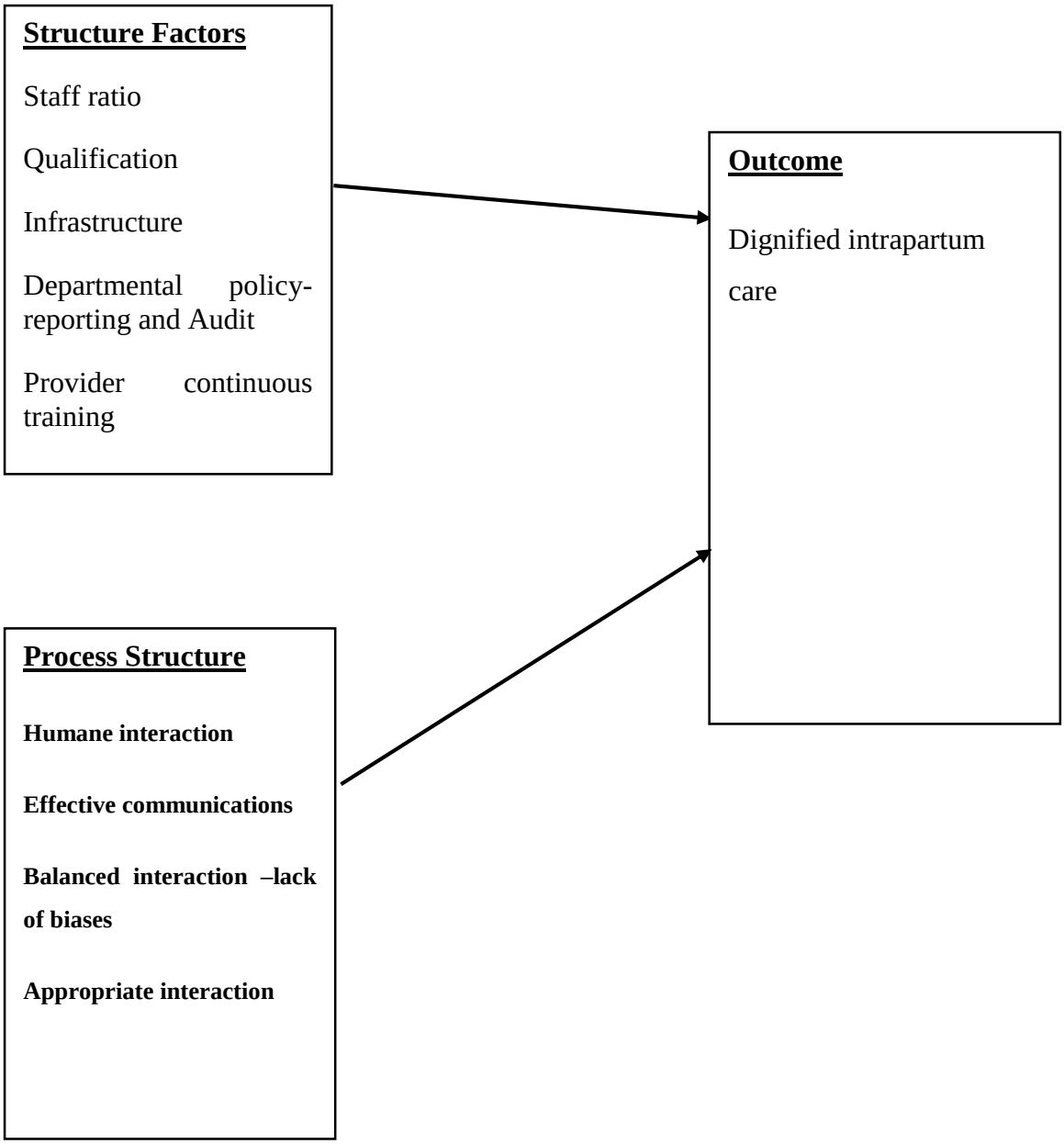

Figure 1.2: Conceptual Framework

Proposed for assessing dignified intrapartum care by the researcher.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Positive maternal experience is a global concern. In order to achieve positive maternal experience, it is necessary to incorporate dignity during intrapartum care. WHO (2018) defines dignified intrapartum care as planned care for all women during labour and childbirth that maintains and promotes dignity, offers privacy and is confidential, ensures freedom from harm from harm and mistreatment, and enables informed choice and continuous support.

This chapter focuses on the dignified intrapartum care, the structural and process factors that influence dignified intrapartum care. Lack of respect and mistreatment during the labour and childbirth has widely been studied globally and within the Kenyan context, however the influence of structural and process factors on dignified intrapartum care has not been researched on in Kenya. The chapter, represents the research strategies used to gather information on dignified intrapartum care. The rest of the chapter are dedicated to the literature review on the influence of structural and process factors on dignified intrapartum care among midwives, focusing on the magnitude of undignified intrapartum care, the importance of dignified intrapartum care globally and within the Kenyan context. The literature search will also address the practice of dignified intrapartum care, beginning with the introduction, the magnitude of undignified and dignified care globally, sub-Saharan Africa, East Africa, and Kenya. Directed by the objectives set for the study the presenting the practice of dignified intrapartum care, structural and process factors with their influence on dignified intrapartum care. The review of chapter highlights the gaps in the literature on dignified intrapartum care.

2.2. Search Strategy

Databases used in literature review included: Cochrane, CINAHL plus, Hinari, PubMed, Google scholar and science direct. The key words and phrases used for search of literature were: dignified intrapartum care, structure, process, respectful maternal care, mistreatment, abuse and disrespectful care. The articles found from the use of key words were used as a reference point to locate additional relevant literature. Additionally, the researcher used the

university of Nairobi library to access the thesis repository which provided local studies which may have not been published.

2.3 Dignified Intrapartum Care

Dignified intrapartum care in this context is related to respectful intrapartum care (Kruk et al., 2018 & Warren *et al*.,2017); WHO (2018) defines as planned and organized care for women in a manner that promotes and maintains their dignity, provides privacy, and confidential care, ensuring freedom from harm and mistreatment, and enabling informed choice and continuous support during labour and childbirth. Dignified intrapartum is a component of quality of care. Kenya constitution (2010) states "Every person has inherent dignity and the right to have that dignity respected and protected", including pregnant women. WHO advocates for quality intrapartum care that is respectable, upholding the dignity of the woman (WHO, 2018). Disrespect and mistreatment of women during childbirth is a violation of human rights in a period of vulnerability. (THE UNITED NATIONS GENERAL ASSEMBLY 1948). Every woman has the right to the quality standard of health. A right to dignified, health care throughout pregnancy and childbirth. A right to be freedom from abuse and segregation (WHO 2018). Lack dignity during childbirth amounts to a violation of a woman's human rights (WHO, 2016). Dignified intrapartum care is synonymous with a positive birth experience and respectful care (WHO, 2016), physical, clinical and spiritual, and cultural needs are met (Gurung *et al.*, 2020).

2.4 Magnitude of Undignified Intrapartum Care

Globally, there are reports of mistreatment of women during labour and delivery, in studies done India showed mistreatment during labour and childbirth, an element that discouraged women from facility-based childbirth (Bruce *et al.*, 2015). In a study conducted in Bolivia found out that women experienced mistreatment during (Otis and Brett, 2008b), in Mexico (Brenes Monge *et al.*, 2021), in Brazil 17% of women experience undignified intrapartum care (Silveira *et al.*, 2019). Women in Canada are being coerced into unnecessary interventions (Jenkinson, Kruske & Kildea, 2017). Women in New Zealand are denied the right to privacy (Bohren, Mehrtash & Fawole, 2019).

In sub-Saharan Africa, undignified intrapartum care has been reported in middle and low-economic settings, studies were done in Nigeria (Bohren *et al.*, 2015a, Bohren *et al.*, 2020b, & Ishola, Owolabi and Filippi, 2017) 29% of women reported undignified care during (Okafor *et al.*, 2015). In Ghana, an explorative descriptive study was conducted to show

evidence of undignified intrapartum care from women (Dzomeku *et al.,* 2020)). Studies done in Mozambique found out evidence of abuse and mistreatment during childbirth (Galle *et al.*, 2019), in Malawi studies showed evidence of undignified intrapartum care. A study conducted in Gambia showed related evidence of undignified intrapartum care Gambia (Colley *et al.*, 2018). The experiences ranged from hostile or insensitive staff.

Failure to allow birth companion in the labour rooms. disrespectful care and lack of autonomy, with poor reception at health facilities. Some women cited lack of privacy during examination, with the attending midwives aloof and non-approachable, and poor readiness of health facilities (Avortri and Modiba, 2018).

In east Africa, undignified intrapartum care has been reported in Tanzania (Kruk *et al.,* 2018), in Ethiopia (Gebremichael *et al.*, 2018). According to Kane *et al.*, (2018) women reported disrespect and lack of dignity during labour and childbirth, hindering them from utilizing skilled childbirth services in future.

2.5 Importance of Dignified Intrapartum Care

Maternal mortality has remained a pressing problem in sub- Saharan Africa and Kenya (Afulani *et al.,* 2020), efforts to reduce the ratio have been hampered by poor intrapartum care (Anderson *et al.*, 2020). Undignified intrapartum care contributes directly, and indirectly to negative maternal events, (Molina *et al.*, 2020) leading to poor community belief of facility-based childbirth care (Asia *et al.*, 2020), discouraging women from giving birth in health facilities (Downer *et al.,* 2018). Women who countered disrespect during childbirth may shun health facility childbirth in the future either deliver on their own or with the help of unskilled birth attendants (Downe *et al.,* 2018) resulting in poor maternal and neonatal outcomes. Women require assurance for dignity and respect preservation during childbirth (Asefa and Bekele, 2015 and Moyer *et al.*, 2014). Women and their families often decide the site of childbirth depending on their formed opinions, evaluations, and previous experience of the services (Hadjigeorgiou *et al.*, 2012 & Avortri and Modiba, 2018). Respectful maternal care has been flagged as a strategy for reducing preventable maternal mortality and morbidity accelerating progress towards achieving the sustainable development goals (SDG) targets for improving maternal health (WHO, 2015, & Moyer *et al.,* 2014).

Although perinatal depression is multifactorial, negative birth experiences, as such as abandonment during delivery, have been linked to depression and post-traumatic stress disorder during postnatal period. According to a study conducted by Silveira *et al.*, (2019), showed a relationship between postpartum depressions with undignified intrapartum care. In analysis, mistreatment and abuse during childbirth were associated with an increased postpartum depression prevalence. Dignity during childbirth can be used to reduce the prevalence of postpartum depression and blues. Women who encounter non-dignified care during childbirth are subjected to long term negative impact physically, psychologically as well as their sexual wellbeing (Chattopadhyay *et al.*, 2018).

2.6 The Practice of Dignified Intrapartum Care

Dignified care are aspects that provide a positive birth experience to the woman irrespective of culture and orientation (Er *et al.*, 2018). They include maintaining their values and having a positive attitude (Downe *et al.*, 2018 & Avortri and Modiba, 2018). Downe *et al.*, (2018), reported that women wished midwives humanely communicated to them, stating that being shouted at was demeaning. Lack of privacy during examination and history taking and care undermines women's dignity (Dzomeku *et al.*, 2020, Oluoch-Aridi *et al.*, 2018(Abuya et al., 2015a). Other aspects of non-dignified care from other studies included: midwife not introducing herself to the woman cited as poor reception at the hospital. Failure to provide a clean bed for the woman. Women reported that not being cleaned after birth made them lose their dignity as human (Ratcliffe *et al.*, 2016 & Downe *et al.*, 2018). Five categories of dignified care as identified in various studies included: (K *et al.*, 2018) respectful and warm interactions between midwives and women, (Ratcliffe *et al.*, 2016), providing of standard and timely midwifery care (Lusambili *et al.*, 2020) active engagement of women during the labour process (Kruk *et al.*, 2018). Respect and dignity, effective communication, and emotional support are key pillars of the WHO in intrapartum care (Tunçalp *et al.*, 2015).

