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The Childbirth Experiences and Perceptions of Sierra Leonean Women Relating to Basic Maternal Rights

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MHPE, Suez Canal and Maastricht Universities, 2014

BSc (Hons.), Edge Hill University, 2017

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Sierra Leone faces immense challenges in supporting good quality, woman-centered care, with one of the world's highest maternal mortality ratios of 717 per 100,000 live births. In countries with high maternal mortality, evidence of the fear of disrespect and abuse women usually confront in maternity care is a more solid deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance. This qualitative phenomenological study aimed at understanding the childbirth experiences and perceptions of Sierra Leonean women relating to basic maternal rights. The ecological systems theoretical framework and the respectful maternity care charter conceptual framework guided the study. Data collection involved in-depth semi structured interviews conducted in religious settings with 21 postpartum women aged 18 to 45 years in three district hospitals in Northern Sierra Leone. The data were analyzed using the content analysis method. Thirteen themes were identified as relevant to the two research questions: accountability, empowerment, participation, sustainability, transparency, support factors, maternal care setting, healthcare providers' behavior, social factors, conflict in healthcare facilities, and factors that impact women's decision making. Participants reported diverse experiences of healthcare facility-based childbirths. Some shared that poor quality care is characterized by abuse and mistreatment and, consequently, negative implications; others reported quality care and positive impacts on care. Any approach to prevent and eliminate the identified bad and negative practices to enhance quality maternal care can contribute to positive social change. The study offers recommendations for relevant stakeholders' action and further research.

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Dedication

I wholeheartedly dedicate this dissertation to my beloved family, who has been my source of inspiration and strengthened me by providing their moral, spiritual, emotional, and financial support. To my husband, Rev. Dr. Usman Jesse Fornah, for his deposits of support and sanity in all the falling apart and triumphant moments of the Ph.D. journey. In exchange for their love and support, I hope I have taught them that learning, and growth are possible at any age,

To my best cheerleader and sister, Joan F. Sesay, for being there for me throughout the entire doctoral program,

To the women who offered me their stories so that we can understand better how to provide respectful maternity care for other women during birth,

And finally, I dedicate this study to the memory of my mother, Mrs. Marie Sesay. She was, and is, my role model for how to live a life of learning, passion, humor, and integrity. I can only hope that what I have accomplished personally, professionally, and academically is a testament to the gifts she gave me and the values she instilled in me.

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Lastly, I would like to thank God for the power of the mind in letting me through all the difficulties. I have experienced your guidance day by day. It has been a long, arduous journey, but nothing in life is easy.

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Chapter 1: Introduction to the Study

Significant progress has been made globally in maternal and neonatal health (MNH) care, and both maternal and neonatal mortality rates have dropped in recent decades (World Health Organization [WHO], 2010). However, several challenges remain in Sierra Leone, a country in West Africa, where limited health resources exist, drugs and medical supplies are unreliable, and the number of doctors, midwives, and nurses is insufficient to cover the needs of the people (Amnesty International, 2016). As a result, Sierra Leone has some of the poorest health indicators in the world, including one of the highest maternal mortality ratios, making the country a dangerous place for women to give birth (Statistics Sierra Leone [SSL] & ICF International, 2014; WHO, 2016). Furthermore, between 2014 and 2015, Sierra Leone was hit by the Ebola epidemic, which claimed the lives of more than 3,000 people, including 221 health care workers and 11 specialized physicians, further deteriorating the health system (Government of Sierra Leone, 2015). These setbacks resulted in the closure of significant health facilities exacerbated by existing inequities in healthcare access; facility-based deliveries and antenatal care visits reduced by about 2%, driven by mistrust of health care workers; and health staff reluctance to care for maternity cases (Figueroa et al., 2018). Access to quality health care remains one of the significant public health concerns attributed to inadequate human resources, limited health expenditure, and problems associated with the breakdown of the drug and medical supply chain (SSL and ICF International, 2014).

Given the global efforts to improve maternal health and quality of care, the mistreatment of women during childbirth has received increasing attention in the past few

years. Similarly, the WHO has identified improving women's care experiences as a critical component of strategies to improve the quality of care (as cited in Tuncalp et al., 2015). Sierra Leone needs to make pregnancy and childbirth physically, socially, culturally, emotionally, and psychologically safe for all women (Amnesty International, 2016). For women, pregnancy and birth are regular physiological life events and not just physical acts; it is an emotional, social, and psychological act (Olza et al., 2018). The effects of a birth experience can be positive and empowering or negative and traumatizing (Safe Motherhood for All Inc. [SMFAI], 2017). Childbirth should be part of a respectful relationship whereby women are respected to create an outcome that empowers the woman and ensures safe delivery and birth for her baby with the health professional's help only when indicated (Lalonde & Miller, 2015). However, women and girls in Sierra Leone face discrimination and violence in all aspects of their lives that directly affect their right to health (Witter et al., 2016). They face many barriers that prevent them from accessing the health services they need during pregnancy and childbirth (Amnesty International, 2016).

The global maternal health strategy for ending preventable maternal mortality, grounded on applying a holistic human rights framework, ensures that high-quality sexual, reproductive, maternal, and newborn health care is available, accessible, and acceptable to all who need it (WHO, 2015a). A focus group discussion on barriers to access in Sierra Leone revealed the unfriendliness of health care workers in providing maternity services (Witter et al., 2016). However, there is a lack of qualitative evidence on women's experiences during childbirth and the extent to which Sierra Leonean women

perceive these experiences. Maternity care can either protect or violate the fundamental human rights of women. While it is likely that disrespect and abuse are often multifactorial and may be perceived differently and sometimes normalized depending on the specific setting, many stakeholders and maternal health experts have agreed that disrespect and abuse in facility-based childbirth care are a global problem affecting low, medium, and high-income countries; sometimes seen as normal and acceptable; an essential barrier to skilled care utilization; and a violation of women's human rights; but also may have direct adverse consequences for mother and baby (Hazard, 2013; White Ribbon Alliance, 2011).

Therefore, this study explored the childbirth experiences and perceptions of Sierra Leonean women relating to basic maternal rights. There is a lack of or limited evidence on the effectiveness of interventions that promote respectful maternity care (RMC) or reduce the mistreatment of women during labor and childbirth (WHO, 2019a). Therefore, there is an urgent need for a nationally agreed, consistent, and standardized minimum dataset that could provide an evidence-based platform upon which a national benchmarking program for maternity services can make, using fundamental maternal rights. According to WHO (2019a), delivering RMC to reduce maternal morbidity and mortality is under a human rights-based approach. The findings of this study contribute to the body of existing evidence on the childbirth experiences of women and the status of the RMC Charter in the Sierra Leonean context.

Additionally, the evidence generated from this study can influence maternal health stakeholders to plan, design, and implement appropriate policies relating to RMC

Charter. For national development, the information needed on the quality of care during childbirth relates to fundamental maternal rights to apply evidence-based solutions and address challenges (Child, 2015; WHO, 2017). Thus, it is critical to the reduction of maternal morbidity and mortality.

Overview of the Chapter

This chapter presents the background of the study, the problem statement, and the purpose of the study. It also includes the nature of the research and research questions alongside the theoretical framework. Furthermore, the chapter presents an overview of recent literature related to the scope of the study, including a review of the theories that formed the basis of the research and the methodological approaches explored in previous related studies. The study builds on current knowledge of childbirth experiences and perceptions of women relating to fundamental maternal rights. A description of what is known and contentious about the phenomena of interest is offered. Finally, the assumptions, scope, delimitations, limitations, and significance of the study are explained.

Background

Despite a recent demographic and health survey report showing a decline in the maternal mortality ratios from 1,165 per 100,000 live births in 2013 to 717/ 100,000 live births in 2019 (SSL & ICF International, 2019), Sierra Leone faces immense challenges in supporting good quality, woman-centered care (Ministry of Finance and Economic Development, 2016). Thus, distance from meeting the Sustainable Development Goals (SDGs) target 3.1 is as follows: "By 2030, reduce the global maternal mortality ratio to

less than 70 per 100,000 live births." Quality maternal care should be safe, effective, timely, efficient, equitable, and women centered (Tuncalp et al., 2015). Tuncalp et al. (2015) identified respect, dignity, equity, and emotional support as essential components of high-quality maternal care. However, these factors are often overlooked or ignored in childbirth. The WHO framework for improving the quality of care for women during childbirth highlights that women's care experiences are equally important to clinical care provision (Tuncalp et al., 2015). However, Miller et al. (2016) noted that even evidence-based clinical care provisions could not consider quality care unless the care is respectful. A growing body of evidence demonstrates that disrespectful and nonconsented treatment of childbearing women within the health system is widespread (Bohren et al., 2015; Bowser & Hill, 2010). Rosen et al. (2015) provided evidence of disrespectful and abusive facility-based childbirth care, with a strong connection between lack of quality of care and significantly high maternal mortality. Rosen et al. argued that the interpersonal relationship between client and provider influences women's experiences and maternity care perceptions. Kana et al. (2018) described both respectful and disrespectful care received by women from midwives during their labor period through observations in two hospitals in urban Tanzania. The study revealed that all participants showed respectful and disrespectful care, and some practices that have not been reported were also observed. Understanding how Sierra Leonean women are cared for during childbirth contributes to the body of evidence and can influence policies that promote RMC.

Problem Statement

Despite international and national efforts to improve maternal and newborn health outcomes, emerging evidence has shown global disrespect and abuse of childbearing women's universal rights to life, health, bodily integrity, and freedom from discrimination (WHO, 2014). In Sub-Saharan Africa (Eastern and Southern Africa), there is increasing evidence of rude, disrespectful, abusive treatment and a lack of responsiveness to women's needs during labor and childbirth (Rosen et al., 2015). Even though an increasing proportion of women are giving birth in health facilities globally, expected maternal and newborn mortality and morbidity reductions have not necessarily been met (WHO, 2019a). According to WHO (2019a), accessing labor and childbirth care in a health facility may not guarantee good quality care. The United Nations estimates of 2016 ranked Sierra Leone as one of the countries in Sub-Saharan Africa with the highest maternal mortality, accounting for 1,360 deaths per 100,000 live births, followed by the Central Africa Republic with 882 deaths per 100,000 live births (as cited in Central Intelligence Agency, n. d.). According to the Sierra Leone Maternal Death Surveillance and Response Report [MDSR], (2016), 80% of maternal deaths were from facilities, while 13.5% occurred in the community, and 5.6% of deaths were in transit to a health facility.

Evidence has suggested that in countries with high maternal mortality, the fear of disrespect and abuse those women often encounter in facility-based maternity care is a more powerful deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance (Bohren et al., 2014). High rates of avoidable maternal and newborn mortality and morbidity are often due to poor quality of care (Kruk et al., 2018).

Evidence has suggested that disrespectful and undignified care is common in many settings (Bohren et al., 2019). Research findings of Betron et al. (2018) showed that disrespect and abuse affect maternity care quality and persist as an obstacle to safe motherhood, violating the rights of childbearing women.

While many interventions aim to improve access to skilled birth care, the quality of relationships with service providers has received less attention. Although so much is well-known about disrespect and abuse in many developing countries, limited or no evidence exists on the lived childbirth experiences related to fundamental maternal rights in Sierra Leone. This lack of evidence concerning women's lived experiences can lead to mismanagement of the birthing process, which is negatively traumatizing (SMFAI, 2017).

This study helps fill the gap in understanding Sierra Leonean women's lived experiences and perceptions of those who have accessed facility-based intrapartum care in the past 2 months. There is a strong relationship between childbearing women's experiences and their influence on maternal health outcomes (Redshaw et al., 2019). These can disclose key indicators to maternity care providers on the quality of service provided (Care Quality Commission [CQC], 2015). Further, not much has been included on quality-of-care issues and the care of Sierra Leonean women during childbirth relating to fundamental maternal rights. Substantial reductions in maternal mortality can only be achieved by prompt access to good quality, women-centered and respectful care (WHO, 2016). When women in labor encounter caregivers who do not incorporate respectful care into their practice, they can experience this as disrespect, mistreatment, or in some

instances, as a form of abuse or obstetric violence. The findings of this study draw attention to the development of guidelines and protocols reflecting RMC to be used by providers. RMC 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 labor and childbirth" (WHO, 2019a). Because no national policy emphasizes RMC at the provision of care level, the findings of this study could significantly influence the development of appropriate implementation policies for promoting respectful, dignified, women-centered maternity practice in Sierra Leone. Therefore, the prevention and elimination of disrespect and abuse in facility-based maternity care using the RMC charter can be a crucial strategy toward improved maternal health outcomes, including women's satisfaction with their maternity experiences (Austad et al., 2017).

Purpose of Study

This qualitative research study aimed to understand and describe the childbirth experiences and perceptions relating to basic rights of childbearing women during facility-based intrapartum care in Northern Sierra Leone. A phenomenological approach addressed a group of women's lived experiences focusing on the phenomena of interest (see Creswell, 2014; Creswell & Poth, 2018). It involved an in-depth interview of postpartum women who had given birth in the past 2 months. One key strategy for improving maternal health outcomes and social change is implementing evidence-based practices and providing RMC (Vogel et al., 2015). The research explored the lived childbirth experiences and perceptions of basic maternal rights in Sierra Leone. A better

understanding of this phenomenon could contribute to the body of knowledge relating to the status of disrespect and abuse in Sierra Leone and improved programs and services for women at birth. It justifies the need for effective policies related to RMC, which can influence the prevention and elimination of disrespect and abuse of childbearing women in Sierra Leone. According to Amnesty International (2016), Sierra Leone government needs to intensify its efforts to save women's lives. It must make good quality health care available and accessible to all pregnant women.

Research Questions

Research Question 1: What are the lived childbirth experiences of Sierra Leonean women relating to their fundamental maternal rights?

Research Question 2: How do Sierra Leonean women perceive their childbirth experiences relating to the principles of RMC?

Theoretical/Conceptual Framework for the Study

In this study, I sought to understand Sierra Leonean women's childbirth experiences and perceptions of fundamental maternal rights. A theoretical and conceptual framework guided the study throughout the research process.

Theoretical Foundation

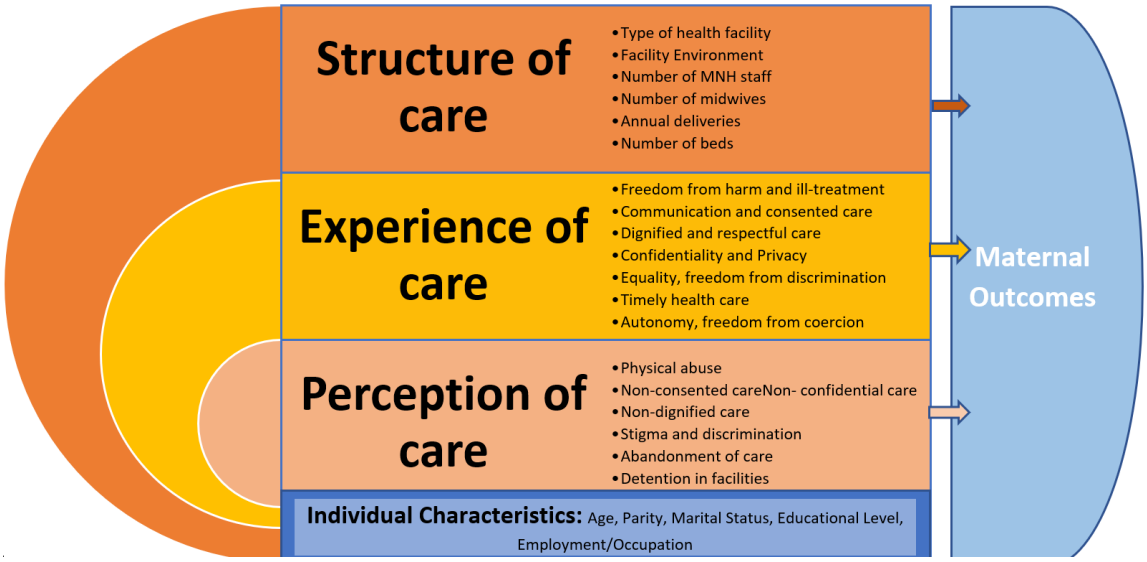
The ecological systems theory served as the theoretical framework for the study. The ecological systems theory comprises four factors that impact the delivery of RMC: individual and community, provider, facility, and national systems. According to d'Ambruoso et al. (2005), women's experiences and perceptions of their care during delivery are best described and interpreted by themselves, respectively. In this way, the

accounts of women's experiences regarding their acceptance of, and satisfaction with, services reflect the services. RMC could improve women's labor and childbirth experience and address health inequalities.