2.7 Instruments of Dignified Intrapartum Care

Drivers of dignified care towards women during labour and childbirth are complex and involve people ("Respectful maternity care," 2020). Availability of resources and infrastructure influence the provision of dignified care, labour may be augmented so that the woman delivers and creasers a bed for the incoming women (Respectful maternity care: 2020). Staffing is another important instrument of dignified intrapartum care; women are

returned home because there no midwives or midwives are on strike (Abuya et al., 2015a), (Kruk *et al.*, 2018) & Respectful maternity care: 2020). Burnout and psychological stress of the midwives, women are forced to seek care else when because midwives are resting or closing their shift (Lusambili *et al.*, 2020 & Galle *et al.*, 2019).

2.8 Factors that Influence the Practice of Dignified Intrapartum Care

Factors that influence dignified intrapartum care can be categorized into institutional and individual midwives. Midwives factors may include; effective communication; addressing and prompt meeting women's need during labour and childbirth. Maintenance of privacy and physical environment and protecting patients. Providing confidential conditions that preserve autonomy and allowing women to have a sense of control (Manookian *et al.*, 2013). Institutional governance and accountability for women-centred care are likely to reduce disrespect and abuse (Manookian *et al.*, 2013). Policy in the health facility supporting dignified and respectable maternal care influence the practice of dignified intrapartum care among midwives and other providers (Oluoch-Aridi *et al.*, 2018). Institutions that held midwives responsible for their actions and behaviour there was a likelihood of upholding dignified care during childbirth (Dzomeku *et al.*, 2021, & Lusambili *et al*., 2020). Training midwives on women's dignity and respectable maternal care has been shown to influence the provision of dignified intrapartum care (Asefa *et al.*, 2020; Galle *et al.*, 2019 & Shimoda *et al.*, 2020). The study results revealed that training improved the providers' awareness of the rights of women during childbirth. Training on dignified care and supervision on delivery, adequate staff numbers and bearable workloads, better remuneration and appropriate working conditions, and functioning of the health system influence the provision of dignified intrapartum care (Molina *et al.*, 2020).

2.8.1 The Practice of Undignified Intrapartum Care

The practice of undignified intrapartum care has been reported globally, the perspectives are according to culture economic background, and religious beliefs. A study conducted in Iran among Muslim women reported that women left dehumanized by repeated vaginal examination. (Bidabadi, Yazdannik and Zargham-Boroujeni, 2017). According to a study conducted in Australia, women reported that their dignity was reaped off the following denial to deliver vaginally after a caesarean section with women narrating how they felt having lost control of their body and disrespected (Tunçalp *et al.*, 2015). Some of the manifestations of undignified care as revealed from other studies found that the provision

of intervention without consent, hindering a birth companion during labour, and withholding food during labour without the woman's understanding or a clinical indication (Ishola, Owolabi, and Filippi, 2017 & Gurung *et al.*, 2021).

2.8.2 Structural Factors Influencing Dignified Intrapartum Care

Donabedian (2005) defined structure as settings of the health facility, qualification of the providers; administrative system where care takes place; the characteristics of the service delivery point and, the healthcare facilities and infrastructures, the attribute of settings where care is delivered (Howell and Stevens, 2020). The context in which care is delivered affects processes and outcomes. The structural dimension of quality care includes facility infrastructure, adequate staffing, and continuous clinical training and prompt treatment, and timely procedures that are well coordinated and evidenced based (Akachi and Kruk, 2017). The administrative structure that would transform how the midwives is engaged on quality improvement, the frequency of training on quality and dignity in care, and the audit of feedback from women concerning the care received from midwives. (Contreras, 2018)

2.8.3 Process Factors Influencing Dignified Intrapartum Care

The process factors depict what the midwives specifically perform to maintain or improve the health outcomes of women. Process factors build upon the pre-existing structures of an organization (Contreras, 2018). Process factors of quality health care includes; the evidenced based quality and the lived experiences of the women. Receiving respectful treatment, convenience, and good communication are important. For promoting adherence to treatment and positive health outcomes while promoting and maintaining dignity in a health care setting (Akachi and Kruk, 2017). These are aspects that reflect the way the health care facility works to deliver dignified intrapartum care. In the childbirth of care, how is the planning of care done, delays in treatment provision, effectiveness in delivering care whether patients are informed of the planned care and during the implementation of care, and in case of delays in the intended care whether the patient is informed. In respect to dignified intrapartum care, planning of care and informing the woman, allowing the women to participate in decision making during the labour process. In cases of delay in intervention, informing the woman of the delay and possible related intervention. Meaning the woman also given consent to any intervention after explanation, for example, if the woman was informed of the process of labour during admission when labour is less intensive she is likely to comply and consent during an intervention.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The chapter provided a framework of the methods used in the study. describing the study design and the study area. Outlining the target population, sample size, and sampling technique. Data collection instruments and procedures, validity and reliability of research instrument, data analysis, and ethical considerations.

3.2 Study Design

This was a descriptive cross-sectional study, employing quantitative methods.

3.3 Area of Study

The setting of the study was at Kenyatta National Hospital (KNH), Labour ward. The area of study was appropriate for the assessment of dignified care during intrapartum care. Intrapartum is the period between onset of labour and childbirth, during this transition time the women are admitted to the labour ward under the care of the midwives.

KNH is a regional and national referral and teaching hospital located in Nairobi County serving the entire country and parts of East Africa. It has a bed capacity of 1,800, has a total of 50 Wards, and 24 operating theatres. KNH also has a private wing with a bed capacity of 208 and 1 renal units (KHN, information Centre, 2020).

The obstetric gynaecologic unit comprises antenatal wards, gynaecological wards, a maternity theatre, and a labour ward. The labour ward is located on the ground floor behind the accident and emergency department. Has a bed capacity of 55 beds, with 82 midwives attached in the department. The midwives work on rotational schedules which include: morning shift, afternoon shift, and night shift. During each shift, 9 midwives are directly involved in patient care and each of them on average has 8 patients to provide care. The Unit attends to approximately 990 deliveries in a month of with Caesarean section births are approximately 498 in a month.

The labour ward was an ideal setting for the study; childbirth takes place, where intrapartum care is offered to the women by the midwives. Midwives interact with the women during the labour process, offering care during the process of childbirth until the women and their babies are discharged to the postnatal ward.

3.4 Study Population

The study population included midwives working in the labour

ward during the study.

3.4.1 Inclusion Criteria

The inclusion criteria for the study were:

- Midwives working in the labour ward KNH and were actively involved in direct patient care.
- Midwives who were in attendance during the study
- Midwives who were willing to participate in the study after explanation about the study purpose and giving informed consent.

3.4.2 Exclusion Criteria

The exclusion criteria for this study were:

- Midwives who were on job probation during the study.

3.5 Sample Size

The sample size will be calculated using the following formulae:

(Fisher et al., 1998

$n= Z^2 X P (1-p)/ (e)$

n was the desired sample size

Z was standard normal deviation at 95% confidence interval (standard value of 1.96)

P was the proportion in the target population estimated to be the prevalence of undignified intrapartum care from other studies= 19 %

E =Margin of error at 5%.

The estimated sample size will be 237

Given that the population for the study (that was, 88) was less than 10,000, the sample size was moderated for using the Finite Population Correction formula as recommended by Fishers et al. (1998) as follows:

nf = n / [1 + n/N]

Where nf = was the desired sample size when the total population is less than 10,000

n = estimated sample size when the total population (N) was greater or equal to 10,000

N = estimated total population

237/ {1+237/82)

Nf= 79

Hence, the study sample size comprised of 79 midwives

3.5 Sampling Technique

To obtain the study's sample size of 79 midwives, the researcher used a simple random sampling method. In the Simple random sampling technique, the researcher selected a group of subjects for study from a larger group. Each subject was chosen entirely by chance and each member of the population has an equal chance of being included in the sample. Every possible sample of a given size has the same chance of selection.

There are 90 midwives in the labour ward, upon explaining the study to the participants and obtaining consent, the researcher wrote the names of the eligible participants down and number them, then entered a table of random numbers to drew a random sample of the desired sample size which was 79 midwives.

3.6 Data Collection Instruments

The study employed self-administered questionnaire for data collection. Questionnaires allow practicability, applicability to the research problem, and the size of the population and are cost-effective (Denscombe, 2014). The questionnaire was used to contained both close-ended and open-ended questions. The first part of the questionnaire was structured to captured demographic data, while the other parts of the questionnaire contained questions

based on the research objectives. The responses targeted information relating to the structural and process factors related to dignified intrapartum care.

3.8 Pretesting of Tools

Pretesting of the study tool was carried out at the GFA ward, an antenatal and postnatal ward in Kenyatta national hospital, where 8 questionnaires representing 10% of the study sample will be used. Mugenda and Mugenda (2003) asserted that 10% of the sample size is adequate for purposes of pre-testing the research tools.

3.9 Validity and Reliability of Study Instruments

Validity indicates the degree to which an instrument measures what it is supposed to measure (Kothari, 2010). The degrees to which the results obtained represent the phenomena in the study (Denscombe, 2014). The research instrument was availed to the supervising lecturers to establish its content and construct validity to ensure that the items are adequately representative of the study subject.

Reliability is a measure of the degree to which a research instrument yields consistent results after repeated trials (Nsubuga, 2006). Using data from the pretesting study, the reliability of the research instrument was estimated using the Cronbach's Alpha Coefficient. A Cronbach's Alpha Coefficient of at least 0.70 is accepted.

3.10 Data Quality Assurance

Quality assurance in research study comprised of the techniques, systems, and resources deployed to give assurance about the care and control under which research was conducted. The responsibilities of those involved in the research; data was collected by the researcher and assistant after the purpose of the research was explained and consent obtained. To ensure the quality of in the research, the right questions were asked as per the research design, and an appropriate sampling design was employed.

Precision and accuracy; operationalization of concepts was made to define the distinction made between the attributes that compose a variable, to achieve the highest degree of precision and accuracy during data collection.

Reliability; whether a particular instrument, applied repeatedly to the same object yields the same results each (Babbie, 2010, & Nsubuga, 2006). Reliability used to measure the

quality of the research instrument, whether the results will be consistent in a different setting.

Validity the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie, 2010, & Denscombe, 2014). To ensure the quality is maintained the research instrument will be reviewed by the supervisors and also the research committee.

During data collection the researcher adhered to the principles of justice, maleficence, and beneficence, ensuring no harm to the participants. The principle of autonomy and confidentiality, respecting the privacy of the participants. The researcher is at liberty to withhold or give information as they choose.

Honesty and integrity, the researcher refrained from plagiarism and acknowledge reference materials and infringement of other scholarly works. The researcher complied with the ethical and legal requirements of the study area. There were no potential or actual conflict of interest during the study.

The dignity, rights, safety, and well-being of all the participants was maintained and upheld there were no unreasonable risk or harm to research participants. The researchers would report and address any concerns relating to the dignity, rights, safety, and wellbeing of those involved in the research if any was identified.

Data collected was stored in password-protected computers, answered questionnaires were stored under lock and key accessible only by the researcher. Data would be disseminated in conferences, peer reviews for critiquing, and corrections.

3.11 Data Collection Procedures

The study questionnaire was administered to the study respondents by the principal researcher and the research assistant after explaining the purpose of the study and obtaining their informed consent. The data collection exercise entailed the study participants reading and writing down their responses only to sought clarification when needed arose.

In response to Covid 19 pandemic in the country, to curb the spread of the diseases the researcher adhered to the Ministry of Health's Covid 19 prevention directives during the data collection exercise which included; the researcher assistant, and participants donned

in a face mask; ensured both the researcher, assistant, and the participants adequately maintained hand hygiene through hand washing with soap and running water or using a sanitizer before handling out the questionnaires and after handing in the questionnaire, avoided handshaking with the participants, adhered to recommended social distancing rule.

During the data collection exercise, the researcher allowed the respondents to answer the questions, without interfering with their responses. Upon receiving filled questionnaire from the study participants, the researcher confirmed their completeness and codded the questionnaire. The filled-in questionnaires were stored safely under lock and key in readiness for data entry and analysis. The data collection exercise took four weeks, data collected will be stored in computers encrypted with a password.

3.12 Data Analysis and Presentation

Data was coded, and entered in a data entry software. Descriptive data was analysed in accordance with the study objectives and questions. Inferential statistics was analysed using the Statistical Package for Social Science (SPSS, version 25). The process and structural process factors were correlated with independent variable using chi-square test of association. Statistical significance was interpreted at a level of significance of 5% (0.005 equal to or greater than P value). The study results were presented in tables, graphs, and charts.

3.14 Ethical Considerations

The authority to conduct the study was sought from the Kenyatta National Hospital-University of Nairobi (KNH/UoN) Ethics and Research Committee (ERC). Permission to collect data was sought from the department of medical research, department of obstetrics, and gynaecology at Kenyatta National Hospital. Respondents' consent was sought individually before participation in the study.

Confidentiality was maintained for information obtained from the study respondents. In addition, anonymity was observed by coding the questionnaires, filled questionnaires were kept under lock and key accessible to the researcher only**.**

The researcher respected the participants to make their own informed decision about whether to participate in the study. The participants were provided with complete information about the study purpose and decided on their own to enrol.

The principle of beneficence; the purpose of the study was to discover new information that would be helpful to the institution. The research will maximize the benefits for the participants minimizing the risk for participants. There was no harm to the participants emotionally, socially, and in terms of their service and contract with the institution. The study did not involve any harmful treatments and experiments.

The principle of justice that involves the concept of fairness, the researcher was fair treatment during the recruitment of participants. The location of the study was within the institution, did not interfere with the work schedule of the participants.

3.15 Study Limitations

The study results were based on results gathered from a single hospital in the country. The findings may not be generalized to all other hospitals in the country due to differences in size, geographical location, and institution setup. To counter this limitation, the researcher shall recommend similar studies be conducted in other hospitals in the country to allow for comparison and generalization of the study findings**.** Responder bias, the study involves assessing the structural and process factors from the midwives' perspective. This bias will be reduced by explaining the purpose of the study, explaining that the study will have no risk associated with their employment of future employment at KNH, and allowing voluntary participation.

CHAPTER FOUR: RESULTS

4.1 Introduction

This section focuses on the findings of the research assessment of structural and process factors that influence dignified intrapartum care among midwives at KNH. The research was guided by the research objective. The purpose of the study was to establish the practice of dignified intrapartum care among midwives working at KNH labour, and determine the influence of structure and process factors on dignified intrapartum care.

During this study a total of 79 questionnaires were distributed, out of the 79 distributed 64 were duly filled and returned, this translated to a response rate of 81.01% which was deemed appropriate to proceed with analysis. According to Fincham (2008) a response rate of around 60% is considered appropriate for valid analysis.

4.2 Socio-demographic Characteristics of the Participants.

Results found that almost half of the respondents, 45.2% (n=28) were between the ages of 24 – 29 years old. In regard to religion majority of the respondents, 96.8% (n=60) were Christians. Majority of the respondents had worked at KNH labour ward between 1-3 years 45.2% (n=28). Majority of the respondents 66.7% (n= 42) reported having worked in another facility. In terms of the highest level qualification, the majority of the respondents were diploma holders, 63.5% (n=40). Regarding training on dignified intrapartum care, a majority indicated 61.9% (n=39) to have received training.

Table 4.1: Socio-Demographic Characteristics

		Frequency (n)	Percentage (%)
Age	24-29	28	45.2%
	30- 34	20	32.3%
	35- 40	7	11.3%
	41-44	2	3.2%
	45- 50	3	4.8%
	51-60	2	3.2%
	Total	62	100.0%
Religion			
	Christian	60	96.8%
	Muslirns	1	1.6%

	Hindu	1	1.6%
	Total	62	100.0%
Time Worked at KHH Labour Ward	Below 1 year	13	21.0%
	1-3 years	28	45.2%
	4- 6 years	13	21.0%
	7 -9 years	5	8.1%
	Over 10 year's	3	4.8%
	Total	62	100.0%
Have you Worked in another facility in the labour ward department before?	Yes	42	66.7%
	No	21	33.3%
	Total	63	100.0%
Highest Academic Qualification	Diploma	40	63.5%
	Higher Diploma	4	6.3%
	Bachelor's degree	17	27.0%
	Postgraduate	2	3.2%
	Total	63	100.0%
Do you have training on dignified intrapartum care or women's dignity?	Yes	39	61.9%
	No	24	38.1%
	Total	63	100.0%

4.2.1 Association between Highest Academic Qualification and Process Factors

This study examined the association between highest academic qualifiaction and process factors.. There was however no significant association between highest academic qualification with process factros. Highest academic qualification and midwives interaction with womans had a $X^2 = 6.451$, $P>0.375$.

Table 4. 2: Association between Academic qualification and midwives interaction with women

		What is your highest qualification?					
		Diploma	Higher Diploma	Bachelor's degree	Postgraduate	Chi-Square	p-value

Do you involve the woman in the labour process care?	Yes	32	3	14	2	.608	0.895
	At times	8	1	3	0		
Do you seek permission/ obtain consent before an assessment?	Yes	32	4	12	2	4.536	0.605
	No	0	0	1	0		
	sometimes	8	0	4	0		
While implementing care in the ward do treat all women's equally?	Yes	28	2	8	1	3.155	0.789
	No	2	0	1	0		
	Depends on woman's status	10	2	7	1		
How would you rate your interaction with women during intrapartum care?	Very good	11	1	7	2	6.451	0.375
	Good	22	3	7	0		
	Fair	7	0	3	0		

4.3 The Practice of Dignified Intrapartum Care

The study sought to assess the practice dignified intrapartum care among midwives' involved in direct patient care, at the labour ward KNH.

4.3.1 Definition of Dignified Intrapartum Care according to the midwives

Respondents were asked to describe dignified intrapartum care using their words. According to the response, dignified intrapartum care was described as care given to women in labor while maintaining women's privacy, this is according to 37.5% (n=19) of the respondents. Further, 23.5% (n=12) of the respondents thought that dignified intrapartum care described care given to women in labor while maintaining respect to women. In addition, 15.7% (n=8) of the respondents defined dignified intrapartum care as concerned with confidential care for women. According to findings, 13.7% (n=7) of the respondents dignified intrapartum care as concerned with maintaining women's dignity in the process of care. Lastly, 9.8% (n=5) of the respondents, stated that dignified intrapartum care defines a kind of care that is offered to women's according to their preference.

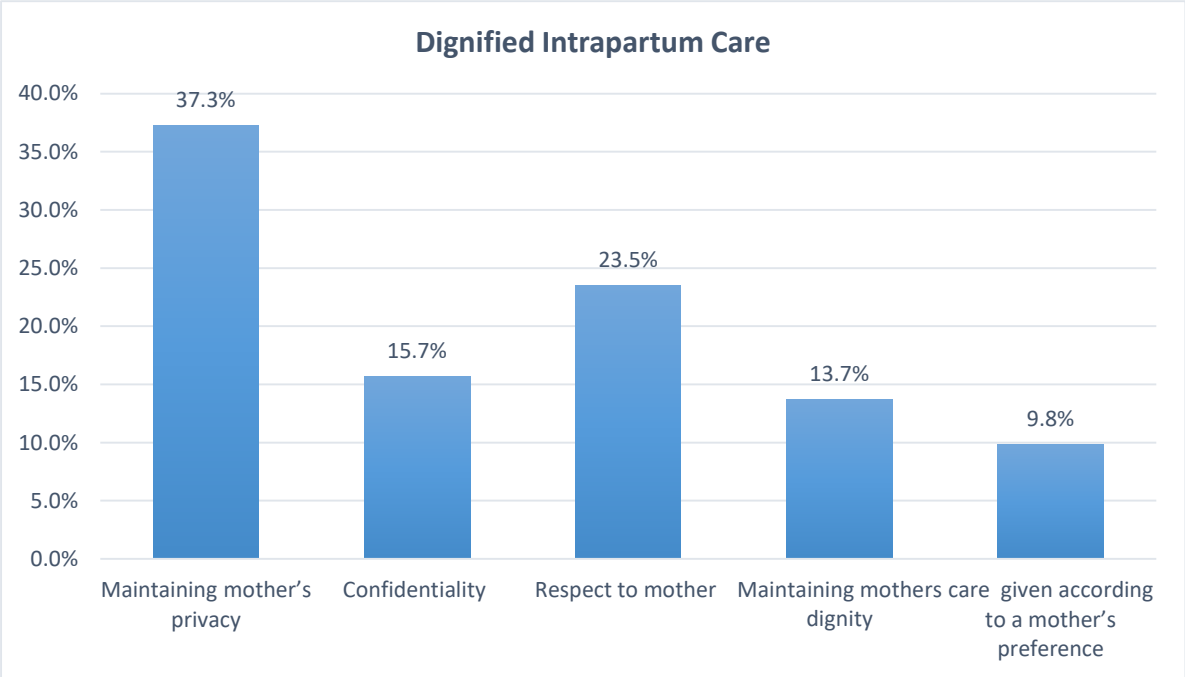

Figure 4. 1: Definition of Dignified Intrapartum Care

4.3.2 Welcoming Women During Admission

Results showed that most of the respondents, 98.4% (n=62) agreed that they welcomed women during admission.

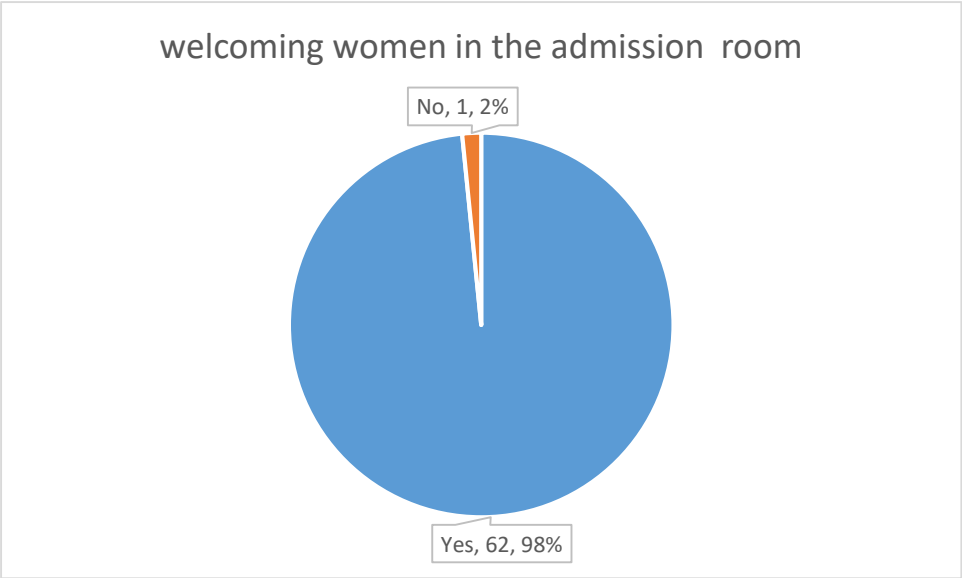

Figure 4. 2: Welcoming Women in the Admission

4.3.3 Self Introduction to the Women

Results showed that most of the respondents, 71.4% (n=45) indicated that they always introduced themselves to women.