Conceptual Framework

Figure 1

Conceptual Framework for Childbirth Experiences and Perceptions of Women Relating to RMC Charter and D&A Typology



A conceptual framework clarifies why a study is significant and relevant and how the study design appropriately and rigorously answers the research questions (Ravitch & Carl, 2016). The conceptual framework for this study was the RMC Charter: The universal rights of childbearing women, which demonstrates how fundamental human rights apply in the maternal health context (see White Ribbon Alliance, 2011). RMC could improve women's labor and childbirth experience and address health inequalities. It

comprises components of RMC, such as freedom from harm and ill-treatment; dignity and respect; privacy and confidentiality; the right to information, informed consent, and refusal; respect for her choices and preferences, including companionship during maternity care; equality, freedom from discrimination, equitable care, right to timely health care, and the highest attainable level of health; liberty, self-determination, and autonomy; and freedom from coercion. The framework includes women who have delivered in a health facility to conduct in-depth interviews in the past 2 months of delivery. The framework has been used to educate health workers about maternity care and human rights and raise awareness of the problem to avoid blaming and shaming health workers.

In addition, I used Bowser and Hill's (2010) framework to investigate disrespect and abuse (D&A). In a landscape evidence review, Bowser and Hill described seven categories of D&A: physical abuse, nonconsented care, nonconfidential care, nondignified care, discrimination, abandonment of care, and detention in facilities. According to WHO (2018a), reducing mistreatment and improving women's experience of care requires interventions at the interpersonal level between a woman and her health care providers and the status of the health care facility and the health system.

Nature of the Study

A qualitative design was employed for this study, and I used a generic approach to emphasize the socially constructed nature of reality. Qualitative methods focus on understanding the experiences of those who live them (Rudestam & Newton, 2015). According to Morse (2003), qualitative methodology is used when little is known about a

topic and there is a poorly understood research context. For example, the boundaries of a domain may be ill-defined. If the phenomenon under investigation is not quantifiable, the nature of the problem is not strong, or the researcher suspects that the phenomenon needs to be studied. The study design focused on the phenomenological type of inquiry. Phenomenological research is a qualitative strategy in which the researcher identifies the essence of human experiences about a phenomenon as described by participants in a study (Creswell & Creswell, 2018). In the early 20th century, phenomenology was founded by Edmund Husserl and Martin Heidegger and originated from philosophy. Phenomenology is employed to identify phenomena, focus on subjective experiences, and understand those lived experiences' structure. A researcher undertaking a phenomenological study investigates various experiences and perceptions of a particular phenomenon. I employed the primary data collection method through in-depth interviews, applied to phenomenologically oriented research. Thus, a phenomenological inquiry is used to describe the typical characteristics of the phenomena that have occurred to the structures that underscore the essential nature of the idea (Rudestam & Newton, 2015). The method used universal childbearing rights from the RMC Charter to respectfully investigate disrespectful maternity care categories.

This study also involved in-depth face-to-face interviews on the childbirth experiences and perceptions of women who have given birth in a health facility in the past 2 months in Northern Sierra Leone. Creswell and Creswell (2018) argued that face-to-face interviews might be helpful when participants cannot be directly observed and can provide historical information. Interviews are beneficial for exploring experiences,

opinions, and views on a phenomenon. However, a provision is made where the participant prefers telephone rather than personal face-to-face interviews. The primary advantage of face-to-face interviews is that it allows for much more in-depth data collection and comprehensive understanding. In addition, body language and facial expressions are more clearly identified and understood, and the interviewer can probe for explanations of responses (Creswell & Creswell, 2018). However, the information provided can be subjective; not all participants are equally articulate and perceptive (Creswell & Creswell, 2018).

Recognizing that women's childbirth experiences can positively or negatively impact MNH outcomes, I sought eligible postpartum women who had delivered in a hospital setting. I recruited and interviewed participants in religious settings (churches/mosques) within the catchment areas of their birthing facilities. Data were analyzed using hand-coding and NVivo software. Researchers have suggested using multiple strategies for data triangulation (Creswell, 2014). Peer checking of information, hand-coding, and NVivo computer software for triangulation of the data were used for this study, ensuring the credibility and trustworthiness of the data.

Definitions

The following are definitions of key terms used in this research:

Childbearing: The process of conceiving, being pregnant, and giving birth (Merriam-Webster, n.d.).

Childbirth: The process entailed delivering a baby through ordinary means (Every Woman, Every Child, 2015; UNFPA et al., 2014; WHO, 2016).

Consent: An individual's moral right to make decisions about themselves and their health care (Harris, 2003).

Dignity: A legal principle enshrined in human law and defined as the state or quality of being worthy of honor or respect (McCrudden, 2008).

Health facility: A private or publicly managed hospital (secondary/tertiary), primary health care center, or primary health care unit providing health care services to clients (Ministry of Health and Sanitation [MOHS], 2013). In Sierra Leone, health care is delivered through primary community health centers, community health posts, maternal and child health posts, and secondary and tertiary facilities (Basic Package of Essential Health Services, 2018).

Human rights: The inherent value of each person, regardless of background, where they live, what they look like, what they think, or what they believe. These are based on dignity, equality, and mutual respect shared across cultures, religions, and philosophies. They are about being treated fairly, treating others fairly, and having the ability to make real choices in their daily lives (Australian Human Rights Commission [AHRC], n.d.).

Maternity: The antenatal, intrapartum, and postnatal period for women and babies (Chalmers et al., 2001).

Maternity care: Maternity care in Sierra Leone includes antenatal, intrapartum, and postnatal care for women and babies up to 6 weeks after birth (Chalmers et al., 2001).

Maternal death: The death of a woman while pregnant or within 42 days of termination of the pregnancy, regardless of the duration of the pregnancy. Maternal mortality could be because of any cause related to or made worse by the pregnancy or the management of this pregnancy (Say et al., 2014; WHO et al., 2015).

Maternal health: This is women's health during prepregnancy, pregnancy, labor, delivery, and after childbirth (UNFPA et al., 2014).

Midwife: A person who has completed a midwifery education program who is duly recognized in the country where it is located and is based on the International Confederation of Midwives (ICM) essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education, who has acquired the requisite qualifications to be registered and legally licensed to practice midwifery and use the title midwife, and who demonstrates competency in the practice of midwifery (Butler et al., 2018).

Phenomenology: The approach used to describe the experiences of several individuals related to a particular issue or phenomenon (Creswell, 2014).

Respect: A due regard for feelings, wishes, or rights (Pivotal Education, n.d.).

Respectful Maternity Care Charter: A charter that demonstrates the legitimate place of maternal health rights in the broader context of human rights (Health Policy Plus, n.d.). It is an approach focusing on factors that support human health and well-being: Care that does no harm and culturally sensitive care valued by the woman and her community.

Assumptions, Limitations, and Delimitations

Assumptions

I assumed that the phenomenological approach was most suitable for answering the questions and bringing new viewpoints to this study. One of the grounds for this research was that participants would freely provide detailed and in-depth descriptions of their experiences and perceptions of facility-based maternity care. Additionally, researchers are the principal instruments in qualitative studies and are expected to make known early personal biases and perspectives, influencing the research (Creswell, 2016; Creswell & Poth, 2018; Marshall & Rossman, 2016). Robust data quality assurance and authentication measures limited inaccurate and wrong information risk.

Scope and Delimitations

I sought to investigate Sierra Leonean women's childbirth experiences and perceptions. The study sample population included women aged 18 to 45 years who had recently had a facility-based birth in the past 2 months before implementing the study. Sample adequacy and saturation are vital criteria for determining an acceptable sample size for interview research (Rubin & Rubin, 2012). According to Rubin and Rubin (2012), qualitative researchers achieve balance and thoroughness during the qualitative interview process when the number of respondents is adequate to guarantee suitable depth and diversity of perspectives and insights. Based on the number of study sites (three districts) and a recommendation for conducting two to three interviews at each location to achieve saturation (Rubin & Rubin, 2012), I targeted a total interviewee pool size of 21 to 24 study participants. Bernard (2013) noted that small sample sizes are

typical of qualitative studies involving purposeful sampling. O'Reilly and Parker (2013) observed that the nature of the research and the sufficiency of sample size for enabling adequate exploration of study research questions determine sample size.

Limitations

A significant drawback of qualitative research is that data collection from in-depth interviews can be time-consuming. It is based on participants' appointment dates and is relatively costly, as interviews were done in participants' communities. In addition, because qualitative study probes into personal interaction for data collection (Chetty, 2016), I anticipated that participants might not feel comfortable discussing experiences during childbirth in their workplace or other public settings. Therefore, I conducted the interviews in a private environment.

Creswell (2014) highlighted the importance of qualitative researchers knowing their opinions and prejudices first in the study to control biases. Thus, as the qualitative researcher of this study and, at the same time, a midwife educator, I set aside my opinions to bring forth the meanings and descriptions of the participants and not bias the data collection, analysis, and interpretation of the results.

Significance

The issue of violations of women's human rights has gained recognition globally. Importantly, two resolutions recognizing maternal mortality as a severe human rights concern have been adopted by the UN Human Rights Council in recent years (Human Rights Council, 2016). Moreover, following the adoption of the 2030 Agenda by the UN General Assembly in September 2015, a Joint Statement was issued by UN human rights

experts, the Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights, and the Special Rapporteurs on the Rights of Women and Human Rights Defenders of the African Commission on Human and Peoples' Rights (African Commission on Human and People's Rights, 2015)

> The statement called on States to address acts of obstetric and institutional violence suffered by women in health care facilities, including forced or coerced sterilization procedures, refusal to administer pain relief, disrespect and abuse of women seeking healthcare, and reported cases of women being hit while giving birth.

The results of this qualitative inquiry could be used to advance positive social change, as violations of childbearing women's rights are issues of social injustice and inequality that affect the quality of care and contribute to maternal mortality in Sierra Leone. Global concerns on social change represent a wide range of social issues, including poverty, inequalities, health risk, and climate change, requiring society to invest in social change (WHO, 2019b). Change creates problems that need solutions, generating more change through research (Laureate Education, 2009). There is evidence from some countries that mistreatment and violence during childbirth are often linked to socioeconomic inequalities and disrespect for women's rights and equal status. For example, in the Caribbean, teenage mothers and women from ethnic minorities and lower socioeconomic status often face mistreatment in health facilities (UNFPA, 2019).

In 2015, WHO released a statement on disrespectful and abusive treatment that violated women's rights to respectful care and called for great action, dialogue, research,

and advocacy on this significant human rights issue. Even though Sierra Leone has one of the highest maternal mortalities globally, making it the worst place for women to deliver their babies, there is no research on respectful and dignified maternity care. Global efforts to address maternal mortality focus on the quality of care, including implementing evidence-based practices and providing RMC (Vogel et al., 2015).

Implications for Social Change

I investigated the experiences and perceptions of Sierra Leonean women during childbirth. The outcomes are likely to contribute to positive social change in three ways: First, it adds to the body of existing evidence on women's childbirth experiences and their impact on the quality of care, thus supporting advocacy efforts for a human rights-based approach to maternal care, legislation, and evidence-based policy, ensuring that women and girls' rights and choice are completely respected during childbirth. Second, the findings of this study could contribute to developing policies, protocols, guidelines, and programs, which could guide RMC implementation to improve women's experiences giving birth at health facilities and increase the uptake of maternity services. Third, the findings could help integrate components of RMC, including the universal rights charter of women of childbearing, into midwifery education, training, and practice standards for healthcare providers as recommended by the WHO (2018a).

Summary

Sierra Leone has one of the poorest indicators with one of the highest maternal mortalities in the world. High rates of avoidable maternal and newborn mortality and morbidity are often due to poor quality of Care (Kruk et al., 2018). Increasing evidence

suggests that disrespectful and undignified care is commonplace in many settings (Bohren et al., 2019). D&A of women seeking maternity care is an urgent problem, creating a growing community of concern that spans healthcare research, quality, education; human rights; and civil rights advocacy (White Ribbon Alliance, 2011). According to Witter et al. (2016), women and girls in Sierra Leone face discrimination and violence in all aspects of their lives that directly affect their right to health. Maternity care can either protect or violate the fundamental human rights of women. The global maternal health strategy for ending preventable maternal mortality is rooted in a holistic human rights framework. The framework ensures that high-quality sexual, reproductive, maternal, and newborn health care is available, accessible, and acceptable to all who need it (WHO, 2015). In addition, global efforts to address maternal mortality focus on the quality of care, which includes implementing evidence-based practices and providing RMC (Vogel et al., 2015). The Universal Rights of Childbearing Women demonstrates how fundamental human rights apply to maternal health (White Ribbon Alliance, 2011). RMC could improve women's labor and childbirth experience and address health inequalities. However, there is a lack of qualitative evidence on experiences and perceptions of Sierra Leonean women during intrapartum care relating to fundamental maternal rights to guide evidence-based policy and future programming.

In this study, I investigated Sierra Leonean women's childbirth experiences and perceptions of fundamental maternal rights. According to WHO (2019a), the provision of RMC is strongly linked to a human rights-based approach to reducing maternal morbidity and mortality. RMC is increasingly recognized as central to quality maternal and

newborn health care and outcomes and is defined as an approach centered on the individual and based on principles of ethics that recognize and promote women's rights, including respect for their autonomy, dignity, emotions, choices, and preferences (UNFPA, 2019). However, too many women experience care that does not match this image. The findings of this study first contribute to the body of existing knowledge available in other countries on the experiences of childbearing women and their perceptions. Second, the results support advocacy efforts for a human rights-based approach to maternal care and can influence the incorporation of RMC in national legislation and healthcare policy, ensuring that the rights and choices of women and girls are fully respected during childbirth. Evidence from the countries that shared their experiences suggests that mistreatment and violence during childbirth are often linked to socioeconomic inequalities and disrespect for women's rights and equal status. No such research evidence exists in Sierra Leone to guide evidence-based policy and future programming. For example, in the Caribbean, studies found that teenage mothers, women from ethnic minorities, and women of lower socioeconomic status often faced mistreatment in health facilities (UNFPA, 2019). Third, the study findings could support the integration of the components of RMC, including the Universal Rights Charter of childbearing women, midwifery education, and training and standards for healthcare providers as recommended by the WHO (2018a). These changes can ultimately impact maternal and newborn health outcomes in Sierra Leone.

In this chapter, I presented a broad introduction of the foundation of my research study, describing its purpose, significance, and implications for social change. The study

was guided by a conceptual framework adapted from the RMC Charter, which directed this phenomenological study. In addition, a framework by Bowser and Hill (2010), which describes seven categories of D&A in the landscape evidence review, was employed. Finally, I used an ecological systems theoretical framework comprising four factors that impact the delivery of RMC for this study.

The next chapter emphasizes literature delineating evidence on the use of the phenomenon of interest in this study. It includes reviewing similar peer-reviewed studies and other relevant publications. The gaps in the literature are acknowledged and linked to the new body of evidence this research study demonstrates.

Chapter 2: Literature Review

Background to the Problem

Even though a growing number of women are giving birth in health facilities globally, expected maternal and newborn mortality and morbidity reductions have not necessarily been met (WHO, 2019). In Sierra Leone, the number of births attended by skilled personnel has increased from about 60% (Sierra Leone Demographic & Health Survey [SLDHS], 2013) to 81% (SLDHS, 2019), while the number of births delivered in health facilities has grown from 54% (SLDHS, 2013) to 76% (SLDHS, 2019). However, there has been slow progress in the decline of maternal mortality from 1,165/100,000 live births (SLDHS, 2013) to 717/100,000 live births (SLDHS, 2019), ranked as the country with the third-highest maternal mortality in the world (Central Intelligence Agency, 2020). Amnesty International (2016) noted that the Sierra Leone government needs to intensify its efforts to save women's lives. It must make good quality health care available and accessible to all pregnant women. According to WHO (2019a), accessing labor and childbirth care in a health facility may not guarantee quality care. Evidence has suggested that in countries with high maternal mortality, the fear of D&A those women often encounter in facility-based maternity care is a more powerful deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance (Bohren et al., 2014). Despite international and national efforts to improve maternal and newborn health outcomes, emerging evidence demonstrates global D&A of childbearing women's universal rights to life, health, bodily integrity, and freedom from discrimination (WHO,

2014). Abusing women's rights affects maternity care quality and persists as an obstacle to safe motherhood, thus violating the rights of childbearing women.

Rosen et al. (2015) reported increasing evidence of rude, disrespectful, abusive treatment and lack of responsiveness to women's needs during labor and childbirth in Eastern and Southern Sub-Saharan Africa. Although much is known about D&A in many countries, limited or no evidence exists in Sierra Leone, a country with one of the highest maternal mortalities in the world. This lack of evidence concerning women's experiences can lead to mismanagement of the birthing process, which can have an adverse and traumatizing effect (SMFAI, 2017).

High rates of avoidable maternal and newborn mortality and morbidity are often due to poor quality of care (Kruk et al., 2018). Increasing evidence has suggested that disrespectful and undignified care is commonplace in many settings (Bohren et al., 2019). In this study, I sought to fill a gap in understanding the lived experiences and perceptions (relating to their fundamental maternal rights) of Sierra Leonean women who delivered in a health facility in the past two months. A better understanding of this phenomenon could improve programs and services for women at birth. It further justifies the need for effective policies related to RMC, which influence preventing and eliminating D&A (if any) of childbearing women in Sierra Leone.

Further, not much has been included on quality-of-care issues, explicitly regarding Sierra Leonean women's care during childbirth relating to fundamental maternal rights. While many interventions aim to improve access to skilled birth care, the quality of relationships with service providers has received less attention. There is a

strong relationship between childbearing women's experiences and their influence on maternal health outcomes (Redshaw et al., 2019). This can disclose key indicators to maternity care providers on the quality of service provided (Care Quality Commission, 2015).

Therefore, this research contributed to this body of knowledge on women's childbirth experiences (positive or negative), confirming or disproving previous studies. Substantial reductions in maternal mortality can only be achieved by prompt access to good quality, women-centered and respectful care (WHO, 2016a). The findings of this study also drew attention to the development of guidelines and protocols reflecting RMC to be used by care providers. Because there is limited national implementation policy that emphasizes RMC at the provision of care level, the findings of this study could significantly influence the development of appropriate implementation policies for promoting respectful, dignified, women-centered maternity practice in Sierra Leone.

I conducted a detailed review of the literature to understand the issue to present a contextual and substantial base of examination for the primary research question: What are the childbirth experiences of Sierra Leonean women relating to their maternal rights? What are the perceptions of Sierra Leonean women relating to the principles of respectful maternity care. The literature review has been categorized into various phenomenology of interest. It begins with an overview of safe motherhood, quality of care in childbirth, intrapartum care for a positive childbirth experience, fundamental maternal rights in childbirth, rights-based approach to maternity care, towards evidence-based maternity care: a global agenda, RMC during childbirth, RMC and its relationship to childbirth

experience, sociocultural perspectives of childbirth, understanding mistreatment during childbirth, predictors of traumatic childbirth experiences, women's perceptions of childbirth experiences, and women's knowledge on fundamental maternal rights. The review also includes mitigating factors of D&A, addressing D&A, and discussing effective, respectful care policies. This chapter summarizes key highlights of the general problem of childbirth experiences and perceptions relating to basic maternal rights and the study's potential impact.

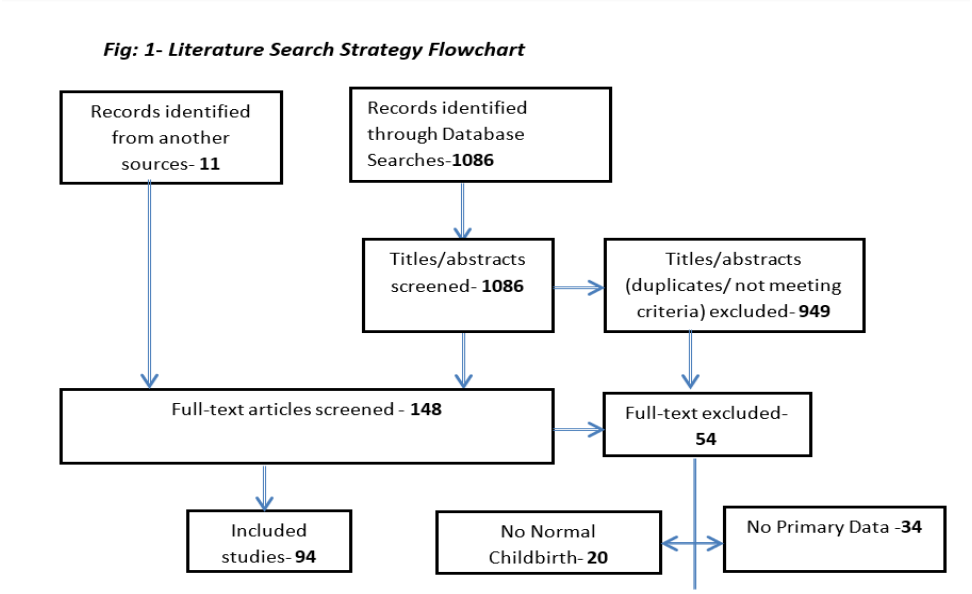
Literature Search Strategy

Relevant literature relating to women's lived childbirth experiences, and perceptions regarding their basic maternal rights are described below. I conducted the literature search using keywords and phrases such as *childbirth experiences, childbirth perceptions, childbearing rights, respectful maternity care, mistreatment of childbearing women, disrespect, abuse,* and *intrapartum care*. I then identified and examined peer-reviewed articles from preliminary research. I explored Walden Library by searching Health Sciences electronic databases (Cochrane, CINAHL, and MEDLINE combined search, ProQuest, EBSCO, PubMed, and Dissertations and Theses) and Google scholar for holdings such as scholarly journal articles, dissertations, and eBooks. I then identified other sources through a business, academic, nonprofit organization, the United Nations, or government agency websites that were evaluated to determine if they should be considered reliable, credible, reputable, and relevant. Next, the unpublished work of the Sierra Leone MoHS and its development partners formed part of the materials explored to inform the literature review. First, the search was extended without a date limit. It was

later limited to articles published between 2016 and 2021 to ensure that the findings reflected the current issues of the phenomena of interest. The retrieved articles were screened by examining the titles and abstracts, and the papers selected were then reviewed thoroughly. About 1,086 potentially relevant articles were found and filtered based on their titles and abstracts. Of those, 137 full-text articles were thoroughly reviewed, and 83 were selected for the studies. After examining references and websites of phenomena of interest, 11 additional papers were thoroughly reviewed. A total number of 94 articles were included in this study. Figure 2 presents a flowchart of the search strategy.

Figure 2

Literature Search Strategy Flowchart

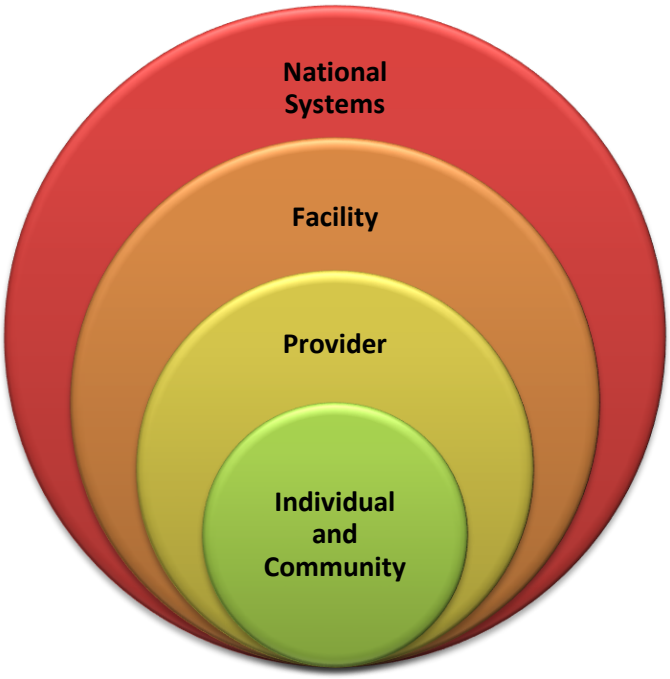


Theoretical Foundation

The theoretical framework used for this study is presented here as an ecological model of overlapping concentric circles to illustrate the dynamic interrelations between personal and systems-level factors that impact the delivery of RMC (see Figure 3).

Figure 3

Framework of Risk Factors for Disrespect and Abuse During Childbirth



Bronfenbrenner developed the ecological systems theory in the 1970s as a framework for understanding child development (Bronfenbrenner, 1979). Bronfenbrenner's ecological model was designed to illustrate that the entire ecological systems theory in which growth occurs, including family, community, and society subsystems, needs to be considered to understand the complex process of human

development. Similarly, the provision of RMC is a complex process affected by various systems, including the national health system and policies, facility subsystems, provider training and attitudes, and individual and community beliefs and behaviors. Each of these subsystems is complex and influenced by the systems surrounding it. The framework illustrates four levels of the framework that are potential targets for interventions while underscoring that no group exists in isolation and that the entire context must be considered when selecting appropriate interventions for any given setting.

Ratcliffe (2013) used this framework in research about creating an evidence-based for the promotion of respectful maternity care. At the core of the framework are the individual and community. There are four risk factors for D&A (normalization of D&A during childbirth, lack of community engagement and oversight, financial barriers, and lack of autonomy and empowerment). The next level of the framework is the provider. Risk factors at this level include individual and internal factors (prejudices and training experiences), interactions with the health facility and national health system, and interactions with patient groups and communities. The third level of the framework is the facility. Facility factors that impact the provision of RMC include management and supervision, facility administration, accountability mechanisms, and facility infrastructure. Finally, the fourth level of the framework is national systems, including health systems, laws, and policies. Components of this level set the stage for providing RMC and establishing accountability standards for facilities and providers to meet.

Conceptual Frameworks

The literature synthesis uncovered several ways women report their experiences and perception of care relating to their fundamental human rights. I used the existing framework to identify women's childbirth experiences who had given birth 2 months before data collection. Compared with the White Ribbon Alliance's Universal Rights of Childbearing, the results and findings were presented using Bowser and Hill categories of D&A. Evidence from multiple countries in Sub-Saharan Africa shows that women would prefer to deliver in a facility but choose not to because of previous experiences (their own or a relative's/friend's) of inadequate, low quality, and disrespectful care in facilities (Bangser et al., 2011). Academic researchers examining the problem of RMC against D&A have previously applied conceptual/theoretical frameworks focused on understanding the childbirth experiences and perceptions relating to the basic rights of childbearing women.

In 2010, Bowser and Hill released a landscape analysis on RMC from the USAID-commissioned TRAction Project. They proposed a model to categorize seven types of lack of respect and abuse in labor and delivery: physical abuse, discrimination, nonconsented clinical care, nondignified care, nonconfidential care, abandonment of care, and detention in health facilities (see Table 1). Using the categories proposed by Bowser and Hill, four recent studies in sub-Saharan Africa have measured D&A through direct labor observations, facility exit interviews, and community-based follow-up surveys (Bradley et al., 2019).

Table 1

Seven Categories of Disrespect and Abuse

Category	Example
Physical abuse	Slapping, pinching
Nonconsented care	The absence of informed consent or patient communication forced procedures
Nonconfidential care	Lack of privacy (e.g., laboring in public) and confidentiality (e.g., disclosure of patient information)
Nondignified care	Intentional humiliation, rough treatment, scolding, shouting, blaming, negative perceptions of care
Discrimination based on specific patient attributes	Discrimination is based on race, ethnicity, age, language, HIV status, economic status, educational level, etc.
Abandonment of care	Women are left alone during labor and birth, failure of providers to monitor women and intervene when needed
Detention in facilities	Detention of mother and baby in the facility after delivery, usually due to failure to pay

Note. Browser and Hill, 2010

The concept of RMC, however, is not new. The 1970s and 1980s in Brazil witnessed the inception and growth of the humanization of childbirth movement (Misago et al., 2001). RMC is defined as "the 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 labor and childbirth" (WHO, 2018a). RMC has been flagged as a potential strategy for reducing preventable maternal mortality and morbidity to accelerate progress toward meeting the SDG targets for improving maternal health (WHO, 2015b). In addition to the use of Bowser and Hill framework is the RMC Charter: Universal rights of childbearing women framework, which clarifies and clearly articulates the rights of women and newborns while receiving maternity care within a healthcare facility, namely the right to

freedom from harm and ill-treatment; right to information, informed consent, and refusal and respect for choices and preferences (including the right to the companionship of choice wherever possible); right to confidentiality and privacy; right to dignity and respect; right to equality, freedom from discrimination, and equitable care, due to timely healthcare and to the highest attainable level of health; and right to liberty, autonomy, self-determination, and freedom from coercion (White Ribbon Alliance, 2011).

Table 2

Human Rights That Are Violated by Disrespect and Abuse During Childbirth

Category of disrespect and abuse	Corresponding rights
Physical abuse	Freedom from harm and ill-treatment
Nonconsented care	Right to information, informed consent and refusal, and respect for choices and preferences, including the right to the companionship of choice wherever possible
Nonconfidential care	Confidentiality, privacy
Non-dignified care (including verbal abuse)	Dignity, respect
Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
Abandonment or denial of care	Right to timely healthcare and the highest attainable level of health
Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

Note. White Ribbon Alliance, 2011

After identifying the most relevant risk factors for D&A, these risk factors were organized into a framework that considers the various subsystems that impact the provision of RMC (Individual clients, providers, health facilities, and national systems).

Literature Review Related to Key Variables and Concepts

Experiences of Childbirth (Labor and Birth/Intrapartum Care)

The concept of childbirth experience has received increasing attention from various disciplines over the last two decades. The experience of labor and birth, referred to as childbirth, is complex, multidimensional, and subjective, relating to both the outcome, i.e., the safe delivery of the baby, and the process, i.e., the physical and cognitive functions of labor and birth experienced by individual women. A positive birth experience is associated with extended-lasting benefits, an affirmative relationship with the newborn, and a positive attitude towards motherhood that contributes to the woman's self-esteem and feelings of accomplishment. A negative birth experience may define or alter future pregnancies by affecting a woman's future reproductive decisions (Waldenstrom et al., 2004), including, for some, a preference for a cesarean section for future births. Studies have consistently provided evidence of childbirth experiences worldwide.