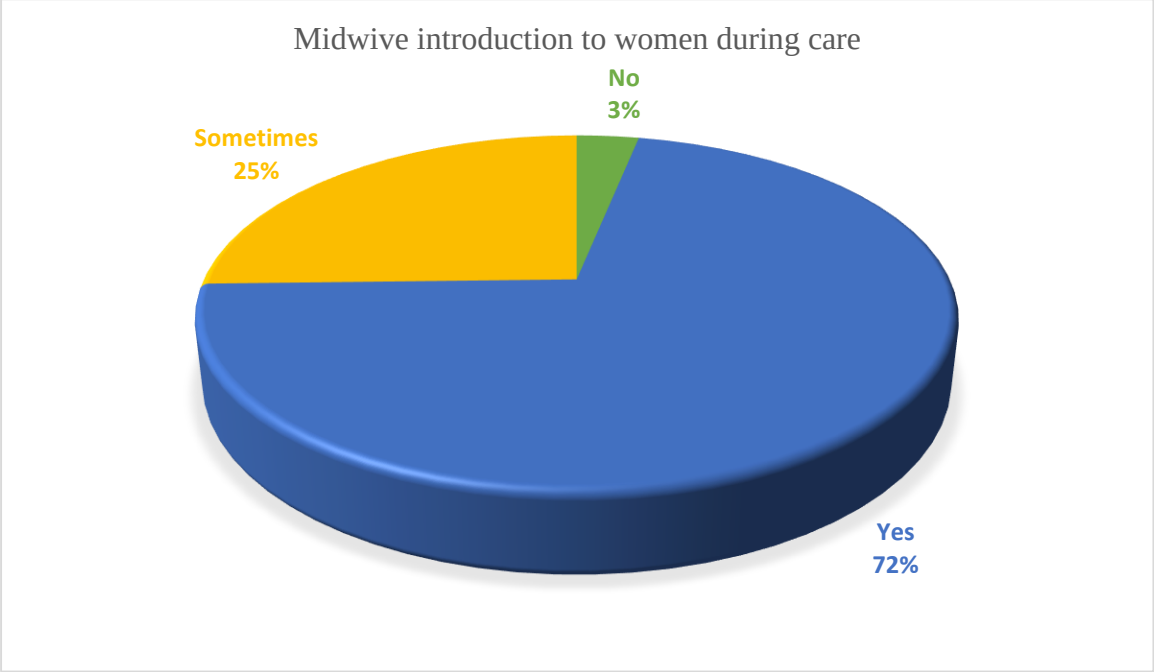

Figure 4.3: Self introduction to the women

4.3.4 Identification by Name

Majority of the Midwives, 79.7%(n=51) agreed that they refered to women by name.

Table 4.3: Identification by Name

	Frequency (n)	Percent (%)
Yes	51	79.7
No	13	20.3
Total	64	100

4.3.5 Privacy during History Taking

Respondents were asked if they took womens medical histroy in the presence of other patients.Majority of the respondents, 95.3% stated that they did not take womans history in public.

Table 4.4: Privacy during History Taking

	Frequency (n)	Percent (%)
Yes	3	4.7
No	61	95.3
Total	64	100

4.3.6 Maintaining Dignity during Intrapartum Care

Respondents were asked to indicate whether they maintained womens ' dignity during admission. Majority of the respondents, 98.4% indicated that they maintained the dignity of the womans. However, 1.6% of the respondents indicated that they did not maintain the dignity of the women.

Respondents were asked how they maintained womans' dignity during admission. Results in Figure 4.3, showd mostly womans' dignity during admission was maintained through ensuring privacy (51.8%; n=43) and confidentiality (25.3%; n=21).

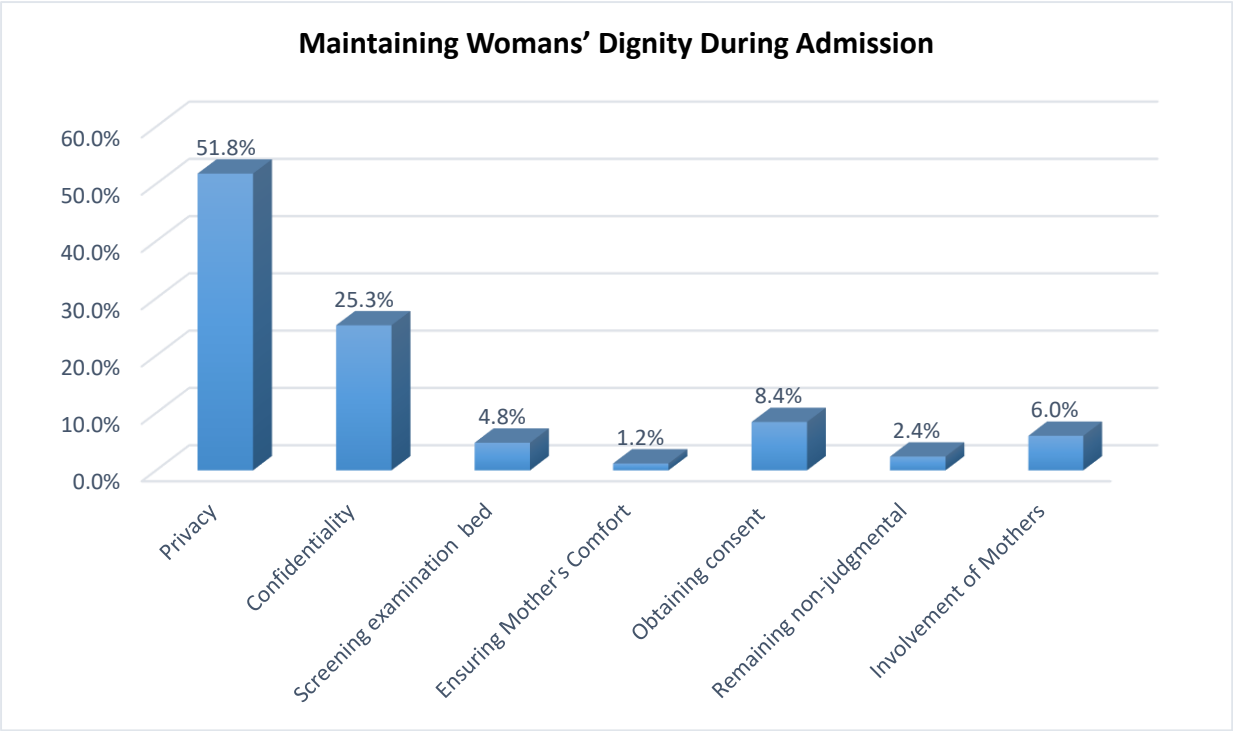

Figure 4.4: Maintaining Women's Dignity during Admission

4.3.7 Admission Process

Respondents were asked if they explained the process of admission to womens. Most of the respondents stated that they explained to womens the process of admission.

Table 4.5: Admission Process

	Frequency (n)	Percent (%)
Yes	59	92.2
No	4	6.3
Total	63	98.4

4.6.8 Use of Wheelchair

Respondents were asked whether they took women to bedside using wheelchair. Results demonstrated that most of the respondents 76.6% (n=49) indicated that it is only at times that they took women to bedside using wheelchair.

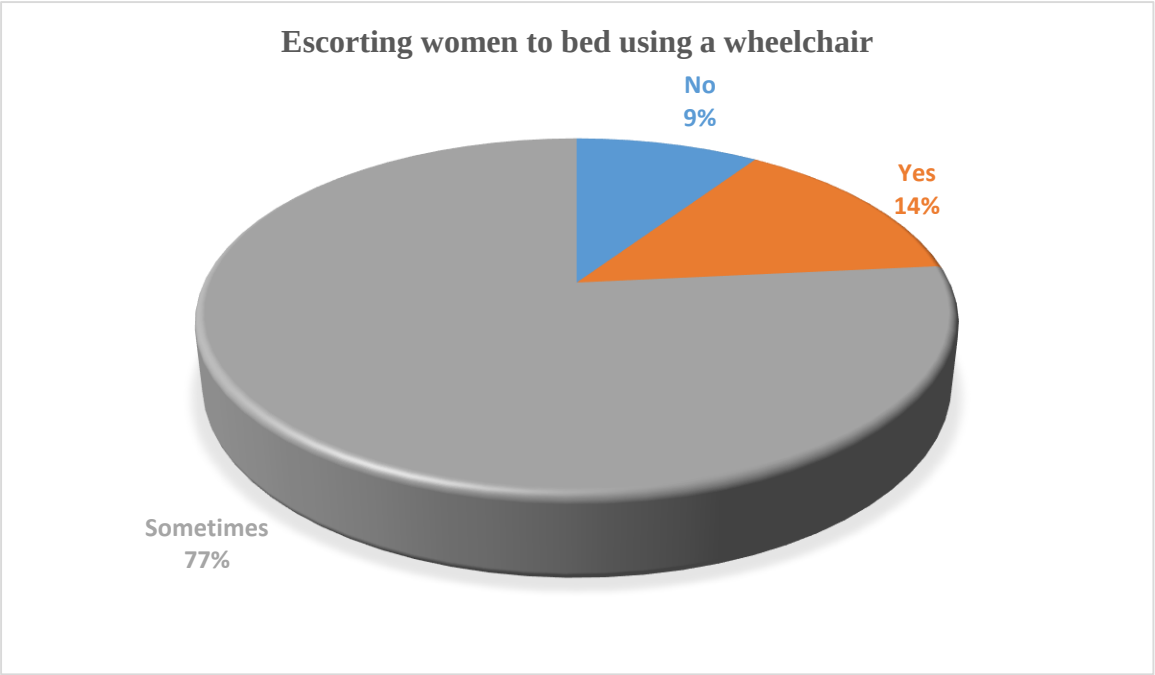

Figure 4. 5: Use of Wheelchair to Escort Women

4.3.9 Association between Practice of Dignified Intrapartum Care and Training on Dignified Intrapartum Care

This study examined the association between components of dignified intrapartum care and training on dignified intrapartum care and components of dignified intrapartum. Results in Table 4.11 showed that training on dignified intrapartum care had a statistically significant relationship with midwives introducing themselves to patients, X^2=9.783 ($p<0.008$). In addition, training on dignified intrapartum care had a statistically significant relationship with midwives always referring to the woman by their name X^2=8.561($p<0.003$). Training on dignified intrapartum care had a statistically significant relationship with midwives explaining the process of admission to the woman X^2=6.941($p<0.008$).

Table 4.6: Association between the practice of Dignified Intrapartum Care and the training of Dignified Intrapartum Care.

		Do you have training on dignified intrapartum care or women's dignity?			
		Yes	No	Chi-square	p
During admission did you welcome the woman	Yes	39	23	1.651	0.199
	No	0	1		
Do you always introduce yourself to the patients	Yes	33	12	9.783	0.008
	No	0	2		
	Sometimes	6	10		
Do you always refer to the woman by her name	Yes	36	15	8.561	0.003
	No	3	9		
Do you take the woman's history in public/ in the presence of other patients?	Yes	2	1	.030	0.862
	No	37	23		
Do you explain the process of admission to the woman	Yes	39	20	6.941	0.008
	No	0	4		
Do you take the woman to bed using a wheelchair	Yes	7	2	1.279	0.528
	No	4	2		
	Sometimes	28	20		

4.4 Structural Factors Influencing Dignified Intrapartum Care at Kenyatta National Hospital Labor Ward

This section focused on structural factors within KNH labor ward that, the influence of dignified intrapartum care, in this study we examined, midwives' ratio, room occupancy and incident reporting and complaint audit.