Positive Experiences of Childbirth

The prevailing model of intrapartum care in many parts of the world, which enables the health care provider to control the birthing process, may expose healthy pregnant women to unnecessary medical interventions that interfere with the physiological function of childbirth (WHO, 2018b). Therefore, global agendas are expanding their focus to ensure that women and their babies survive labor complications if they occur and thrive and reach their full potential for health and life. Labor and childbirth practices should be provided to all pregnant women and their babies during

labor and childbirth, irrespective of socioeconomic setting (WHO, 2018a). WHO defined a positive childbirth experience as fulfilling or exceeding a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment. Using standard operating procedures, the WHO developed 56 evidence-based recommendations for intrapartum care, recognizing a positive childbirth experience as a significant endpoint for all women undergoing labor. These recommendations target primarily national and local policymakers, implementers, and managers of MCH, healthcare professionals (including nurses, midwives, general medical practitioners, and obstetricians), and academic staff involved in training healthcare professionals. This guideline promotes the delivery of a package of labor and childbirth interventions critical to ensuring that giving birth is a safe and positive experience for women and their families. It highlights how woman-centered care can optimize the quality of labor and childbirth care quality through a holistic, human rights-based approach, recognizing, among others, RMC throughout labor and birth. The delivery period is critical to the survival of women and their babies, as the risk of morbidity and mortality could considerably increase if complications arise. Therefore, improving the quality of care around birth has been identified as the most impactful strategy for reducing stillbirths and maternal and newborn deaths compared with antenatal or postpartum care techniques (WHO, 2021).

Designing and provision of good quality maternity care should incorporate what matters to childbearing women. In a systematic qualitative review of 35 studies conducted by Downe, Finlayson, Oladapo, Bonet, and GuÈlmezoglu (2018) on women's

childbirth beliefs, expectations, and values, 19 countries aimed to explore what matters to healthy women about labor and birth. The findings revealed that what mattered to most women was a positive experience that fulfilled or exceeded their prior personal and sociocultural beliefs and expectations. These included giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions and competent, reassuring, kind clinical staff. In addition, most women wanted physiological labor and birth. However, they acknowledged that delivery can be unpredictable and fearsome and should actively be in control throughout the decision-making process. According to Downe and colleagues (2018), finding out what matters to women about labor and birth (rather than only asking about their experiences of intrapartum care) offers the potential to establish what women value, irrespective of what is on offer. This was linked with a strong desire for safe, supportive, kind, respectful, and responsive care during labor and birth. Recent WHO antenatal guidelines incorporate evidence from systematic qualitative reviews, indicating that women value the psychological, cultural, and emotional experience of pregnancy and the health of themselves and their growing baby (WHO, 2016b). These factors could provide a basis for providing care and service improvement locally and internationally. Maternity care should thus be designed to fulfill or exceed women's personal and sociocultural beliefs and expectations for optimum uptake of effective and RMC.

Intrapartum RMC is a fundamental human right that can affect the mother's experiences. Hajizadeh et al. (2020) conducted a recent prospective cohort study among 334 Iranian postpartum women to determine the status of RMC and its relationship with

childbirth experience. The General Linear Model was used to determine the relationship between RMC and childbirth experience. The mean RMC score was 62.58, with a range of 15 to 75, and the total childbirth experience score was 3.29, with a range of one to four (Hajizadeh et al., 2020). After adjusting for sociodemographic and obstetrics characteristics, this study revealed a statistically significant direct correlation between RMC and a positive childbirth experience ($P < 0.001$). The findings revealed a direct relationship between RMC and a positive childbirth experience. Therefore, it was recommended that managers and policymakers in childbirth facilities reinforce facilitating RMC to improve women's childbirth experience and prevent potential adverse effects of negative childbirth experiences.

Consequences of a positive childbirth experience include increasing self-esteem, self-efficacy, skills, maternal and infant attachment, and better acceptance of the maternal role (Ekström & Nissen, 2006). Hosseini Tagbaghdehi et al. (2020) explored the meaning of a positive childbirth experience expressed by ten women aged 20-30 years who had given birth within 72 hrs-2 months after birth in Iran using a qualitative exploratory approach. Data analysis led to two themes and five subthemes. The themes included control and empowerment. The controlling theme consisted of three subthemes: preparation, coping, and support, and the empowerment theme consisted of two subthemes of self-efficacy and self-esteem. Women's sense of empowerment in childbirth can result from a positive experience. For instance, the participants stated that the support and presence of husbands and relatives play a valuable role in their childbirth experience: "I wanted my spouse to be by my side during childbirth. The lonely delivery room is annoying. My husband

supported me during all the pregnancy moments; he was with me at delivery and after it". In another study in Uganda, researchers found that healthcare provider support and care effects childbirth experiences. Physical and psychological support leads to a positive experience, and inappropriate communication and care guide to negative experiences (Namujju et al., 2018). Therefore, providing positive experience factors of childbirth plays a vital role in women's self-efficacy and self-esteem, which requires cooperation and effort from the individual, family, education system, and healthcare system.

On the contrary, a systematic review study by Hosseini Tabaghdehi et al. (2019) shows the prevalence of negative childbirth experiences varies across communities and influences various factors, including individual factors (age, parity, participation, control, expectations, preparation, fear, self-efficacy), interpersonal factors (care provider support, husband support) and unexpected medical problems for mother and child (Hosseini Tabaghdehi et al., 2019). The negative experience of childbirth leads to the choice of cesarean section or abortion for subsequent pregnancy.

Negative Experiences of Childbirth

A negative childbirth experience can affect a woman's health well beyond the episode of the labor and birth itself. A qualitative phenomenological study explored the meaning of a poor childbirth experience, as expressed by 898 women who had given birth in Rwanda 1 to 13 months earlier (Mukamurigo et al., 2017). Participants were asked to rate their overall childbirth experience from 0 (very bad) to 10 (very good). Of these, 28 women (3.1%) who had rated their childbirth experience as bad (≤ 4) were contacted for in-depth individual interviews. The essential meaning of a 'poor' childbirth

experience was that the women had been exposed to disrespectful care, constituted by neglect, verbal or physical abuse, insufficient information, and denial of their husband as a companion ((Mukamurigo et al., 2017). The actions of careers included abandonment, humiliation, shaming, and insult, creating feelings of insecurity, fear, and distrust in the women. For instance, a primiparous woman could not stay calm due to severe pain. Several times, she asked for pain relief:

> "Contractions became intense and painful. When I called them, they intimidated me, stating that I am bad and telling me not to shout and that the reason for shouting was that I was still young and that it is childish. After having called her four times without getting any support, I realized that she would not help me at all".

With this challenge, there is also a need to explore negative experiences and understand the reasons behind them and whether there are any factors related to health care that can be improved. Two of the women did not report any experience of indigent care; their low rating was related to having suffered from medical complications. To Provide an equitable and high-quality maternal health care system, Rwanda needs to focus on implementing respectful, evidence-based care for all. One such activity is developing and providing education programs for midwives and nurses about professional behavior when caring for and working with women during labor and birth. In the struggle toward developing good quality and equitable maternal health care systems, there is an urgent need to implement respectful, evidence-based care for all (Miller et al., 2016).

The effect of a birth experience can be positive and empowering or negative and traumatizing (Aune et al., 2015). Nevertheless, cultural, emotional, social, psychological, and spiritual safety rarely appear in the discussions. Yet, these factors dominate women's thinking, and research also indicates ignoring its importance is potentially deadly" (Lock, 2014; Dahlen, 2015). In a descriptive phenomenological qualitative approach to exploring Chinese women's lived experiences of psychological birth trauma during labor and birth, Zhang et al. (2020) conducted an in-depth interview with 24 women who self-reported having experienced psychological trauma within the first week after birth. "Psychological birth trauma, also known as traumatic childbirth, refers to the maternal severe psychological harm caused by the events occurring during labor and birth" (Greenfield, Jomeen & Glover, 2016). The study found that women who experienced traumatic childbirth had a similar experience and described the psychological birth trauma as psychological distress due to unbearable physical pain, emotional vulnerability under a heavy mental burden, feeling neglected, and fear of uncertainties (Zhang et al., 2020). Reducing the psychological burden on childbearing women might help keep them away from the psychological trauma of childbirth. The social and health systems could prevent psychological harm during the birthing process. Therefore, hospital settings and other maternity care professionals are critical in reducing the negative psychological experience of birth and improving maternal and neonatal outcomes (Hodnett, Gates, Hofmeyr & Sakala, 2013).

Bante et al. (2020) conducted a facility-based cross-sectional study to assess RMC and associated factors in Harar hospitals Eastern Ethiopia. The data collected from 425

women revealed that only 38.4% (95% CI: 33.7, 42.0%) of women received RMC. Among the participants, about 45% received discriminative free care. Specifically, 17.6% didn't receive information about pain relief measures, and 16.5% complained that HCPs showed no concern or empathy. One-third (33.2%) of women reported that the HCPs did not respond to their needs. A significant number (14.8%) of women complained that some HCPs shouted at them during childbirth. Nearly one-fifth (18.6%) were insulted due to the presence of a birth companion and personal attributes. Only four out of ten women received respectful care during labor and delivery. Providing women-friendly, abusive-free, timely, and discriminative-free care is the basis for improving the uptake of institutional delivery. Execution of respectful care advancement must be the business of all healthcare providers. Furthermore, to develop a substantial reduction in maternal mortality, great emphasis should be given to making the service woman centered.

The absence of respectful care, especially during childbirth, is a significant barrier to women's positive birth experiences. A review of the international literature reveals abundant studies on childbirth experience, demonstrating that the quality of relationships with caregivers and the sense of control during birth are essential to a woman's birth experience. Stankovic (2017) conducted an exploratory qualitative study to explore how Serbian women, users of public maternity healthcare services, experience birth and the most problematic relational aspects of institutional context associated with negative or even traumatic aspects of birth experiences as described by the women themselves. The author conducted a semi-structured interviews with 15 women aged 26 to 49 who were recently having their first birth in different public healthcare institutions in Belgrade. The

basic framework for analyzing interview transcripts was interpretative phenomenological analysis (IPA). Four relatively broad and partly interrelated themes emerged from the study: (a) feelings of isolation and abandonment, (b) lack of communication, (c) lack of a caring relationship, and (d) lack of control and agency. The aspects of the institutional environment that were considered distressing in most of the childbirth experiences are those related to distance and cold relationships with healthcare providers, which adds to the feelings of isolation and abandonment, in addition to the lack of insight into and control over the process of birth that is managed in the hospital context without relying on women's subjective involvement in any relevant way. Therefore, giving women both insight into and more authority over their birth is vital for a positive childbirth experience. Although appropriate policies and guidelines have been introduced, additional monitoring standards and procedures should be raised, and reasonable steps planned to bridge this gap between policy and practice.

Disrespectful and undignified care of women is a significant barrier influencing the use and non-use of health facilities for delivery in many countries in sub-Saharan Africa. In a phenomenological study, Garnett (2018) conducted structured interviews with 20 women between the ages of 18 and 45 who delivered at the Juba Teaching Hospital in South Africa. Interviews were voice recorded, transcribed, and analyzed by hand-coding and NVivo computer software. Five broad themes emerged based on the research questions linked to a theoretical model. Although findings revealed that women received support and assistance during their childbirth experience from their husbands, mothers-in-law, health workers, and neighbors, yet women reported negative factors such

as overcrowding, sharing a bed with other women, hunger, the poor state of the hospital, and lack of privacy as some of the factors affecting their childbirth experience in the hospital (Garnet, 2018). This research disagrees with much evidence showing mistreatment and disrespect of women during childbirth and could improve women's and newborns' health outcomes. However, the negative experiences can influence quality care and thus has implications for positive social change by transforming the provision of the mother-baby-friendly birthing facility.

Freedman et al. (2014) built on the Bowser and Hill categories to define disrespectful and abusive care during childbirth and a conceptual model to incorporate how this definition can vary across individual, structural, and policy-level factors. According to Freedman and colleagues, D&A during childbirth are defined as "interactions or facility conditions that local consensus deems humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified" (Freedman & Kruk, 2014).

The problem of disrespect towards women in labor is a growing concern globally. Healthcare professionals need to have a deeper understanding of the empowering effects of the psychological experience of physiological childbirth because the benefits of this process can be expanded through physical, emotional, and social support for women. On the contrary, the effects can devastate women even when the immediate outcome is a physically healthy mother and newborn. A meta-ethnographic approach by Olza et al. (2018) explored women's psychological experiences of physiological birth using qualitative methods. According to the authors, physiological childbirth was defined as an

uninterrupted process without significant interventions, such as induction, augmentation, instrumental assistance, cesarean section, and epidural anesthesia or other pain relief medications. When women in labor encounter caregivers who do not incorporate emotional needs into their care, they can experience this as disrespect, mistreatment, or in some instances, abuse (WHO, 2018a) or obstetric violence (Declercq et al., 2011).

The lack of woman-centered maternity care, which emphasizes patient experience quality, contributes directly and indirectly to these poor outcomes. Afulani, Kirumbi, and Lyndon (2017) conducted a study to examine women's facility-based childbirth experiences in a rural county in Kenya to identify aspects of care that contribute to a positive or negative birth experience. The findings from 8 focused group discussions (FGDs) from 58 mothers aged 15-49 years who gave birth in the preceding two months suggested four factors that influence women's perceptions of quality of care: responsiveness, supportive care, dignified care, and effective communication (Afulani, Kirumbi & Lyndon, 2017). According to the authors, women had a positive experience when they were received well at the health facility, treated with kindness and respect, and given sufficient information about their care. The reverse led to a negative experience. For instance, Verbal abuse from providers also negatively affected the birth experience:

> You are not given [a sanitary pad, so] you bleed on the floor. When sister [nurse] comes, she will start shouting at you, "What is this? So, you have brought your filthy nature from home to this hospital? …" it may make you not want to go back to such a facility. (Afulani et al., 2017).

These experiences were influenced by the behavior of clinical and support staff and the facility environment. Such experiences may affect women's health-seeking behavior and, thus, affect the care dimensions in the WHO quality of care framework for maternal and newborn health (Tunçalp et al., 2015).

In a cross-sectional population-based study, Mesenburg et al. (2018) described the prevalence of D&A in women during childbirth in Pelotas City, Brazil. They investigated the factors responsible for such D&A. Household interviews of 4087 biological mothers obtained information about D&A during childbirth out of 4275 women three months after delivery- the information about verbal and physical abuse, denial of care, and invasive and inappropriate procedures. Poisson regression was used to evaluate the factors associated with one or more and two or more types of disrespectful treatment or abuse. Results showed that approximately 10% of women reported having experienced verbal abuse, 6% denying care, 6% undesirable or inappropriate procedures, and 5% physical abuse. At least one type of disrespect or abuse was reported by 18.3% of mothers (95% confidence interval [CI]: 17.2–19.5); and at least two types by 5.1% (95% CI: 4.4–5.8). Women relying on the public health sector, and those whose childbirths were via cesarean section with previous labor, had the highest risk, with approximately a three- and a two-fold increase in risk, respectively (Mesenburg et al., 2018). According to the authors, D&A during childbirth was high and primarily associated with payment by the public sector and labor before delivery. This type of disrespect/abuse has a policy implication. It can be eliminated through policy development and actions specific to this

type of violence, including women's rights on basic maternal and economic rights regarding women's access to jobs and education.

Sethi et al. (2017) described the prevalence of D&A during labor and delivery through the secondary analysis of direct observations of labor and delivery and described the association between the opinion of D&A items with the place of delivery and client background characteristics in Malawi. Frequencies of D&A items organized around the Bowser and Hill categories of D&A presented in the White Ribbon Alliance's Universal Rights of Childbearing Women Framework were calculated. Bivariate analysis was done to assess the association between selected client background characteristics and the place of delivery with the disrespect and use during childbirth (Seth et al., 2017). The results showed that while women were frequently greeted respectfully (13.9% were not), they were often not encouraged to ask the health provider questions (73.1%), were not given privacy (58.2%), and were not encouraged to have a support person present with them (83.2%). Results from the bivariate analysis did not show a consistent relationship between place of delivery and D&A items, where the odds of being shouted at was lower in a health center when compared to a hospital (OR: 0.19; CI: 0.59–0.62) while there was a higher odds of clients not being asked if they have any concerns if they were in a health center when compared to a hospital (OR: 2. 40; CI: 1.06–5.44). Women who were HIV+ had significantly lower odds of not having audio and visual privacy (OR: 0.34, CI: 0.12–0.97), not being asked about their preferred delivery position (OR: 0.17, CI: 0.05–0.65), and not being asked if she has any other problems, she is concerned about (OR 0.38,

CI:0.15–0.96). Measurement of the poor treatment of women during childbirth is essential for understanding the scope of the problem and how to address this issue.

Tanzanian women have experienced physical and verbal abuse and being ignored and neglected when birthing at facilities. Shimoda, Horiuchi, Leshabari, and Shimpuku (2018) conducted a qualitative descriptive study using naturalistic observation to make actual observations and describe the respectful and disrespectful care received by women from midwives during childbirth in two hospitals. Content analysis was utilized to analyze data. Results showed that all the 14 midwives showed respectful and disrespectful care and some practices that have not been clarified in previous reports of women's experiences. For respectful care, five categories were identified: 1) positive interactions between midwives and women, 2) respect for women's privacy, 3) provision of safe and timely midwifery care for delivery, 4) active engagement in women's labor process, and 5) encouragement of the mother-baby relationship. For disrespectful care, five categories were recognized: (a) physical abuse, (b) psychological abuse, (c) nonconfidential care, (d) nonconsented care, and (e) abandonment of care. Two additional categories emerged from the unprioritized and disorganized nursing and midwifery management: (a) lack of accountability and (b) unethical clinical practices. In Tanzania, Sando et al. (2016) quantitative studies on midwifery have also revealed the negative care experiences of women. Approximately 12 to 70% of women have been found to experience D&A when birthing at facilities. To promote respectful care of women, pre-service and in-service training, improving working conditions and environment, empowering pregnant women, and strengthening health policies are crucial.

A traumatic birth experience can significantly impact her infant's and her family's physical and emotional well-being. A meta-ethnographic study reporting women's perceptions and experiences of traumatic birth identified six significant themes from 10 qualitative studies: 'feeling invisible and out of control,' 'to be treated humanely,' 'feeling trapped: the reoccurring nightmare of my childbirth experience,' a rollercoaster of emotions, 'disrupted relationships' and 'strength of purpose: a way to succeed as a mother (Elmir, Schmied, Wilkes & Jackson, 2010). The authors found that some women who experience a traumatic birth do not necessarily have physical or psychological adverse outcomes, but others identify a significant personal impact. Healthcare professionals must recognize women's need to be involved in decision-making and fully informed about all aspects of their labor and birth to increase their sense of control.

Predictors of Negative Childbirth

Bradley, McCourt, Rayment, and Parmar (2019) examined the drivers of disrespectful care during labor and delivery in sub-Saharan Africa using a qualitative study approach focused on the interpersonal aspects of care and were eligible if they captured midwives' voices and perspectives. The authors noted that psycho-social components of intrapartum care are critical to any woman's birth experience yet ignored for birth technology. Six major themes emerged from the study: power and control and maintaining midwives' status reflected midwives' focus on the micro-level interactions of the mother-midwife dyad. Meso-level drivers of disrespectful care were the constraints of the work environment and resources; concerns about midwives' position in the health systems hierarchy; and the impact of Midwives' conceptualizations of RMC (Bradley et

al., 2019). An emerging theme outlined the impact on midwives' of (dis)respectful care. Overall, findings revealed a prevailing model of institution-centered maternity care rather than woman-centered care.

In a systematic review, Ishola, Owolabi, and Filippi (2017) conducted a synthesis of current evidence on the D&A of women during childbirth in Nigeria to understand its nature and extent, contributing factors, and consequences. The type of abuse most frequently reported was non-dignified care in the form of negative, poor, and unfriendly provider attitudes. The least frequent were physical abuse and detention in facilities. According to findings, these behaviors were influenced by low socioeconomic status, lack of education and empowerment of women, inadequate provider training and supervision, weak health systems, lack of accountability, and legal redress mechanisms (Ishola, Owolabi & Filippi, 2017). Overall, disrespectful, and abusive behavior undermined the utilization of health facilities for delivery and created psychological distance between women and health providers.

Substantial evidence of women's unhappiness with their care experience has raised awareness of D&A of women during birth as a significant global public health issue. Sheferaw et al. (2017) cross-sectional study investigated the prevalence of RMC and mistreatment of women during institutional labor and childbirth services and identified factors associated with the occurrence of RMC and abuse of women in Ethiopia. About 240 women in 28 health centers and hospitals were assessed using structured observation checklists during labor and childbirth. The authors found that women, on average, received 5.9 (66%) of the nine recommended RMC practices; health

centers demonstrated higher RMC performance than hospitals. At least one form of mistreatment of women was committed in 36% of the observations (38% in health centers and 32% in hospitals). Facilities implementing a quality improvement approach, Standards-based Management and Recognition (SBM-R), and having a companion during labor and delivery were associated with RMC. Policymakers must consider the role of quality improvement approaches and accommodating companions in promoting RMC.

Quality of Care in Childbirth

Perceptions of what constitutes a good quality of care differed substantially. Women, as well as healthcare providers, want good quality, professional care at birth. In Malawi, Mgawadere, Smith, Asfaw, Lambert, and Broek's (2019) study explored women's and healthcare providers' perspectives of the quality of care during childbirth and how this can be improved. Focus group discussions with women and key informant interviews with healthcare providers across two districts showed a similar view on what constitutes poor quality of care; unwelcoming reception on admission, non-consented care, and physical and verbal abuse was described as examples of poor care (Mgawadere et al., 2019). However, for healthcare providers, the essential characteristics of good quality care include structural aspects of care, such as the availability of materials and sufficient human resources. For women, patient-centered care, including a positive relationship and experience, was prioritized. The key barriers identified were the shortage of staff, poor labor room design, and a non-functional referral system. There is a need to incorporate women's and healthcare providers' views when designing, implementing,

monitoring, and evaluating maternal health programs. For a positive birth experience, a healthcare facility needs to have an enabling environment, and good communication between healthcare providers and women should be actively promoted.

In another study in one district in Malawi, O'Donnell, Utz, Khonje, and van den Broek (2014) conducted an in-depth interview with 33 postnatal mothers and ten healthcare providers from four significant hospitals through 27 in-depth interviews and two focus group discussions. According to findings: For caregivers, characteristics of good quality care included availability of resources, while for postnatal mothers' positive relationships with their caregivers were important (O'Donnell, Utz, Khonje & van den Broek, 2014). According to the authors, a lack of autonomy and decision-making power is a barrier to the quality of care. It exists both at the level of the patient (mother) and her caregiver, with healthcare providers unable to influence decisions made by more senior staff or management. The lack of autonomy was linked with the emerging themes of team de-motivation, frustration, lack of empowerment to make a change, and poor quality of care provided. A renewed focus is needed on improving communication and strengthening patient rights and autonomy while simultaneously motivating and enabling healthcare workers to provide comprehensive and inclusive quality of care.

Australia faces a challenge in achieving high-quality, woman-centered maternity care (Safe Motherhood for all [SMFA], 2017): First, providing maternity services that respect the childbearing woman's right to RMC and the highest level of health. Second, in achieving effective, efficient, and appropriate use of the funds available while maximizing the health outcomes for society. The financial costs associated with current

maternity care practices create a demand for health services that are not clinically indicated and reduce/limit access to clinical interventions for those who need them (SMFA, 2017). Third, reducing the productivity implications of lost work performance due to ongoing ill health following maternity care.

Lambert et al. (2018) explored the experiences of care during labor and birth from the perspectives of both the healthcare provider and women who had given birth in the preceding 12 weeks to inform recommendations for how the quality of care can be improved and monitored, and, to identify the main aspects of care that are important to women. The authors conducted in-depth interviews, focus group discussions, and key informant interviews with women, healthcare providers, managers, and policymakers in South Africa. The results showed that: Both women and healthcare providers essentially feel alone and unsupported; there is mutual distrust between women and healthcare providers aggravated by word of mouth and the media; and a lack of belief in women's ability to make appropriate choices negates principles of choice and consent (Lambert et al., 2018). Procedure- rather than patient-centered care is prioritized by healthcare providers. Although healthcare providers know the principles of good quality care, the authors noted that this was not reflected in the care women described as having received. Beliefs and attitudes and structural and organizational problems make it challenging to provide good quality care. Caring behavior and environment, as well as companionship, are the most critical needs highlighted by women (Lambert et al., 2018). Improvements in quality that focus on caring, competence, and increased dialogue between healthcare providers and users should be encouraged and prioritized. A renewed focus is needed to

facilitate companionship during labor and birth. Training in RMC needs to prioritize caring behavior and supportive leadership.

Quality of care must be reflected in the care for pregnant women and their infants have two equal parts that influence each other: Firstly, the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems); and secondly, the patient's experience of care (effective communication, respect and dignity, and emotional support) (WHO, 2015a). All health professionals have a role in ensuring that they provide evidence-based respectful care and that the women they care for are empowered to be equal partners in this process. Focusing on maternity care and infant health linked to the RMC Charter would be an innovative approach to reforming maternity care.

Despite reports of poor doctor-patient communication, non-evidence-based care, and informal cash payments, there is scarce quality assessment instrument. Rubashkin et al. (2017) validated and tested an online questionnaire to study maternity care experiences among Hungarian women. Validated items and scales from two previous surveys were collated and adapted to the Hungarian context. The authors designed nine new items concerning informal cash payments and seven new "model of care" categories based on the mode of payment. Overall, a validated and comprehensive questionnaire was developed to evaluate RMC, evidence-based practice, and informal cash payments in the CEE region and beyond. Results showed significant differences across the model of care categories in terms of everyday expenses, informed consent practices, and women's perceptions of autonomy (Rubashkin et al., 2017). Thematic analysis (N = 1015) of

women's responses identified 13 priority areas of the maternity care experience, 9 of which were addressed by the questionnaire.

Evidence has shown a strong connection between lack of quality of care, adverse maternal and newborn health outcomes, and continuing high maternal mortality, despite increasing facility-based deliveries with skilled attendants. According to Miller and Lalonde (2015), international and national organizations have documented the lack of quality care and professional accountability at birthing facilities (Kruk et al., 2009), and various types of abuse, such as physical abuse, non-consented care, and discriminatory care (Bowser & Hill, 2010), which have been termed disrespectful/abusive care during childbirth in facilities (DACF). The article also acknowledged the global definition of disrespect, including care that local consensus finds undignified or humiliating. DACF directly affects outcomes when women are ignored or abandoned during labor or birth and delivered unattended. The problem of DACF is multifactorial; therefore, the response to DACF must be between, among, and across all stakeholder groups involved in maternity health and between, among, and across ministries of health, education, finance, and gender (Miller & Lalonde, 2015).

SMFAI (2017) summit in 2016 explored the challenges and opportunities of achieving RMC to inform maternity services. It was acknowledged that, amongst others, these services should reflect the WHO framework for quality of care for pregnant women and newborns, which breaks down the quality of care into two equal parts that influence each other: the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems); and the patient's experience of

care (effective communication, respect, and dignity, and emotional support) (WHO, 2015b).

Midwives are experts in normal, healthy pregnancy and birth. They are also skilled at recognizing problems and involving doctors and other health professionals in a woman's care if the need arises. The International Confederation of Midwives (ICM) defines midwives as working in partnership with women to give the necessary support, care, and advice during pregnancy, labor, and postpartum. The midwife practices a wellness model, understanding that most pregnancies and births are normal biological processes. The midwife is responsible for identifying problems early on and referring them to the medical officer. Countries with low cesarean section rates and excellent maternal and perinatal outcomes are consistently rated as the best places in the world to be mothers. In all these places, midwives are the primary care providers (WHO, 2015b). Given this knowledge, a midwife best provides the maintenance of a well pregnant woman. Notably, the WHO states that 85% of births do not require interventions. The World Health Organization has identified midwives as "the most appropriate and cost-effective type of health care provider to be assigned to the care of women in normal pregnancy and birth, including the risk assessment and the recognition of complications" (WHO, 1999).

Apart from the known deficiencies in labor care, attempts to improve the quality of care in low-resource settings have also failed to address and integrate women's birth experience into quality improvement processes (Oladapo et al., 2015). The WHO embarked on the 'Better Outcomes in Labor Difficulty (BOLD)' project, aimed at:

Improving the quality of intrapartum care in low- and middle-income countries, and reducing intrapartum-related stillbirths, maternal and newborn mortality, and morbidity. by addressing the critical barriers to the process of good quality intrapartum care and enhancing the connection between health systems and communities. Oladapo et al. (2015) developed an evidence-based, easy-to-use labor monitoring-to-action decision-support tool (Simplified, Effective Labor Monitoring-to-Action – SELMA). The authors co-designed with users of health services (women, their families, and communities) and health providers to promote access to respectful, dignified, and emotionally supportive care for pregnant women and their companions at the time of birth ("Passport to Safer Birth"). This two-pronged approach is expected to positively impact essential domains of quality of care relating to both provision and experience.

The gold standard for clinical quality assessment is a direct observation that captures birth attendants' real-life experiences and behavior; however, they are rarely used. At a low-resource tertiary hospital, Housseine et al. (2020) non-participatory, structured, and direct observation study on 121 women assessed the quality of intrapartum care and adherence to locally tailored clinical guidelines. Results showed that the nurse/midwife-to-laboring-women ratio of 1:4 resulted in doctors providing a significant part of intrapartum monitoring. Care during labor and two-thirds of deliveries were provided in a one-room labor ward with shared beds (Housseine et al., 2020). Screening for privacy and communication of examination findings were done in 50 and 34 percent, respectively. For the majority, there was delayed recognition of labor progress and insufficient support in the second stage of labor. According to Housseine et

al., fetal heart routine monitoring was performed sub-optimally with a median interval of 105 (interquartile range 57–160) minutes. Thus, the occurrence of an intrapartum risk event (non-reassuring FHR, oxytocin use, or poor progress) increased assessment frequency significantly (rate ratio 1.32 (CI 1.09–1.58). The authors found that neither international nor locally adapted standards of intrapartum routine care were optimally achieved. Ensuring a safe and positive birth experience requires local stakeholders to urgently address the structural barriers and invest in sufficient numbers of adequately trained and motivated staff for continuous support during labor.

The mother-baby-friendly birthing facility (MBFBF) initiative was launched to promote the active involvement of stakeholders to improve the quality of care and reduce abuse, neglect, and extortion of childbearing women in facilities. This initiative was in response to findings that low quality of care and DACF violate women's human rights and are intrinsically linked to poor maternal and neonatal outcomes. FIGO, Safe Motherhood, and Newborn Health (SMNH) Committee, in collaboration with colleagues from the International Confederation of Midwives, White Ribbon Alliance, the International Pediatrics Association, and the World Health Organization (WHO), developed guidelines (10 criteria and indicators) for mother-baby friendly birthing facilities (WHO, 2014). The ten criteria for a mother-baby-friendly birthing facility includes: Mobility and positions of preference for labor and birth; privacy; choice of birth partner; non-discriminatory policies for the treatment of women with HIV, youth, minorities, etc.; no physical, verbal, emotional, or financial abuse; affordable or accessible maternity care; no routine practices used that are not evidence-based; non-

pharmacological and pharmacological pain relief as required; and promotes immediate skin-to-skin mother-baby care and breastfeeding. According to the authors, adherence to the indicators developed jointly by the participating stakeholders should build trust, security, and perceptions of quality among childbearing women and their families (WHO, 2014). This can lead to higher facility-based deliveries with better outcomes leading to a decrease in maternal mortality.