4.4.1 Number of Patients

Respondents were asked to indicate the number of patient they cared for in a shift. Results in showed that 38.1% (n=24) of the respondents, cared for 1-5 patients.

Table 4.7: Number of Patients

	Frequency (n)	**Percent (%)**
1 – 5 Patients	24	38.1
5 – 10 Patients	21	33.3
More than 10 Patients	18	28.6
Total	63	100

4.4.2 Room Sharing

Respondents were asked to indicate how manywomen shared a room. Results showed that most of the respondents, 52.4% (n=33) indicated that only 2 womens shared a room.

Table 4. 8: Room Sharing

	Frequency (n)	**Percent (%)**
2 patients	33	52.4
3 - 4 Patients	21	33.3
More than 4 Patients	9	14.3
Total	63	100

4.4.3 Complaint Box Availability

Respondents were asked if they had a complain box in their department.

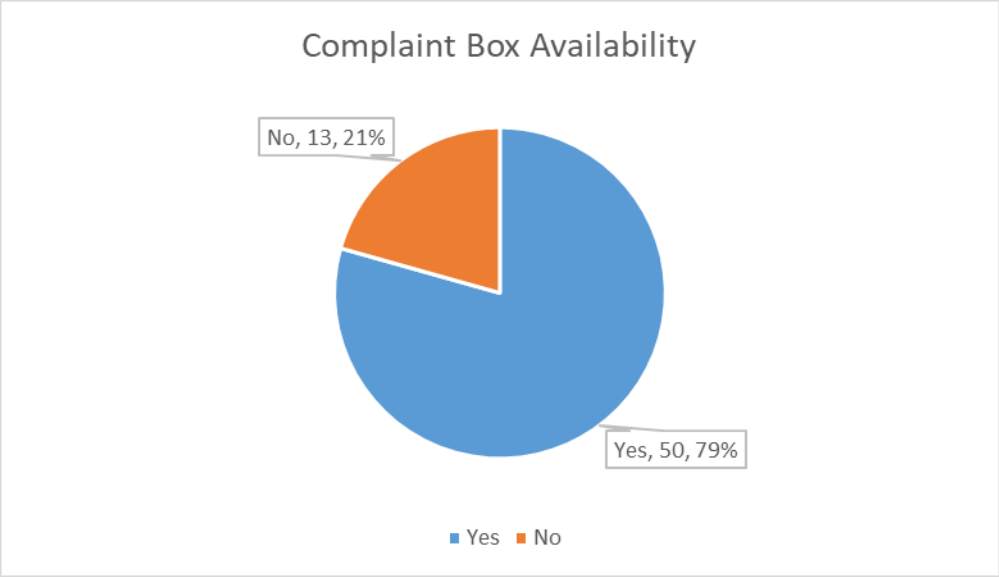

Figure 4. 6: Complaint Box Availability

Further, respondents were asked to indicate who is designated open the complaint box.

Table 4.9: Complaint Box Opening

	Frequency (n)	Percent (%)
Ward manager	46	80.7
Social worker	3	5.3
Others	8	14
Total	57	100

4.4.4 Addressing Women's Complaints

During this study I sought to establish how women complaints are addressed. Complaints were mainly addressed through the implementation of the recommendations made by the patients (35.7%, n=10). Addressing complaints in meeting was common indicated by the respondents (25%; n=7).

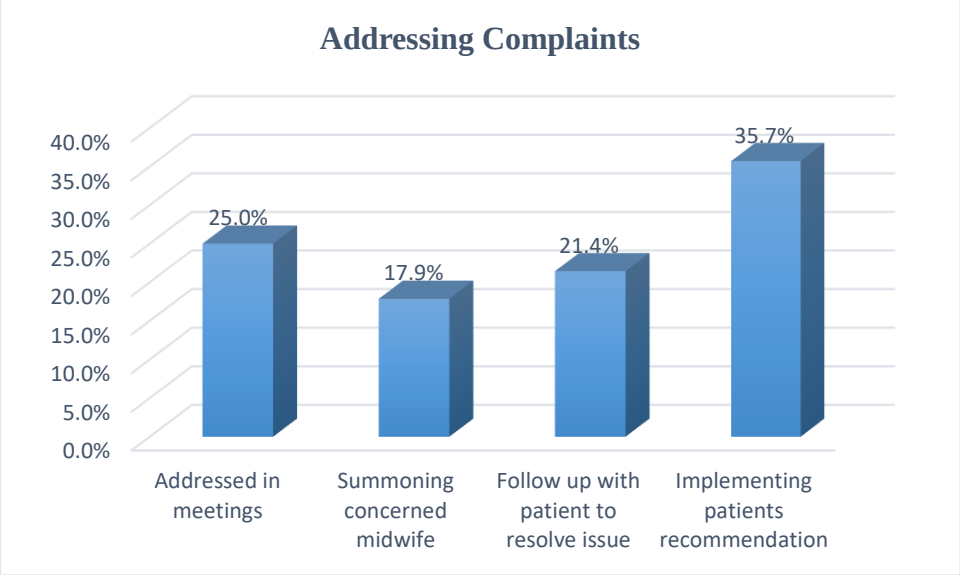

Figure 4.7: Addressing Complaints

4.4.5 Association between Structural Factors and the practice Dignified Intrapartum Care

This study sought to examine the association between structural factors and dignified intrapartum care. Results showed that having training on dignified intrapartum care had a significant association with the number of patients that one took care of during their shift, X^2 =1.902; p<0.386. According to findings showed that having training on dignified intrapartum care had a significant association with the number of patients sharing a room, X^2 =0.86; p<0.65.

Table 4.10: Association between Structural Factors and the practice of Dignified Intrapartum Care

		Do you have training on dignified intrapartum care or women's dignity?			
		Yes	No	Chi-square	P
How many patients do you take care of during your shift	5 patients	17	7	1.902	0.386
	10 patients	12	8		
	Others	9	9		
How many patients share a room?	2 patients	22	11	.860	0.65
	4 patients	11	9		
	Others specify	5	4		
In the department, do you have a complaint box?	Yes	32	18	.799	0.371
	No	6	6		
Who opens the box?	Ward manager	29	17	1.085	0.581

	Social worker	2	1		
	Others specify	3	4		

4.5 Influence of Process Factors on Dignified Intrapartum

The study sought to identify the process factors at labour ward KNH. In this section , we considered involvement of women in continuity of care , communication with women and interaction of midwives and women.

4.5.1 Women Involvement

Respondents were asked whether they involved womans in the labor process.

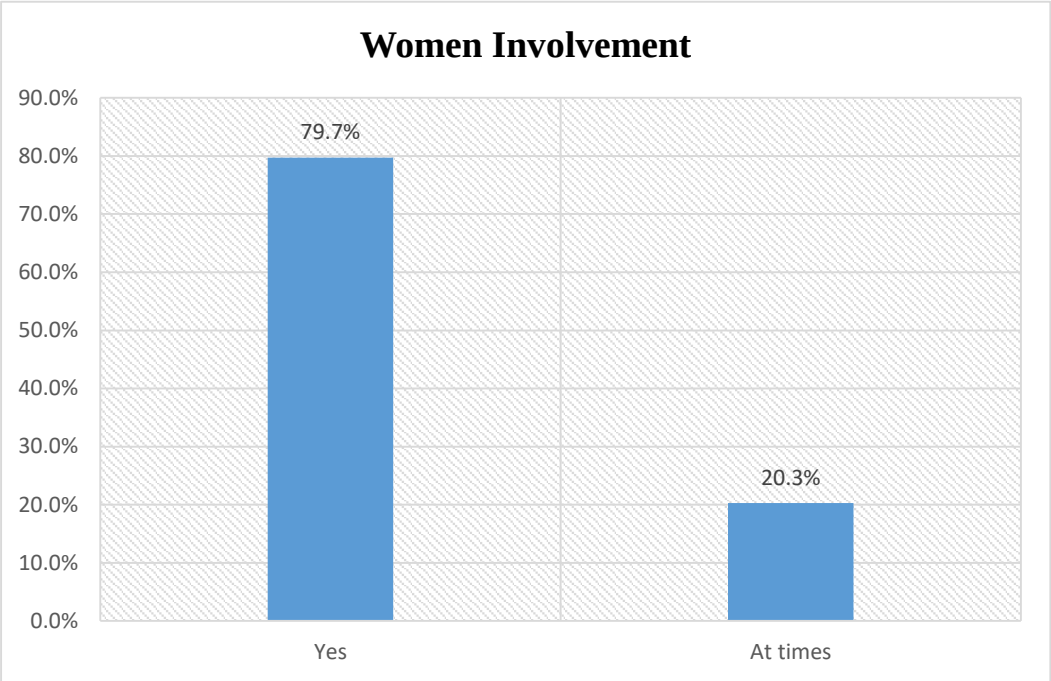

Figure 4.7: Women Involvement

4.5.2 Maintaining women Dignity during Labor

During this study I sought to find out the reason behind participants involving women in care process. Results showed that 20% of the respondents, indicated that they involved women in the intrapartum period.

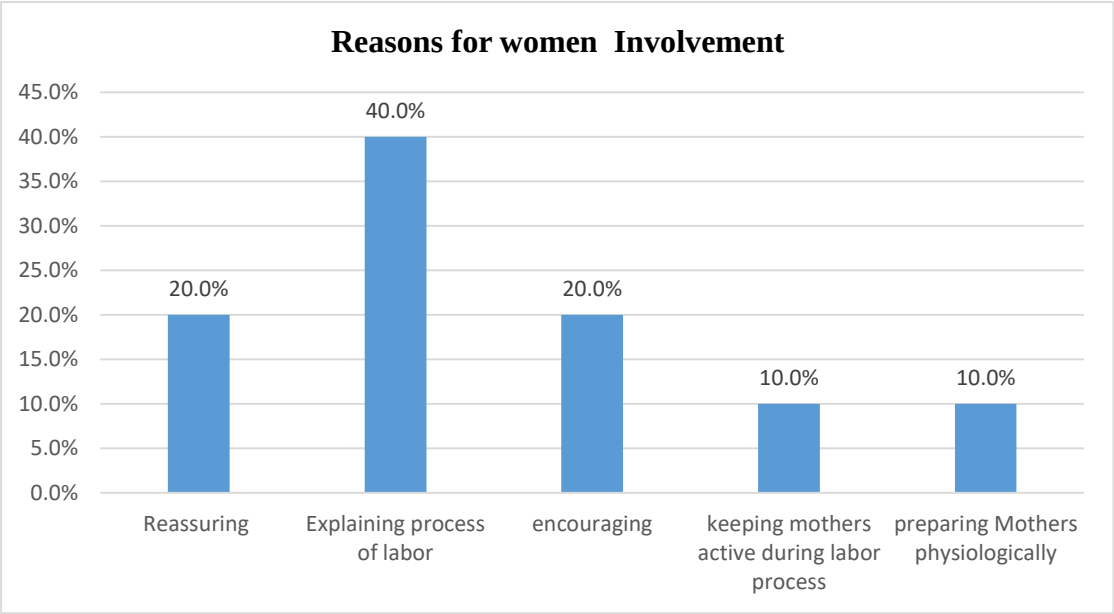

Figure 4.8: Reasons for Woman Involvement

4.5.2 Maintaining Womens' Dignity During Assesment

This study sought to determine midwives perspective of how womens' dignity was maintained during an assessment of a woman in labor. According to results most of the respondents, 61.3% (n=51) indicated that they maintained womans' dignity during an assessment of a woman in labor by ensuring their privacy. In addition, the respondents, 17.2% (n=16) indicated that they maintained womans' dignity during an assessment of a woman in labor by ensuring their confidential care of woman.