Mousa and Turingan (2018) cross-sectional retrospective study offered a descriptive overview of the care provided in the delivery room focused on RMC as perceived by women during labor and delivery among women who received delivery services from 6 hours to 7 days before the study period, in a hospital in Egypt. The dimensions examined were those related to patient-friendly services, free of abuse, timely, and free discrimination. The 15-item RMC Scale was used for this study. The findings from 501 women indicated that most of the postpartum mothers felt that they received friendly care, abuse-free care, and timely care to a moderate degree during childbirth (Mousa & Turingan, 2018). Generally, the postpartum mothers felt that they received a high degree of discrimination-free care during delivery. Overall, the postpartum mothers in this study experienced a moderate degree of RMC during delivery. The findings indicate that women consistently appreciate and value RMC, and providers perceive RMC as critical to providing safe, good-quality care (high confidence in the evidence). Although the general findings show reasonable, RMC, more than fifty percent of the postpartum mothers experienced being shouted at by healthcare workers. More than half of the postpartum mothers claim that the healthcare workers did not give them

prompt service, and waiting time is extended. These aspects of maternity care need to be improved.

Perceptions of Childbirth Experiences

Globally, women's and providers' perspectives on what constitutes RMC are also entirely consistent. These stakeholders identify the critical components of RMC as being free from harm and mistreatment; having privacy and confidentiality; dignified care; receiving information and being supported in the process of informed consent; continuous access to family and community support; high-quality physical environment and resources; equitable maternity care; effective communication; having choices and the opportunity to make decisions; availability of competent and motivated human resources; and receiving efficient, effective and continuous care. The evidence shows some variability in the relative importance of some aspects of RMC. For example, women living in HICs emphasize their rights to decision-making and active participation in their childbirth experience (moderate confidence in the evidence). Comparatively, women in lower-income countries are less likely to demand personal choices and decision-making over their childbirth process (reasonable belief in the evidence).

With pregnancy monitoring protocols prioritizing the mother's physical health, there is a lack of literature documenting the traumatizing effects of the birth process. To address this knowledge gap, Rodríguez-Almagro et al. (2019) conducted this qualitative descriptive study in Spain to investigate women's perceptions of living a traumatic childbirth experience and the factors related to it. Data analysis revealed five major themes— "Birth plan compliance," "Obstetric problems," "Mother-Infant Bond,"

"Emotional wounds," and "Perinatal experiences"—and 13 subthemes. Most responses mentioned feeling un/misinformed by healthcare personnel, disrespected, and objectified, lack of support, and various problems during childbirth and postpartum. Participants' responses were recurrent themes of fear, loneliness, traumatic stress, and depression. As the actions of healthcare personnel can substantially impact a birth experience, the study findings strongly suggest the need for proper policies, procedures, training, and support to minimize the negative consequences of childbirth.

Another qualitative study in Abuja, Nigeria, explored women and providers' experiences and perceptions of mistreatment during childbirth in two health facilities and catchment areas (Bohren et al., 2017). Using in-depth interviews and focus group discussions, participants were asked about their experiences, perceptions, and perceived factors influencing mistreatment during childbirth. Women reported experiencing or witnessing physical abuse, including slapping, physical restraint to a delivery bed, detainment in the hospital, and verbal abuse, such as shouting and threatening women with physical abuse (Bohren et al., 2017). Further results showed that women sometimes overcame tremendous barriers to a hospital, only to give birth on the floor, unattended by a provider. Participants identified three main factors contributing to mistreatment in this study: poor provider attitudes, women's behavior, and health systems constraints. According to the authors, any intervention to prevent injustice must be multifaceted. Implementers should consider lessons learned from related interventions, such as increasing audit and feedback from women, promoting labor companionship, and encouraging stress-coping training for providers.

Balde et al. (2017) explored the perceptions and experiences of mistreatment during childbirth from the perspectives of women and service providers in two sites in Guinea, an urban area (Mamou) and peri-urban (Pita). Participants described their own experiences, women's experiences in their communities, and perceptions regarding mistreatment during childbirth. Results were organized according to mistreatment during delivery, including physical abuse, verbal abuse, abandonment, and neglect. Women described being slapped by providers, yelled at for noncompliance with provider requests, giving birth on the floor, and without skilled attendance in the health facility (Balde et al., 2017). Poor physical conditions of health facilities and health workforce constraints contributed to experiences of mistreatment.

In a recent qualitative, exploratory study on how women in a rural southern district of Ethiopia experience and perceive essential aspects of delivery care, individual in-depth interviews of 19 women were supplemented with observations conducted at two different delivery wards in the same district in 2020 (Mordal, Hanssen, Kassa & Vatne, 2021). Two main themes emerged from the thematic content analysis: increased awareness and safety were the primary reasons for giving birth at a healthcare facility, and traditions and norms affected women's birth experiences in public maternity wards. Mordal and colleagues noted inadequacies such as shortage of medicine, ambulance not arriving on time, and lack of care at night. For some women, being assisted by a male midwife could be challenging, and the inability to afford necessary medicine made adequate treatment inaccessible. Providing continuous information gave the women a certain feeling of control. Strong family involvement indicated that collectivistic

expectations were crucial for rural delivery wards. The healthcare system must be structured to meet women's needs. Moreover, managers and midwives should ensure that birthing women receive high-quality, safe, timely, and respectful care.

A descriptive cross-sectional study on women's perception of RMC during facility-based childbirth in Nepal Medical College and Teaching Hospital revealed about 84.7% of the women reported they had experienced overall RMC services with a mean score ± SD (61.70 ± 12.12). Despite most women reported having experienced RMC services, they had also experienced disrespectful care in various forms, such as being shouted upon (30.0%), being slapped (18.7%), delayed service provision (22.7%), and not talking positively about pain and relief during childbirth (28.0%) (Bohren et al., 2017). Likewise, length of stay, parity, and time of delivery were found as factors that influenced friendly care (COR = 0.383, 95% CI: 0.157–0.934), abuse-free care (COR = 3.663, 95% CI:1.607–8.349), and timely care (COR =2.050, 95% CI: 1.031–4.076) dimensions of RMC, respectively. Even though RMC emphasizes eliminating disrespectful and abusive environments from health facilities, 15.0% of participants perceived that they had not experienced overall RMC services. So, the health facility should focus on the interventions which ensure that every woman receives this basic human dignity during one of the most vulnerable times in their life.

With many reports of D&A in healthcare facilities in low-resource settings, women's and healthcare providers' understanding and perception of D&A are essential in eliminating D&A, but these are rarely explored. Jolly, Aminu, Mgawadere, and van den Broek (2019) conducted a qualitative study involving eight focus group discussions, nine

in-depth interviews involving 64 women, and nine key informant interviews with health care providers. Essential themes that emerged from Jolly and colleagues' study included: the importance of a valued patient-provider relationship as determined by a good attitude and method of communication, the need for more education for women regarding the stages of pregnancy and labor, what happens at each stage and which complications could occur, the importance of a woman's involvement in decision-making, the need to maintain confidentiality when required and the problem of insufficient human resources (Jolly, Aminu, Mgawadere & van den Broek, 2019). Prompt and timely service was considered a priority. According to findings, neither women accessing maternity care nor trained healthcare providers providing this care were aware of the RMC Charter. Although RMC components are in place, healthcare providers were unaware of them. There is a need to promote the RMC Charter among both women who seek care and healthcare providers.

Basic Maternal Rights

Under international human rights law, governments are obliged to promote, protect, and fulfill the right to health; this includes maternal and prenatal health. Human rights are universal. 'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.' (Article 1, Universal Declaration of Human Rights). Maternity care can either protect *or* violate the fundamental human rights of women. Many stakeholders and maternal health experts agree that D&A in facility-based childbirth is a global problem affecting low, medium, and high-income countries, sometimes seen as normal and

acceptable; an essential barrier to skilled care utilization; and a violation of women's human rights; but also, may have direct adverse consequences for mother and baby (White Ribbon Alliance, 2012; Hazard, 2013).

The United Nations Human Rights Council (HRC) has recognized high maternal mortality and morbidity rates as unacceptable and human rights violations (WHO, 2015). Its resolution emphasizes that maternal mortality is not solely a health and development issue but also a manifestation of various forms of discrimination against women (United Nations Human Rights Council, 2009). However, a human rights approach to maternal and newborn health extends beyond providing services to embrace a broader application of rights-based principles to protect and support populations' health.

In its guidance for addressing maternal mortality and morbidity, the Office of the United Nations High Commissioner for Human Rights [OHCHR], 2012) uses a rights-based approach, including empowerment, participation, non-discrimination, transparency, sustainability, accountability, and accountability, and international assistance as fundamental principles. Furthermore, this OHCHR guidance specifically highlights enhancing the status of women, ensuring sexual and reproductive health rights, including addressing unsafe abortion, strengthening health systems, and improving monitoring and evaluation as necessary elements of a rights-based strategic framework for reducing maternal mortality and morbidity (OHCHR, 2012).

A human rights approach to maternal health is helpful in international efforts to reduce maternal mortality. The RMC Charter- The Universal Rights of Childbearing Women, developed by the White Ribbon Alliance for Safe Motherhood and endorsed by

the World Health Organization, is a recent attempt to demonstrate the link of human rights in maternal health with a focus on the interpersonal aspects of care received by women seeking maternity services (White Ribbon Alliance, 2012). In a qualitative explorative study, Solnes Miltenburg et al. (2016) explored women's perspectives and experiences of maternal health services through a human rights perspective in Magu District, Tanzania. Semi-structured interviews with 17 women supplemented with one focus group discussion. Data analysis was performed using a coding scheme based on four human rights principles: dignity, autonomy, equality, and safety. The results showed that women's experiences of maternal health services reflect several sub-standard care factors relating to violations of multiple human rights principles (Solnes Miltenburg et al., 2016). The authors found out that women were aware that substandard care was present and described a range of ways how the services could be delivered that would venerate human rights principles. Prominent themes that emerged included: 'being treated well and equal,' 'being respected,' and 'being given the appropriate information and medical treatment' (Solnes Miltenburg et al., 2016). Applying such a human rights-based approach to maternal health requires attention to the fundamental human rights principle of dignity and its related principles of autonomy, equality, and safety, which are relevant in all health care settings.

The International Confederation of Midwives (ICM) believes that women have a right to a midwife as the most appropriate care provider in most situations. In keeping with other similar documents, the ICM developed the Bill of Rights and believed that there should be recognition of the following as basic human rights for women across the globe:

- Every woman has the right to receive care in childbirth from an autonomous and competent midwife
- Every newborn baby has the right to a healthy and well-informed mother
- Every woman has a right to be respected as a person of value and worth
- Every woman has a right to security of her body
- Every woman has a right to be free from any form of discrimination
- Every woman has a right to up-to-date health information
- Every woman has a right to participate actively in decisions about her health care and to offer informed consent
- Every woman has a right to privacy
- Every woman has a right to choose the place where she gives birth

Quality of care provided and the interpersonal component of quality of care during pregnancy and childbirth should ensure that women are treated with respect for their 'dignity. By drawing on relevant extracts from established human rights instruments, the RMC Charter (White Ribbon Alliance, 2012) demonstrates the legitimate place of maternal health rights within the broader context of human rights. Seven rights are included, drawn from the categories of D&A identified by Bowser and Hill (2010) in their landscape analysis. All these rights are grounded in international or multinational human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination

Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they mention childbearing women (White Ribbon Alliance, 2012).

The WHO has stated D&A during childbirth, which emphasized the importance of RMC and women's rights during pregnancy and delivery and the need for immediate attention to this global phenomenon (WHO, 2014). Bowser and Hill (2010) analyzed with a worldwide perspective and presented seven categories for D&A, including physical abuse, discrimination based on specific patient attributes, non-consented clinical care, non-dignified care (including verbal abuse), non-confidential care, abandonment of care, and detention in health facilities.

Mitigating and Promoting Positive Childbirth

The International Federation of Gynecology and Obstetrics (FIGO) and the International Childbirth Initiative (ICI) Working Group support the ICI 12 Steps for Safe and Respectful Mother-Baby–Family Maternity Care (Lalonde, Herschderfer & Miller, 2020). The ICI is a template for Mother-Baby–Family-focused timely, effective, and respectful care that can be implemented by facilities, centers, hospitals, and units providing care before, during, and after birth to women and their babies worldwide. The ICI embodies a piece of evidence and a value-based approach that acknowledges the mother-Baby dyad, the importance of family inclusion, and the influence of interactions with healthcare providers and health systems on the health and wellbeing of the mother-

Baby–Family and societies. This initiative promotes quality healthcare practice with a multidimensional approach that ensures evidence-based strategies and interventions focused on better (bio)-medical and psychosocial health and wellbeing outcomes for the mother-Baby Family triad (Lalonde, Herschderfer & Miller, 2020). Within this triad, the mother-Baby dyad remains essential, as the care significantly impacts the other. The ICI initiative also encourages and supports the active participation of providers and users of services in a sustainable quality of care monitoring and evaluation process. This initiative is aligned with the ongoing work on quality improvement and respectful care of many organizations involved in maternity health care worldwide. According to Lalonde and colleagues, physical and mental health; social, lifestyle, and economic environment; stress and fear in work and relationships; nutritional intake; and parenting skills are only some of the many factors influencing pregnancy and birth outcomes and the growth and development of the baby, newborn, and infant. Quality, evidence-based care with respect and compassion is essential for every mother-Baby–Family to have the ability to survive, thrive, and transform their lives.

Austad et al. (2017) implemented an ongoing obstetric care navigator pilot program in rural Guatemala, employing rapid-cycle quality improvement methods to identify implementation successes and failures to promote RMC by presenting a model: obstetric care navigation. Care navigators offer women accompaniment and labor support to improve the care experience for patients and providers and decrease opposition to hospital-level obstetric care (Austad et al., 2017). According to Austad et al. (2017), specific roles include deflecting mistreatment from hospital staff, improving provider

communication through language and cultural interpretation, advocating for patients' right to informed consent, and protecting patients' dignity during the birthing process. Care navigators are specifically chosen and trained to gain the trust and respect of patients, traditional midwives, and biomedical providers. This impacted the implementation lessons to facilitate replication in other settings.

The World Health Organization (WHO) also released a statement in 2015 that emphasized that "every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care" (WHO, 2015a), and identified five areas of action in which researchers, policymakers, and health professionals should work to reduce mistreatment: Increasing support for research and action; creating programs to promote respectful, high-quality maternal health care; developing rights-based frameworks for action; generating data on the prevalence of D&A and interventions to mitigate it, and; driving intersectional initiatives that encourage the participation of women.

Summary and Conclusions

While global maternal health experts urge facility-based delivery with skilled attendance, maternal mortality is not decreasing as rapidly as expected. The last decade has seen a gradual shift in maternal health from reducing maternal mortality to promoting RMC. Between 1990 and 2015, maternal mortality decreased globally by 44% (WHO, 2015b), and skilled birth attendance increased sharply in many low- and middle-income countries (LMICs; United Nations [UN], 2015). However, clinical, and interpersonal quality of care has generally lagged (Miller et al., 2016). As most pregnancy-related

deaths and morbidities are clustered around childbirth, quality of care during this period is critical to the survival of pregnant women and their babies.

The WHO highlighted the importance of woman-centered care to optimize the labor and childbirth experience for women and their babies through a holistic, human rights-based approach. It introduces a global model of intrapartum care, which considers the complexity and diverse nature of prevailing models of care and contemporary practice (WHO, 2019a). Both the quality of the provision of care by the healthcare provider (birth attendant) and the quality of care experienced by users is essential. The uptake of services, including the time of childbirth, results from the availability of that care and women's experiences. However, there are instances of unpleasant childbirth experiences that affect maternal and infant morbidity and mortality, which may turn a woman's experience of childbirth—into something expected to be positive or traumatic (Aune et al., 2015). Aspects of care considered necessary for positive childbirth experiences include shared decision-making, information and communication, equity, respect and dignity, and emotional support (Shakibazadeh et al., 2018; WHO, 2018b). A negative or poor childbirth experience means that the women had been exposed to disrespectful care, constituted by neglect, verbal or physical abuse, insufficient information, and denial of their husband as a companion ((Mukamurigo, Dencker, Ntaganira & Berg, 2017). This crucial negative aspect of maternity care can influence women's decision not to use health facilities in their present or subsequent deliveries. There is a direct relationship between RMC and a positive childbirth experience (Hajizadeh et al., 2020).

Respectful care during childbirth has been described as “a universal human right that encompasses the principles of ethics and respect for women’s feelings, dignity, choices, and preferences.” (Ishola, Owolabi, & Filippi, 2017). The articulation of this new set of childbirth-related rights coincided with the development of “D&A” typologies— categories of behaviors that violate women’s rights (Bohren et al., 2015; Bowser & Hill, 2010; Shakibazadeh et al., 2018). The first (Bowser & Hill, 2010) included seven categories: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. These typologies are increasingly used to document instances of D&A (Bradley et al., 2016; Ishola et al., 2017; Kruk et al., 2014; Lambert, Etsane, Bergh, Pattinson, & van den Broek, 2018) and, more recently, assess its prevalence (Bohren et al., 2018; Sando et al., 2016). Many women worldwide experience a lack of respectful and abusive care during childbirth. A growing body of literature documents instances of D&A in maternity care, seemingly particularly pronounced in LMICs, attributed to factors such as provider attitudes, lack of motivation (Ishola, Owolabi, & Filippi, 2017), and, increasingly, systemic causes, including inadequate resources, poor leadership, and gender- and class-based inequalities (Freedman et al., 2014; Ishola et al., 2017).

RMC is closely related to eliminating D&A during pregnancy and childbirth (White Ribbon Alliance [WRA], 2012). Therefore, improving the quality of care provided to women and their babies during delivery is essential for improving women’s health. In response, the WRA (2011) launched an RMC campaign and published a charter

regarding the rights of childbearing women grounded in universal human rights; the WHO (2014) issued a statement and incorporated respectful care into its maternity care guidelines. Further, these involve all stakeholders in a concerted effort to improve the quality of care and eliminate disrespectful practices. (WHO, 2016a, 2018a). The International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), White Ribbon Alliance, the International Pediatrics Association, and WHO have also recently launched the MBFBFI to provide facilities and health systems with actionable steps to improve respectful care at birth. In 2014, WHO issued a statement on the prevention and elimination of D&A during facility-based childbirth, emphasizing the rights of every woman to dignified, respectful care during delivery, and the need for more significant action, dialogue, research, and advocacy by all health stakeholders on this issue. Many professional societies, international organizations, and civil society groups have recently highlighted the need to address this problem and promote respectful care practices at birth. The White Ribbon Alliance leads a global campaign to promote RMC.

Therefore, and because of the above, I consider it necessary to understand Sierra Leonean women's childbirth experiences and perceptions regarding their fundamental human rights. The RMC Charter: Universal Rights of Childbearing Women and Bowser and Hill were utilized as a conceptual framework to guide my study. Every woman has the right to dignified, respectful sexual and reproductive health care, including during childbirth, as highlighted by the Universal Rights of Childbearing Women charter. Yet, the issue of D&A of women at birth in the Sierra Leone health system has not been

comprehensively documented despite its possible importance in reducing Sierra Leone's high maternal mortality ratio. It is, therefore, crucial to know what forms of D&A exist and how to prevent them and better meet women's emotional, physical, socio-cultural, and psychological needs as part of broader efforts to provide better quality care. This type of study is novel and can help to modify the health policies of different agencies and personnel who work in them and who, in one way or another, are at the bedside of the women who are about to give birth. Detailed knowledge may help improve the quality of maternity care and increase the utilization of facilities for delivery in Nigeria. This literature review has filled a gap in the present study by producing a plethora of current evidence leading to a conceptual framework and methodology. In addition, this literature review supports my potential discussion of findings as they were referenced and directed the conversation and recommendations.

Chapter 3: Research Method

Introduction

Global research has shown that women may avoid maternal health services if they perceive them as low quality or expect to be treated poorly by healthcare providers. The provision of quality maternal and newborn care to pregnant women throughout their perinatal processes must emphasize the provision of care and experience of care. The previous chapter focused on the literature review on women's positive and adverse maternal health experiences and outcomes, including understanding mistreatment during childbirth in health facilities comprising disrespectful, neglectful, and abusive care (see Bohen et al., 2014). The WHO (2016a) released a statement that advocates for governments and development partners to initiate, support, and sustain programs designed to address the quality of MNH services. According to WHO (2016a), a strong emphasis should be positioned on providing RMC as an essential component of quality of care. A study that explores the childbirth experiences and perceptions of Sierra Leonean women with their fundamental maternal rights was essential for several reasons. First, it compiled diverse childbirth experiences (positive & negative), contributing to the currently available evidence. Second, it helped create awareness of the status of maternity services about RMC. Finally, it brings this information to a broader audience of practitioners, policymakers, and organizations to assist them in developing policies, guidelines, protocols, and training for implementing RMC. The identified conceptual framework for the study supported an integrated and holistic exploration of possible D&A of their fundamental maternal rights.

This qualitative research study aimed to understand and describe the childbirth experiences (positive/negative) and perceptions of women relating to basic maternal rights while accessing facility-based maternity care. I conducted this study with participants from three public hospitals in three districts of Northern Sierra Leone. The differences in childbirth experiences and their possible impact on the mothers' health and well-being, babies' development, and mother-infant-interaction (Figueiredo, 2001) revealed the need to explore how women perceive their childbirth experience and which factors interfere in the quality of the changes that occur over time. A phenomenological approach involved speaking to a group of women's lived experiences focusing on the phenomena of interest (see Creswell, 2014; Creswell & Poth, 2018). One key strategy for improving maternal health outcomes and social change is implementing evidence-based practices and providing RMC (Vogel et al., 2015). Through the lens of feminist perspectives, I explored the lived childbirth experiences and perceptions relating to their basic maternal rights in Sierra Leone. Amnesty International (2016) noted, "Sierra Leone government needs to intensify its efforts to save women's lives. It must make good quality health care available and accessible to all pregnant women." A better understanding of this phenomenon could contribute to improved programs and services for women at birth. It further justified the need for effective policies related to RMC, which can influence the promotion of RMC strategies, thereby preventing D&A of childbearing women in Sierra Leone. Promotion of such an approach is necessary to (a) incorporate RMC in national legislation and healthcare policy, (b) support healthcare providers to deliver RMC, (c) integrate the RMC Charter into training and standards for

healthcare providers, and (d) improve women's experience of labor and childbirth at the interpersonal level between a woman and her health care providers, as well as at the level of the health care facility and the health system.

This chapter presents the study's methodology, including my role as the researcher, the selection process of the study setting, and the participants. The study's research design, including the study population and sampling protocol, instrumentation, data collection procedure, and data analysis plan, is also discussed. This chapter also presents ethical considerations, including the study's institutional review board (IRB) approvals. The study builds on current evidence of methods used in childbirth experiences and perceptions of women relating to their fundamental maternal rights. Finally, a description of what is known and contentious about the phenomena of interest is discussed.

Research Design and Rationale

Research Questions

Research Question 1: What are the lived childbirth experiences of Sierra Leonean women relating to their fundamental maternal rights?

Research Question 2: How do Sierra Leonean women perceive their childbirth experiences relating to the principles of RMC?

Philosophical Assumptions of the Phenomenological Study

A phenomenological inquiry was used, focusing on Sierra Leonean women's childbirth experiences and perceptions about their fundamental human rights. Phenomenology is used to identify phenomena that stress subjective experiences and

understand those lived experiences' structure. In the early 20th century, it was founded by Husserl and Heidegger and originated from philosophy and psychology (as cited in Taylor, 2016). Phenomenological studies examine various experiences and perceptions of a particular phenomenon, developing patterns and relationships of meaning formed through interaction with others. The childbirth experience assumes a single meaning for each woman. In most cases, it is perceived as a significant family event, with positive or negative, permanent, and long-term impact on a woman's life, her relationship with her partner, children, and the newborn infant (Costa et al., 2003).

Creswell and Creswell (2018) explained that phenomenology provides more profound descriptions and complete information on lived experiences with a complex issue. Despite the efforts to improve the quality of services, Sierra Leone has one of the highest maternal mortalities in the world. The government highlighted that increasing women's uptake using health facilities for childbirth is a national priority (MoHS, 2017). Even though facility uptake is increased, the decline in maternal mortality is steadily slow. I explored the individual lived experiences and perceptions through in-depth interviews. The participants were chosen because of their unique status, experience, and perceptions of their birthing processes.

The ecological systems theory was used as the theoretical foundation for this study. In addition, the Universal Rights of Childbearing Women, known as the RMC Charter, establishes women's right to timely, high-quality, and respectful care in pregnancy, childbirth, and beyond and was as the conceptual framework. The study collected primary data through in-depth interviewing familiar to phenomenologically

oriented researchers. Thus, the phenomenological inquiry was secondhand to describe, in-depth, the typical characteristics of the phenomena that have occurred to the structures that underscore the essential nature of the idea (see Rudestam & Newton, 2015). This strategy also utilized universal childbearing rights from the RMC Charter to investigate respectfully and the categories of disrespectful maternity care to childbirth in health facilities for a deeper understanding of this problem.

Research Tradition and Rationale

A qualitative approach was employed as a research method for this study. I used a generic approach to emphasize the socially constructed nature of reality. A qualitative approach explores and understands the meaning individuals or groups ascribe to a social or human problem (Creswell & Creswell, 2018). This approach was selected to allow both interpretation and description of the lived experience of women participating in facility-based birth (Willis et al., 2016). The research process comprises emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from specifics to general themes, and making interpretations of the meaning of the data (Creswell & Creswell, 2018). Those who engage in this form of inquiry support a way of looking at research that honors an inductive style, a focus on personal meaning, and the importance of rendering the complexity of a situation rather than narrowing meanings into a few categories or ideas (Creswell and Creswell, 2018).

Morse (2003) maintained that qualitative methodology is used when little is known about a topic, the research context is poorly understood, the boundaries of a

domain are ill-defined, the phenomenon under investigation is not quantifiable, and the researcher suspects that the phenomena need to be studied. Because the childbirth experience is very complex and ambiguous, qualitative analysis from women's perspectives and investigating personal meanings were expected to offer a more precise and relevant insight into the problematic aspects of facility-based childbirth. The questions become broader and more general so the participants could construct the meaning of the situation studied. This study involved in-depth face-to-face interviews on the childbirth experiences and perceptions of women who had accessed facility-based intrapartum care within 2 months postpartum in Northern Sierra Leone. Creswell and Creswell (2018) argued that face-to-face interviews might be helpful when participants cannot be directly observed and can provide historical information. However, the information provided can be subjective; not all participants are equally articulate and perceptive (Creswell & Creswell, 2018).

Role of the Researcher

In qualitative research, it is always essential for researchers to provide information on their biases or opinions (Creswell, 2014). This information helps set aside (bracketing out) those feelings and perspectives so that those of participants become paramount (Creswell, 2014). The relationship between the research and me was thus very critical (see Creswell, 2013). My role as the researcher in this study required identifying my values, assumptions, and biases at the study's outset. As the researcher, I served as a midwife educator and head of the midwifery school in Makeni, the country's Northern region. I am also a member of the Sierra Leone midwives Association and a foundation

Fellow of the Postgraduate College of Nursing and midwifery. In addition, I am a Board member representing the Faculty of Obstetrics and Midwifery at the college. Thus, I believe that these experiences enhanced my awareness, knowledge, and sensitivity to the issues addressed in this study and informed my work in midwifery education and practice. Although every effort ensured objectivity, my personal bias shaped how I viewed and understood the collected data.

Therefore, identifying and managing these personal biases ensured the integrity of data collection, analysis, and interpretation processes. My frequent interactions with maternity units and the country's high maternal mortality have sparked the research questions. Considering this connection, I bracketed my experiences to gain a fresh perspective (see Creswell, 2013). Furthermore, I neutrally asked interview questions and listened attentively throughout each interview. Interviewees had the opportunity to respond to each identified interview question and offered additional insights and perspectives on the issue of their childbirth experiences and perceptions. During this time, I recorded field notes on the observations and any nonverbal cues throughout the interview process. I used this in addition to member checking and computer-generated analysis for comparison and triangulation of the data, which ensured data quality.

Methodology

Sampling: Participants' Recruitment and Selection

The target population was women of childbearing age 18 to 49 years. Women in Sierra Leone have a 1 in 17 lifetime risk of dying due to pregnancy or childbirth (SSL &

ICF International, 2013). Maternal deaths account for 36% of all deaths among women ages 15 to 49 (WHO, 2015b).

A purposeful sampling technique selected eligible postpartum women aged 18 to 45 years who had childbirth experiences in the three districts' hospitals (Koinadugu, Bombali, and Kambia). Purposeful sampling techniques for primary research are widely used in qualitative research to identify and select information-rich cases for the most effective use of limited resources related to the phenomenon of interest (Patton 2015). Despite its wide use, numerous challenges exist in identifying and applying the appropriate purposeful sampling strategy in any study. The selection of participants in qualitative research is purposeful; selected participants can best inform the research questions and enhance understanding of the phenomenon under investigation (Creswell, 2009).

During the early phase of the study, I contacted the chairmen of the Council of Church Ministers (CCMs) in the three study districts via mobile phone calls, requested attendance to one of their meetings, and scheduled a preliminary discussion about the research study. These meetings are usually held monthly. These chairmen of the CCMs were used as gatekeepers to access other church communities. During the sessions, I introduced the study and distributed recruitment flyers (Appendix A) detailing the eligibility criteria, such as age, gestational age before delivery, place of birth, date of delivery, and other relevant information. After an announcement, the church ministers were asked to post and/or share the flyers in their various churches. I contacted each potential participant via mobile phone to administer screening questions for eligibility

using a recruitment form (Appendix B). Successful participants who met the eligibility criteria were recruited. Women interested in participating in the research study chose a convenient time to administer and hand over the informed consent form at the study site. The date for data collection was scheduled.

The eligibility criteria for the study included women aged 18 to 45 years whose gestational age was 28 to 40 weeks, were admitted for no reasons other than labor and delivery, who had delivered in the hospital of the study districts in the past 2 months, and who provided written consent to participate in the study. Women were not eligible if under 18 years or admitted for reasons other than childbirth. Caesarian section was excluded because not all women who go through caesarian section experience the stages of labor pains, have first-degree relative of a facility employee (mother, sister, daughter, cousin), or are unable to provide written consent.

A total of seven eligible participants in each study district who had given birth in the preceding 2 months were interviewed in church settings. Phenomenological studies involve three to 10 individuals to ensure a suitable depth and diversity of perspectives (Rubin & Rubin, 2012). Rubin and Rubin (2012) asserted that including many participants is not necessary to achieve balance and thoroughness during a qualitative study. Therefore, a total sample size of 21 participants was recruited for data collection and interviewed in religious settings until data saturation was reached (the point in data collection when no additional issues or insights emerge from data and all relevant conceptual categories have been identified, explored, and exhausted). This sample size

was appropriate because, in phenomenological studies, Creswell (1998, p. 64) gave a guideline of five to 25.

According to Morse and Niehaus (2009), qualitative methods often rely on precedents for determining the number of participants based on the type of analysis proposed, level of detail required, and emphasis on homogeneity (requiring smaller samples) versus heterogeneity (requiring larger samples).