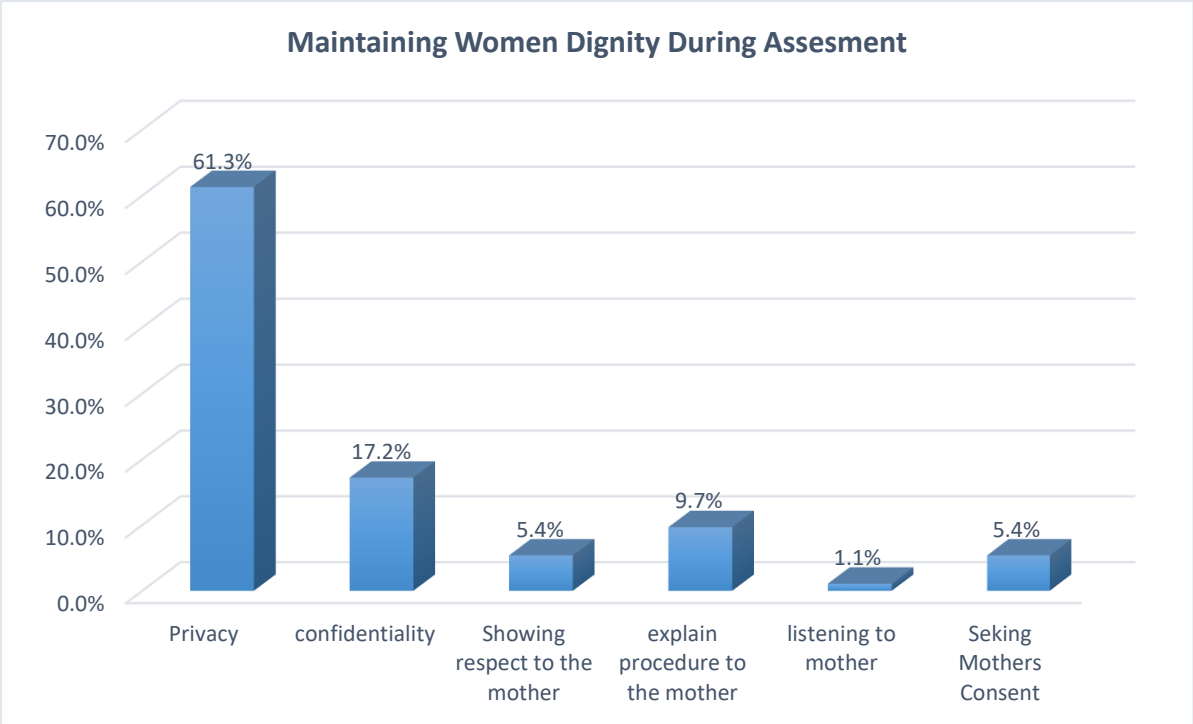

Figure 4.9: Maintaining Dignity during Assessment

4.5.3 Women's Consent

Respondents were asked whether they sought women's consent before assessment. most of the respondents, 78.1 %(n=50) sought consent from women before carrying out the assessment.

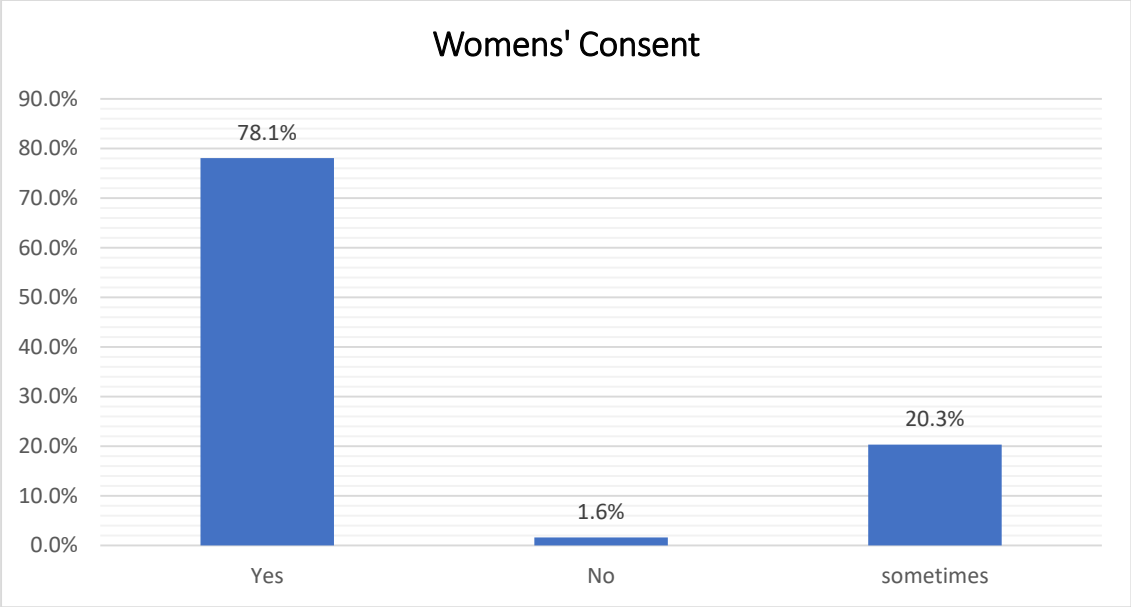

Figure 4.10: Women's Consent

4.5.4 Communicating Findings

The study sought to establish how findings were communicated findings to women after assessment. Results revealed that 40.7 %(n=11) of the respondents indicated that following the assessment of woman in labor they gave a detailed explanation to the woman on the outcome of the assessment. In addition, 37.0 %(n=10) of the respondents indicated that following the assessment of woman in labor they used simple language to communicate to the woman on the outcome of the assessment.

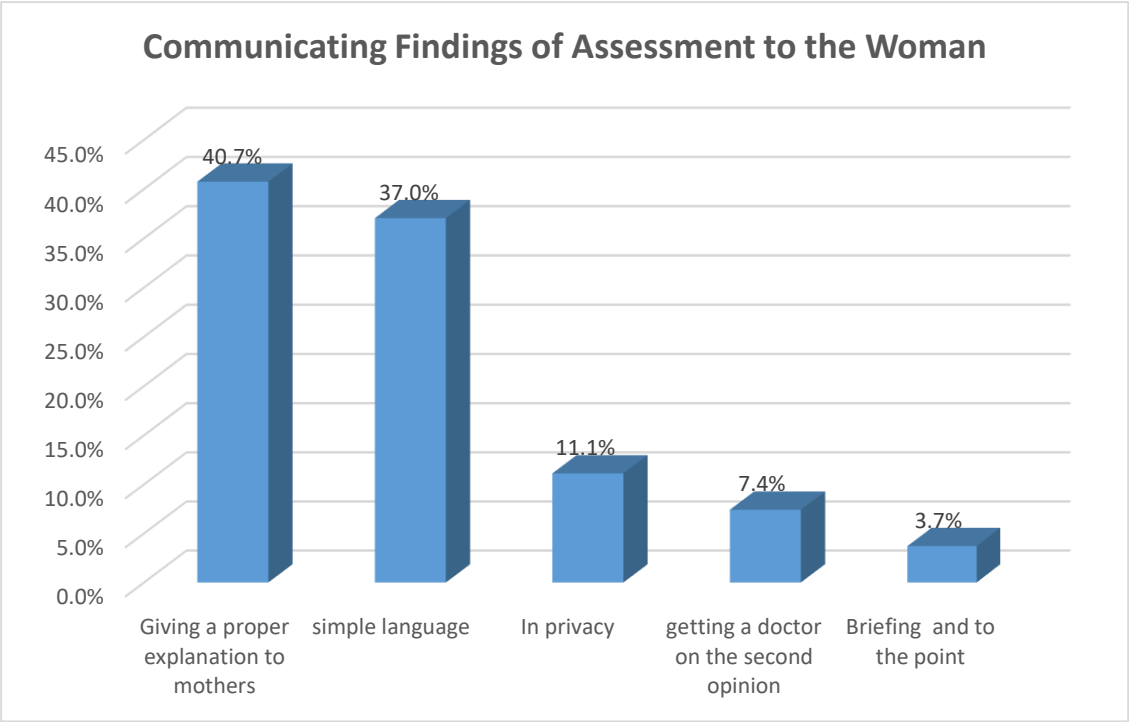

Figure 4.11: Communicating Assessment Findings

4.5.5 Equal Treatment

This study sought to determine whether women were handled in different ways during implementing care in the ward. Results showed that majority of the respondents gave womans equal treatment during implementing care in the ward.

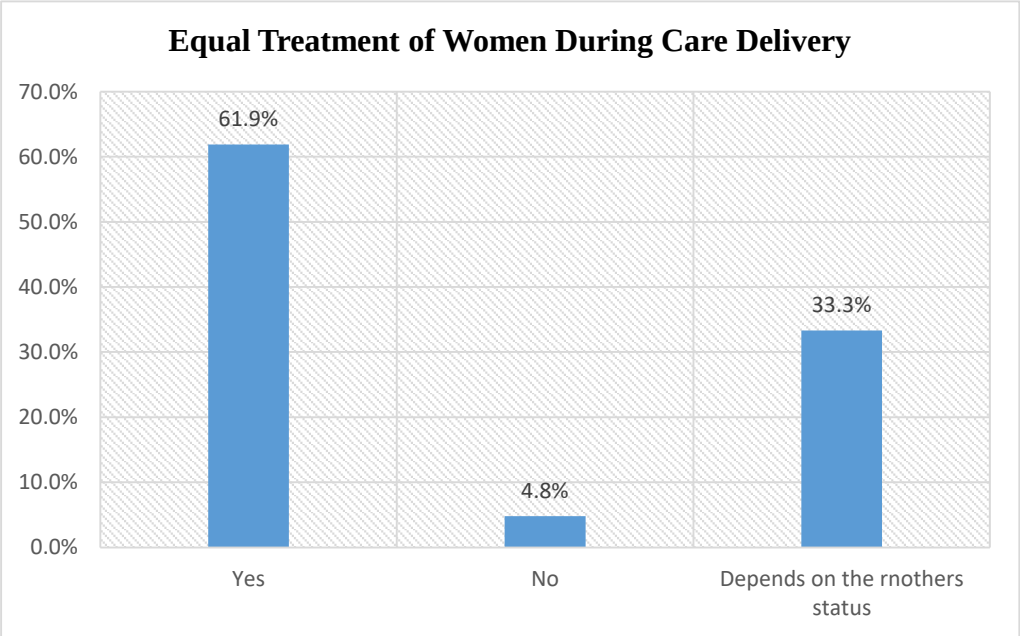

Figure 4.12: Equal Treatment

4.5.6 Interaction with women during Intrapartum Care

Respondents were asked to rate their interaction with womans during intrapartum care.

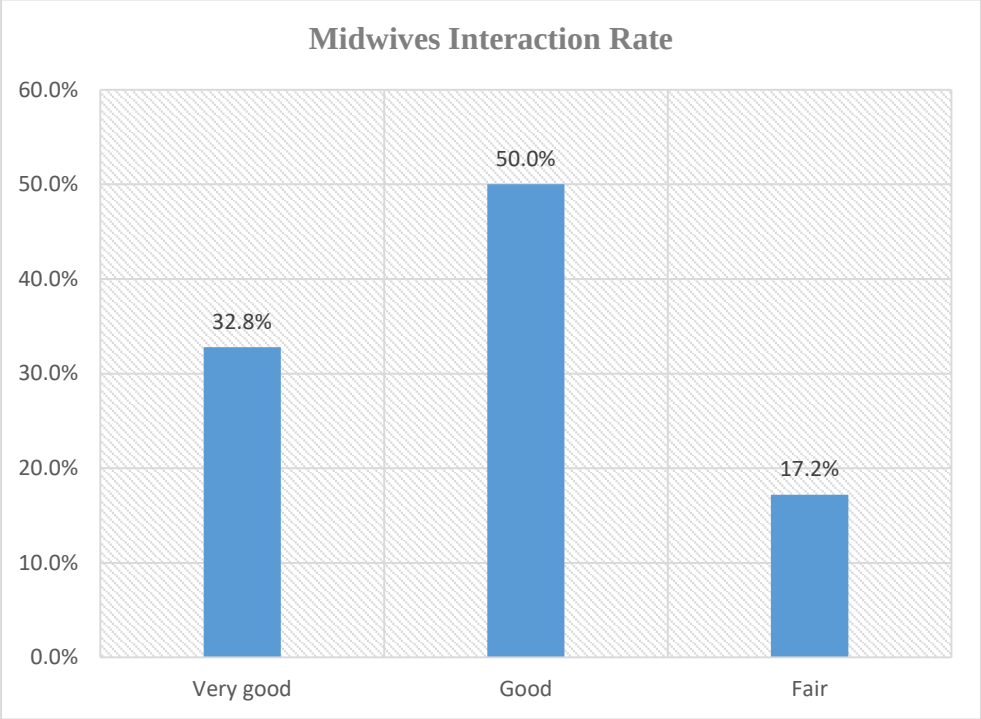

Figure 4. 13: Interaction with women during Intrapartum Care

4.6 Association between the Practice Dignified Intrapartum Care and Training of Dignified Intrapartum Care

This study examined the association between training on dignified intrapartum care and components of dignified intrapartum. Results in Table 4.11 showed that training on dignified intrapartum care had a statistically significant relationship with midwives introducing themselves to patients, X^2=9.783 ($p<0.008$). In addition, training on dignified intrapartum care had a statistically significant relationship with midwives always refering to the woman by their name X^2=8.561($p<0.003$). Training on dignified intrapartum care had a statistically significant relationship with midwives explaining the process of admission to the woman X^2=6.941($p<0.008$).

Table 4.11: Association between Training on Dignified Intrapartum Care and the practice of Dignified Intrapartum Care

		Do you have training on dignified intrapartum care or women's dignity?			
		Yes	No	Chi-square	p
During admission did you welcome the woman	Yes	39	23	1.651	0.199
	No	0	1		
Do you always introduce yourself to the patients	Yes	33	12	9.783	0.008
	No	0	2		
	Sometimes	6	10		
Do you always refer to the woman by her name	Yes	36	15	8.561	0.003
	No	3	9		
Do you take the woman's history in public/ in the presence of other patients?	Yes	2	1	.030	0.862
	No	37	23		
Do you explain the process of admission to the woman	Yes	39	20	6.941	0.008
	No	0	4		
Do you take the woman to bed using a wheelchair	Yes	7	2	1.279	0.528
	No	4	2		
	Sometimes	28	20		

CHAPTER FIVE: DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter focuses on the findings of the research study on the assessment of structure and process factors that influence dignified intrapartum care among midwives at Kenyatta National Hospital labor ward. The discussion was guided by the following research objectives.

This was a descriptive cross-sectional study the participants were midwives who worked in the labour ward in August 2021. The study revealed that both the structural and process factors influenced the practice of dignified intrapartum care.

This chapter summarized all findings of the study and provided useful conclusions and recommendations. The results were compared with other study findings both locally and internationally. The conclusion from the study findings and recommendations and areas of further research are outlined in this chapter.

5.2 Discussion

5.2.1 Demographic Characteristics

From the study results there was no positive association with the level of education with practice of dignified intrapartum care. The study results are in contrast with a comparative study conducted to evaluate the practice of nurse-midwives with the level of education, which showed a positive association between level of education with knowledge and practice (Alanezi, 2018). It should be noted that qualifications do not denote competency and humane caring. The midwives with a higher number of working years, were more aware of the practice of dignified intrapartum care. The study revealed a positive relationship between training on dignified intrapartum care and the practice, this was in contrast with a study conducted in Mozambique citing disconnect between knowledge and practice among midwives and what was practiced in labour ward (D-zomeku *et al.,* 2020). Training increases knowledge and practice among midwives' treatment to the women seeking maternal care, according to (Ndwiga *et al.,* 2017) which is in agreement with study results. A study conducted in Tanzania indicated with the substantial improvement from the midwives' provision of care, following training on respectful intrapartum care (Ratcliffe *et al*., 2016).

There was no significant relationship between religion and practice of dignified intrapartum care. In studies conducted in Kenya and Tanzania, are in agreement with the study findings that no religion affiliation to respectful or disrespectful care in labour ward (Afulani *et al.,* 2020; Kruk *et al.,* 2018; & Warren *et al.,* 2017b).

5.2.2 The Practice of Dignified Intrapartum Care

Midwives in the study indicated they practiced dignified care during labour and childbirth. The concepts that arose from the midwives included: maintaining privacy and confidentiality, respect and maintaining dignity, and maintaining woman's autonomy. This was not in congruent with the World Health Organization description, as organized care provided to all women during labour and childbirth that maintains dignity, privacy and confidentiality, ensures freedom from harm from harm and mistreatment, and enables informed choice and continuous support (WHO, 2018). According to Bowser & Hill 2002, non-dignified care was identified as intentional humiliation, blaming inhumane and rough treatment and shouting, lack of empathy and refusal to assisting, poor staff attitude towards the birthing women, and public divulging of patients' information. Dignified intrapartum care included, proper and effective communication, use of proper language tone while addressing the woman, allowing the woman to have control and allow her to make choices, continuity of care and humane interaction without use of demeaning and scolding words to the woman, (Warren et al., 2017b). During admission to the labour ward, the midwives indicated they introduced themselves to the women and their role in care, a quarter of the midwives indicated they only introduced themselves to the women sometimes. Other studies found that women perceived introduction of the health care provider and referred by their names as a way of upholding their dignity and being respected (Abuya *et al.,* 2015b; Afulani *et al.,* 2018; & Warren *et al.,* 2013).

5.2.3 Structural Factors Influencing Dignified Intrapartum Care

Structural factors related to dignified intrapartum care physical environment midwives' patient ratio and the departmental and institutional policy to handle patients' complaints. With the introduction of free maternity services, the was a surge of women seeking to deliver in the health facility, however the structures have remained constant. According to the midwives in the study, a quarter of the midwives indicated that they took care of more than 10 women in a shift understaffing and overcrowding on the labour ward is likely to create a stress environment, may contribute to midwives' impulsivity and aberration

thereby resulting to aggression to women (Bohren et al., 2017). The findings show the state of health systems as overstretched, which contributes to a lack of privacy and personalized care, study findings by Oluoch-Aridi *et al.* indicated that midwives cited disrespect and undignified intrapartum care as unintentional by attributed by staff shortage and inadequate resources. situational and institutional factors are likely to trigger stress which resulted to non-dignified care during childbirth (Afulani *et al.,* 2020). From the study, mostly at least 2 women shared a room at a given time, occasionally 4 women shared a room, women sharing beds or rooms are likely to overhear each other's interaction with midwives, jeopardizing the confidentiality and privacy aspect in childbirth (Atai *et al.,* 2018; Warren *et al.,* 2017b). Midwives noted in other studies that it was sometimes difficult to maintain women's privacy and confidentiality because of the open nature of the labor wards, which were often small for the number of women in labor (Afulani *et al.,* 2020; Asefa and Bekele, 2015; Lusambili *et al.,* 2020).Regarding departmental policy, the midwives 79% indicated the presence of a complaint box which is opened by the department manager 80.7%, and issues raised were addressed during morning briefs and midwives discussed together with the way forward although it depended on the weight of the matter. The midwives however did not mention how the women who raised concern were reached out.

5.2.3 Process Factors Influencing Dignified Intrapartum Care.

A number of process factors influencing dignified intrapartum care included privacy and confidentiality, respect and dignity to women and maintaining woman's autonomy. Overall, in various studies these concepts appear to in enhance positive maternal experience and likelihood to utilize health facility delivery(Asefa and Bekele, 2015; Kruk et al., 2010; Oluoch-Aridi *et al.,* 2018; Otis & Brett, 2008a).

Although a majority of midwives indicated that they involved women in process of care a 20.3% indicated that they did not always involve women in the care, could be attributed to work load or it was intentional, this is in congruence with finding by a study by Atai *et al*. that 14% of women indicated that they were denied information about their care and progress. Midwives indicate that they sought consent always, a 20.3% indicate they did at times, study findings by Abuya et al are similar where 22% of women experienced a lack of consent during intrapartum care. There was explicit biases which appeared in other studies to promote favoritism towards certain groups and discrimination against others (Afulani *et al.,* 2020; K *et al.,* 2018; Ndwiga *et al.,* 2017; Warren *et al.,* 2017b). Findings

from this showed that midwives indicated that their treatment towards women depends on that status of the woman. These findings are similar to study findings, women from low social-economic status were mistreated by midwives, and young women received improper treatment while women with other comorbidities were treated with inequality (Oluoch-Aridi *et al.,* & Abuya *et al.,* 2015). The Kenyan constitution (2010) outlines the right of every citizen to receive equal treatment and receive no discrimination regardless of their status. The International Confederation of Midwives states: "*This code acknowledges women as persons with human rights, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect and trust, and the dignity of all members of society*" (2008).

5.3 Conclusion

The study found a majority of midwives acceptable interaction with women, at 50.0 % during intrapartum care delivery. There was a positive relationship between training midwives on dignified intrapartum care and the provision of dignified intrapartum care. The structure process in the institution influenced negatively the provision of dignified intrapartum care. As much as the department has a complaint box, some midwives were not aware of how the complaints were solved, those who knew did not mention if the women were reached out. The structural factors seemed to affect the process factors, thus affecting the delivery of dignified intrapartum care.

5.4 Recommendations

More studies on dignified intrapartum care with focus on midwives' and women's perspective.

The hospital administration needs to work out a strategy to ensure adequate midwives' patient interaction.

Ward managers need to advocate for continuous educational programs, these will help in improving intrapartum care.

6.0 LIMITATIONS OF THE STUDY

This study has potential limitations. Firstly, assessment of the influence of structural and process factors on dignified intrapartum care among midwives was based on self-report. Responder bias is thus a potential limitation as midwives may not have accurately give

credible responses.The study was conducted with strict timelines. The research was conducted in a single facility, the results cannot be generalized with other facilities.

7.0 CONFLICT OF INTEREST

I declare no conflict of interest

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APPENDICES

Appendix 1: Letter to KNH-UoN Ethical and Research Committee

Alice Wangeci Mathenge
Reg. No. H56/32334/2019,
School of Nursing Sciences,
College of Health Sciences,
The University of Nairobi.

The Secretary,

KNH/UoN - Ethics and Research Committee,

P.O. Box 20723-00202,

Nairobi.

Dear Sir/Madam,

RE: Approval to Conduct a Research Study

My name is Alice Wangeci a student at the University of Nairobi, School of Nursing Sciences undertaking a Master's of Science Degree in Midwifery and Obstetric Nursing. I am hereby requesting your approval to carry out a research study on **"Assessment of structural and process factors influencing dignified intrapartum care among midwives at Kenyatta National Hospital, labor ward",** as a requirement in partial fulfillment for the award of the degree award.

Thank you in advance.

Yours faithfully

Alice Wangeci Mathenge

Appendix 2: Informed Consent

Title Of The Study: Assessment of Structural and Process Factors Influencing Dignified Intrapartum Care among midwives at Kenyatta National Hospital, Labor Ward.

Principal Investigator\and institutional affiliation: Alice Wangeci .M. University of Nairobi

Supervisors: Dr. Joyce Jebet, & Dr. Miriam Wagoro, University of Nairobi

Introduction

My name is Alice Wangeci a student at the University of Nairobi pursuing a Master of Science Degree in midwifery and obstetric nursing. I am undertaking a thesis study on the **Assessment of Structural and Process Factors Influencing Dignified Intrapartum Care at Kenyatta National Hospital, Labor Ward.**

Purpose of the study

The study aims to explore the structural and process factors and their influence on dignified intrapartum care, looking at the midwives' perspective. I am therefore requesting for your participation in the study to give your views and opinions about the study If you choose to participate, the researcher will ask you a series of questions, to gather information about the structural factors: midwives to patient ratio, availability of facilities, reception of referrals and process factors: the assessment of the patient, planning, and intervention of care during labor and childbirth. It will take 10 minutes to fill in the questionnaire.

Confidentiality

All the information provided will be treated with the utmost confidentiality. In addition, all the information given herein will be used for research purposes only. No name or identification will not appear anywhere in the study as the study will use statistics.

Voluntary participation

Participation in the study is voluntary. There will be no penalties for any decline and participants can withdraw at any stage of data collection with no penalties. However, I will greatly appreciate your participation because your views are very important for the success of this study.

Benefit

This research work is for academic purposes only and if you agree to participate, the information that you will provide will be of great importance to midwives, policymakers, and womans in their effort to improve intrapartum care

Risks

There will be no harm to you or your family as a result of your participation in this study. However, due to the prevailing Covid 19 pandemic in the country, the researcher will strictly adhere to Ministry of Health directives against Covid 19

Contacts

For any queries regarding this study, kindly contact; Principal researcher: Alice Wangeci, Cell: 0722 728762

OR

Secretary, Ethics and Research Committee of KNH/UON, Telephone: 020-2726300 Ext 44355

[*Please ensure that you have read the following, or that the following has been read to you, and that you fully understand what is involved in participating in this study and that your role as the respondent has been fully explained to you.]*

Appendix 3: Consent Form

Respondent's Declaration

I have been fully informed about the nature of the study, I know the benefits, and understand that there are no risks involved. I hereby give my consent to participate in this study.

Signature of participant ……. Date …….

Researcher's Declaration

I have fully disclosed all the relevant information concerning this study to the study respondent.

Signature of researcher ……. Date ……

Appendix 4: Questionnaire

TITLE: ASSESSMENT OF STRUCTURE AND PROCESS FACTORS THAT INFLUENCE DIGNIFIED INTRAPARTUM CARE AT KENYATTA NATIONAL HOSPITAL

Date:

Questionnaire number: **CODE NO.**

Instructions to the participant:

1. Please tick or fill the spaces provided
2. Do not leave any questions unanswered
3. Tick only one response

Part A: social-demographic data

(Mark the appropriate box with X)

1. What is your age in years?

   24-29 □ 30- 34 □ 35- 40 □ 41-44 □

   45- 40 □ 41- 44 □ 45-50 □ 51-60 □

2. What is your religion?

   Christian ☐

   Muslim ☐

   Hindu ☐

   Other, specify ☐

3. How long years have you worked at Kenyatta national hospital labor ward.

Below 1 year □ 7-9 years □

1-3 years □ Over 10 year's □

4- 6 years □

4. Have you worked in another facility in the labor ward department before?

Yes □

No □

5. What is your highest qualification?

Diploma □ Postgraduate □

Higher diploma □ Others specify

Bachelor's degree □

6. Do you have training on dignified intrapartum care or women's dignity?

Yes □

No □

Part B: Components of Dignified Intrapartum Care

1. In your words, what is dignified intrapartum care?

2. During admission did you welcome the woman?

Yes □

No □

3. Do you always introduce yourself to the patients?

Yes □

No □

Sometimes □

They read my nameplate □

Others specify

4. Do you always refer to the woman by her name?

Yes □

No □

5. Do you take the woman's history in public/ in the presence of other patients?

Yes □

No □

6. Do you feel that you maintain the dignity of the woman during admission?

Yes ☐

No ☐

If yes, explain how you maintained

If not, why

7. Do you explain the process of admission to the woman?

Yes ☐

No ☐

8. Do you take the woman to bed using a wheelchair?

Yes ☐

No ☐

Sometimes ☐

Part C Structural Factors Influencing Dignified Intrapartum Care at Kenyatta National Hospital Labor Ward.

1. How many patients do you take care of during your shift?

5 patients ☐

10 patients ☐

Others specify ☐

2. How many patients share a room?

2 patients ☐

4 patients ☐

Others specify

3. In the department, do you have a complaint box?

Yes ☐

No ☐

4. Who opens the box?

Ward manager ☐

Shift leader ☐

Social worker ☐

Others specify ☐

5. How are the patient's complaints addressed _____

_____

Part D Process Factors and Their Influence on Dignified Intrapartum Care.

1. Do you involve the woman in the labor process care?

   Yes ☐

   No ☐

   At times ☐

1a. if yes explain

1b. if not why explain

2. How do you maintain dignity during an assessment of a woman in labor

   _____

   _____

   _____

3. Do you seek permission/ obtain consent before an assessment?

   Yes ☐

   No ☐

   Sometimes ☐

4. If No to No. 3 Explain why

5. How do you communicate the findings of your assessment to the woman? Explain

6. While implementing care in the ward do treat all women equally?

Yes ☐

No ☐

Depends on the woman's status

7. How would you rate your interaction with women during intrapartum care?

Very good ☐

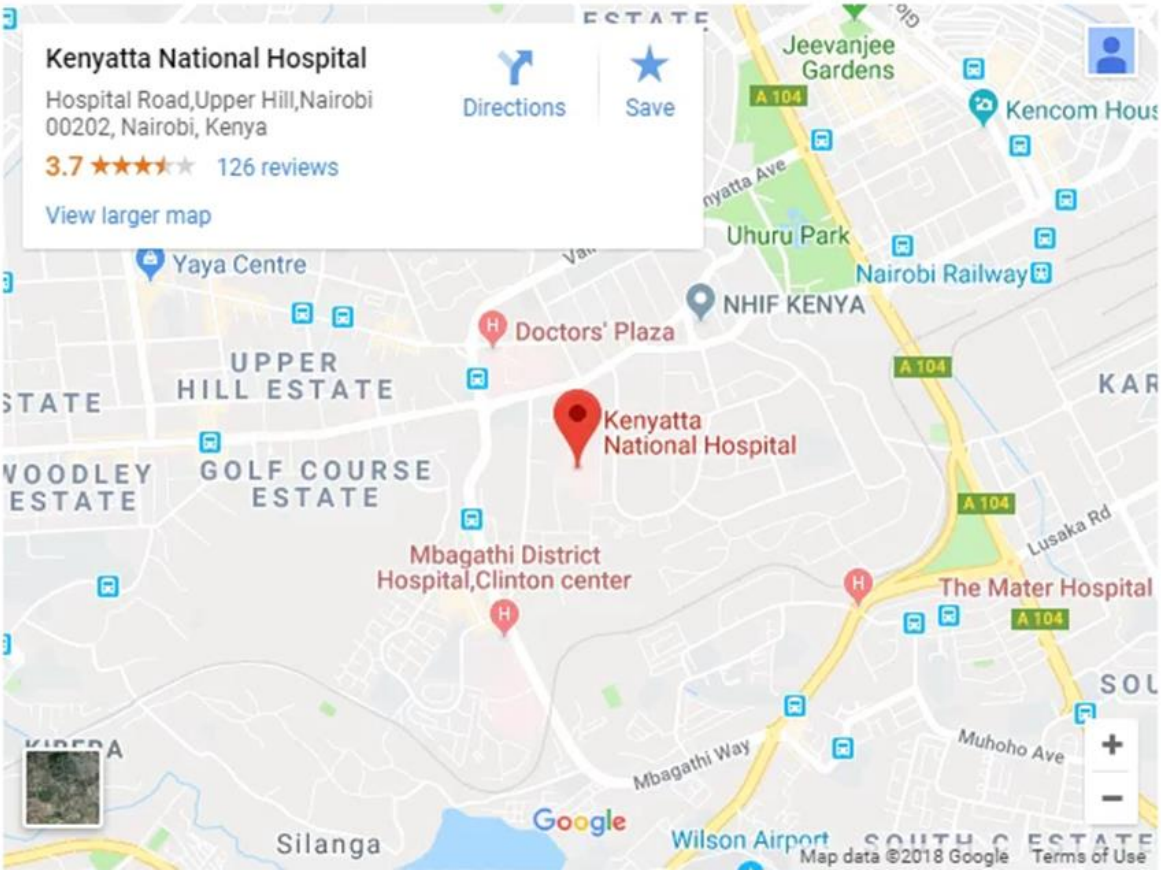
Good ☐

Fair ☐

Bad ☐

Extremely bad ☐

Appendix 5: Map of he Area



Adapted from Google maps

Appendix 6: Budget

Item	**Quantity**	**Cost per unit in Ksh**	**Total cost in Ksh**
Proposal Writing and Development			
Internet and stationaries	-	-	9,500
Fair copies printing	3 copies 150 pages	5 per page	2,250
Final copy printing	3 copies 150 pages	5 per page	2,250
Final copies photocopy	4 copies; 150 pages	5 per page	3,000
Binding	6 copies	1,000	6,000
Ethics research committee fee			2,000
Pretesting			3,000
Data collection			5,000
Final report			
Fair copies printing	3 copies 150 pages	5 per page	2, 250
Final copy printing	3 copies 150 pages	5 per page	3, 000
Transport to KNH	600/ day	600x 15	9,000
Meals	200/day	200x15	3,000
Data analysis statistician			25,000
Publications			
Publication in seminar			12,500
Publication in a peer-reviewed journal	-	-	40, 000
Contingencies	-	-	20,000
Total			**143, 000**

Appendix 7: Work Plan

2021										
Activity	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**
Concept development										
Proposal writing										
Submission to Ethics Committee										
Pretesting of instruments										
Data collection and analysis										
Report writing										
Project presentation										
Results dissemination										

Appendix 8: letter from UON – KNH ethics committee

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/255

15th July, 2021

KENYATTA NATIONAL HOSPITAL APPROVED 15 JUL 2021 KNH/UoN-ERC P. O. BOX 20723 - 00202 NAIROBI

Alice Wangeci Mathenge
Reg. No. H56/32334/2019
School of Nursing Sciences
College of Health Sciences
University of Nairobi

Dear Alice,

RESEARCH PROPOSAL: ASSESSMENT OF STRUCTURE AND PROCESS FACTORS THAT INFLUENCE DIGNIFIED INTRAPARTUM CARE AMONG MIDWIVES AT KENYATTA NATIONAL HOSPITAL (P381/05/2021)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH-UoN ERC) has reviewed and **approved** your above research proposal. The approval period is 15th July, 2021 – 14th July, 2022.

This approval is subject to compliance with the following requirements:

i. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
ii. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
iii. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
v. Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (Attach a comprehensive progress report to support the renewal).
vii. Submission of an executive summary report within 90 days upon completion of the study.

This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website **http://www.erc.uonbi.ac.ke**

Yours sincerely,

PROF. M.L CHINDIA
SECRETARY, KNH- UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Senior Director, CS, KNH
The Chair, KNH- UoN ERC
The Director, School of Nursing Sciences, UoN
Supervisors: Dr. Joyce C. Jebet, School of Nursing Sciences, UoN
Dr. Miriam C.A. Wagoro, School of Nursing Sciences, UoN