Sampling: Study Site Selection

The study sites were purposively selected to recruit participants for this study. Primary data were collected from eligible participants residing in the three selected districts (Bombali, Koinadugu, and Kambia) of the Northern region of Sierra Leone. Sierra Leone has 16 districts distributed within six regions (Eastern, Western, Northern, North-West, Southern, and Western Area), with a national statistic of an estimated total population of 7 million, a maternal mortality rate of 717/100,000 live births, and an annual growth rate of 3.5% (SSL, 2015). In addition, the country has a total fertility rate estimated at 5.2 children per woman (SSL, 2015).

The Northern region comprises six districts: Bombali, Koinadugu, Kambia, Tonkolili, Karene, and Falaba, and only three districts (Bombali, Koinadugu, Kambia) were purposively included in the study because of their unique geographical and diverse cultural characteristics and serving a diverse ethnic population. Bombali district has a total population of 483,087, and 107,245 accounts for WCBA. Koinadugu district has a total population of 238,707, and WCBA accounts for 52, 992; while Kambia district has a population of 404,260 with a WCBA of 89,746. Exclusion criteria include districts in the

North without public/government hospitals (Karene and Falaba), and the other district, Tonkolili, has similar characteristics as Bombali district, which is already included in the study because this district hosts the regional hospital in the region. Rubin and Rubin (2012) argued that the number of sites selected for qualitative research depends on the nature of the study research questions and the number of factors that might influence the study phenomenon. Maternity healthcare services in the selected facilities have been supposed to be free since the launch of the Free Health Care Initiative in 2010. In addition, these referral hospitals receive patients for comprehensive emergency obstetric and newborn care (CEmONC) from all peripheral health units, including basic emergency obstetric and newborn care (BEmONC) facilities in their catchment chiefdoms. One may expect that these hospitals have specialized staff, including midwives, who should provide quality maternity services.

The actual study sites were the three selected church campuses within the three study districts where data was collected. Using convenience sampling, I verbally requested at the end of the CCM meetings by making announcement notices and seeking volunteers to make their church campuses available for data collection in the three study districts. Additionally, written permission was sought for interviews to be held at the nominated church campuses to promote sincerity and comfort in revealing sensitive information about participants' childbirth experiences and perceptions. Based on the three sites included in the study, and an assumption of a minimum of seven participants per site type, a minimum pool size of 21 participants, was determined to be appropriate.

Instrumentation

I conducted primary data collection in a natural setting through IDIs individual face-to-face with participants using semi-structured interview protocol and generally open-ended questions intended to elicit views and opinions on the childbirth experiences and perceptions relating to their basic maternal rights. In addition, I recorded the interviews using an audio-tape recorder. Naturally, in good qualitative research, the researchers draw on multiple qualitative data sources to interpret a phenomenon of interest (Creswell & Creswell, 2018). A semi structured interview guide was handy as a data collection instrument in the qualitative research. A semi structured interview guide was advantageous since it favored an informal setting where the researcher and participants could freely interact. Moreover, a semi-structured interview helped me delve deeper into a question that suited my comfort and the participant. It paved the way for me to obtain adequate and rich data based on the interview guide. I maintained effective control over the direction of the interview while the participant-maintained control over the information provided.

Researcher-Developed Instruments

Considering the embodiment of the researcher as the primary instrument of semi-structured interviews (Rubin & Rubin, 2012), understanding the qualitative interview as social interaction is essential. The questions and probes used for developing the research instrument were adapted from both the WRA and Heshima research projects. The WRA RMC Situational Analysis Tool 3 IDI for women was modified to fit the context and research questions (UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of

Research). The WRA is a torchbearer of safe motherhood across the globe and functions through its national alliances for policy and practice changes at global and country levels that can help make childbearing a safe and respectful experience for mothers. The Heshima ("dignity" in Kiswahili) project is an evidence-based participatory implementation research study conducted in Kenya. I sought permission to adapt and modify the Heshima interview protocol to reflect the research questions to understand better the study on childbirth experiences and perceptions of women relating to their basic maternal rights. The instrument's validity was obtained through an iterative process, wherein sharing the first and second drafts with two expert colleagues in the field gave me critical feedback, which was used to revise and improve the instrument. Collecting data using a research instrument permit sufficient flexibility in the structure of the questioning to allow the interviewee to respond promptly to what is relevant, to ask probing questions about what is heard from the respondent, and not only from what is written on the guide. It guides a face-to-face conversation between a researcher and participants with the sole purpose of collecting relevant information to satisfy a research purpose.

The research instrument (Appendix C) consists of questions categorized under four themes: (a) personal characteristics, (b) experience of care: Section 1: Preparing to give birth; section 2: Decision to give birth at a health facility; section 3: Arrival at a health facility to give birth; section 4: Admission procedures and experiences giving birth, including waiting time; and section 5: Management immediately after delivery; (c)

perception of care: Section 6: Factors that contribute to /risk factors for D&A in health facilities; and Section 7: Future for fertility and delivery, and (d) conclusion.

Interview Protocol

There was an in-depth interview protocol for women of reproductive ages (18-45 years) who had given birth in a district hospital of the study districts two months postpartum. All participants had a one-on-one interview to ensure their comfort in sharing their experiences. The guiding questions were adapted and modified from a combination of published instruments based on a literature review expertise of study investigators from various disciplines (birth equity research, reproductive justice, health services research, OB/Gyns, and sociology).

The interview protocol (Appendix C) consisted of basic information about the interview, including the date and time, location, and the names of both the interviewer and the interviewee (represented by a code). The introduction section of the protocol consisted of several vital components, such as the purpose of the study, a prompt for the participant to submit the signed consent form, and the general structure of the interview. The content questions were divided into four categories: A (Personal characteristics), B (Experience of care), C (Perception of care), and D (Conclusion). These categories are further divided into seven sections. Overall, a total number of 20 questions were included in the interview protocol. These content questions were phrased in a friendly manner to the participants and included probes serving as a reminder to the researcher to ask for more information. Finally, the interview protocol had a closing instruction (category D), where the researcher thanked the participant for her time, assured confidentiality,

answered any final questions, and asked if participants could be followed-up when there was a need to clarify points. Consistently, I recorded information from interviews using an audio recorder and made hand-written notes in the spaces between the questions. Additionally, I kept a journal that focused on my thought process in developing and conducting the study, my ongoing identity and positionality as a researcher, and the themes that began to emerge from the data.

Procedures for Pilot Studies

A pilot study is a way to gain insight into the proposed research. The pilot study allowed me to evaluate if the study worked how it was proposed, the length of time necessary to complete each interview, and affirm all the questions and information were clear to the participant (Stadtlander, 2015). Additionally, piloting contributed to the study's rigor and quality of data. I initially sought informed consent using a pilot consent form. I identified three women who met the study criteria from each district of interest. The potential participants for the pilot study were identified through my professional and social connections. The pilot participants were invited by phone to participate in the pilot study. If the invitation was accepted, the researcher and the participant agreed upon a date, time, and location to meet.

Potential interviewees had the opportunity to decide whether to participate based on the letter contents and information provided in the consent form. The three participants signed a consent form before data collection commenced. Participation helped in modifying the interview guide for the larger study in a way that was acceptable and comfortable for future participants. The pilot study employed a semi-structured

interviewing technique with in-depth and open-ended questions designed for three women (one from each study site) who met the eligibility criteria for the actual study on childbirth experiences and the perception of postpartum women in relation to their basic maternal rights.

I completed a post-interview debriefing with the pilot participant to assess the type of questions for use throughout the research and ensure that the questions' data are valid, reliable, and culturally acceptable. The debriefing involved asking the participants whether the questions were understandable and comfortable to answer.

This process helped to identify the main issues and form the basis of the questions used in the pilot study. Some of the questions were asked in more than one way to assess internal consistency. Acceptability was determined by asking the participants how they found answering the questions during the validity testing.

Procedures for Recruitment, Participation, and Data Collection

During the early phase of the study, I attended CCM meetings in the various three study districts to inform church ministers about the study as well as distribute recruitment forms for postings in their various churches. At the end of each CCM meeting one church campus per study district was conveniently selected after discussions with potential church ministers who gave their verbal consent to allow their sites to be used for recruitment and data collection centers. Then, I sought permission and obtained a letter of cooperation for data collection on the church grounds. Participant recruitment was conducted via mobile phone calls using screening questions for eligibility. Before the interviews, I obtained consent from potential participants on a determined date at the

study sites using an informed consent form. The potential participants were scheduled for interviews the next day and given the consent form to take home. On the interview day, I sought informed consent from the participants by reviewing and signing a consent form. Potential interviewees had the opportunity to decide whether to participate based on the letter contents and information provided in the consent form.

Purposively, primary data collection was conducted from the three established church sites in the three study districts lasting for nine days (3 days per study site), excluding traveling, through individual in-depth interviews using a semi-structured interview guide. In-depth interviews were helpful when participants could not be directly observed to explore experiences, opinions, and views on a phenomenon to enhance the research study's credibility (Creswell & Creswell, 2018). According to Creswell (2007), five to 25 in-depth interviews serve as the primary data sources in a phenomenological study so that researchers can get a complete picture of the phenomenon, they are studying from various vantage points (p.61). The individual interviews with women who had given birth in the preceding two months (to eliminate recall bias of their experiences) lasted for about 60 - 90 minutes in a pre-selected closed-door facility with few interruptions to ensure privacy and confidentiality until I reached saturation. A provision would have been made where the participant would prefer telephone rather than personal face-to-face interviews. However, all the participants preferred personal face-to-face interviews. Confidentiality remains an essential aspect of medical practice, and the same importance is needed to apply to a research project. The anonymity of all participants was guaranteed when personal details were documented within the research study (Finlay, 2011).

Qualitative research often embraces sensitive topics; therefore, the need to approach the participants with respect, care, and sensitivity was mandatory. Boundaries and the role the researcher would play were established at the onset of the interview (Finlay, 2011).

While the interview was going on, study participants were served snacks and drinks, and at the end of the interview, each participant received transportation refunds of Le. 30,000 (An equivalent of $3). During the study, I utilized a non-directive style of interviewing using open-ended questions, allowing the participants the freedom to control the pacing and subject matter. In addition, a more directive style of questioning was used when I required more clarification of the information the participants provided. I anticipated probes that would be used to explore participants' responses (Rubin & Rubin, 2012). I audio-recorded the interviews using a tape recorder and made hand-written notes. Throughout the interview process, I developed effective working relationships with participants by encouraging them to share information from their perspectives, framing initial and follow-up questions in an open-ended manner, and listening attentively (Marshall & Rossman, 2015).

Findings from this qualitative study enabled the identification of RMC and D&A of participants during their care process, recommendations on preventing D&A, and promotion and implementation of RMC strategies are presented.

Data Analysis Plan

The data analysis utilized a thematic content analysis framework and, thus, an inductive approach. According to Marshall and Rossman (2015), data collection and analysis must be simultaneous in qualitative research. While the interviews were

ongoing, I analyzed the interviews collected earlier and wrote memos that were ultimately included as a narrative in the final report. The interviews were audio-recorded and transcribed verbatim. I regularly reviewed field notes and journal entries and coded interesting characteristics across the datasets, noting initial ideas. The transcribed interviews and field notes were read repeatedly to acquire an overview of the data.

The Coliaizzi (1978) method of phenomenology uses Husserlian phenomenology to describe the essential structure of a phenomenon in its analysis. It was used to investigate the lived experiences of nurses giving spiritual care (Deal, 2010). Ballie (1996) conducted a phenomenological study using Colaizzi's method to understand the nature of empathy by nurses. Colaizzi's data analysis method appeared to be appropriate for this study because it focused on finding the essence and meaning of the childbirth experiences of the participants.

The Colaizzi analysis involves the following procedural steps: First, I read all participants' responses and transcribed the data collected from the interviews to get a general sense of the whole and ideas presented. Next, relevant statements and phrases about the phenomenon being studied were extracted from each transcript. I then formulated the meanings from important information. Then the meanings were organized into themes, evolving into theme clusters and eventually into these categories. Data were transcribed verbatim, coded, and analyzed using the thematic framework approach. In addition, I utilized a color-coded system to highlight specific themes/types to perform a preliminary analysis. I solicited validation from the participants to compare the descriptive results with their lived experiences. Then, a detailed and exhaustive

description of women's lived experiences were documented. Partner organization masking was considered throughout the analysis process by assigning codes.

Researchers suggested using multiple strategies for data triangulation (Creswell, 2013; Creswell, 2018). Peer checking of information, NVivo computer software (QSR International, Version 12 Plus), and hand-coding for data triangulation were utilized for this study, ensuring the credibility and trustworthiness of the data. The transcripts were then imported into NVivo software for management and analysis. Thematic analysis using an inductive approach was used to identify themes emerging from the transcripts and later compared for consistency. I reviewed the major themes vis-à-vis the transcripts and the interview guides and selected the final research themes. The consolidated criteria for reporting qualitative research (COREQ) were used to ensure that essential components were well noted. A thorough review of the initial themes was conducted, while the NVivo version 12 software program was used for data coding. I ensured transparency through a comprehensive description of the analytic process, from "raw" data to themes. Rigor and trustworthiness were safeguarded through discussions with my colleague, who critically questioned the formulation of themes and the interpretation of the data. Analytic credibility was ensured through the choice of context, participants, and a research approach suitable for the focus of this study. Quotations are presented to emphasize my findings.

Issues of Trustworthiness

Qualitative validity was determined using strategies to check the accuracy of the findings. It was also captured through authenticity and trustworthiness (Creswell &

Miller, 2000). Authenticity refers to reporting each participant's experiences so that it maintains respect for the context of the data and presents all perspectives equally so that the reader can arrive at an impartial decision. Trustworthiness is determined by credibility, transferability, dependability, and confirmability. Credibility is when the researcher analyzes the data through a process of reflecting, sifting, exploring, judging its relevance, and meaning, and ultimately developing themes and essences that accurately depict the experience. Triangulation or multiple data collection and analysis methods were used to build a coherent justification for the themes and to strengthen reliability and internal validity. In addition, the researcher used member checking to determine the accuracy of the data by reaching participants with their transcripts for review and verification. It was an ongoing collaborative dialogue throughout the analysis process until the final report (Creswell, 2013). Each participant had to agree with their transcript.

Confirmability was determined by linking the data to their sources. In phenomenological research, the researcher sets aside his potential prejudices and biases in a technique called bracketing (Creswell, 2013). Since this study was about fulfilling a doctoral research requirement, my research committee and program director scrutinized and validated the data analysis portion of this report**.** An additional independent review was conducted by a colleague experienced in phenomenological methodology and approved by the researcher's graduate committee chairman at Walden University.

Ethical Procedures

Ethical approval was sought through application to and granted by Walden University IRB (Approval # 04-13-22-0758841) and the Sierra Leone Ethics and

Scientific Review Committee (Appendix D). Thus, the researcher engaged the chairmen (Gatekeepers) of CCM in the study districts to attend bi-weekly meetings. Further, permission was sought from clergy members in charge of the church campuses, and a letter of cooperation was obtained for recruitment and data collection on the church premises. Phenomenological research solicits sensitive and profound answers to questions extracting meaning from statements and opinions (Creswell & Creswell, 2018). Notably, the reputation and position of the participants are visible, especially when the findings of the study could be shared with other people and institutions/organizations. This is an essential concern of this study, where the participants' position and institution are visible. Therefore, I ensured the interviews are conducted according to the guidelines governing research ethics: informed consent, the principle of voluntariness, and estimating the risk against the benefit of the study. The researcher must anticipate ethical issues that may arise during the qualitative research process (Creswell, 2013).

Research involves collecting data from people about people (Punch, 2005). Therefore, I ensured the protection of study participants by developing trust with them, promoting the integrity of the research, safeguarding against misconduct and any impropriety that might reflect on their organizations or institutions, and coping with new challenging problems (Creswell, 2013). Furthermore, the researcher should respect the participants' rights, needs, values, and desires (Creswell & Creswell, 2018). Thus, I collected the data outside the health care settings in the participant's environments. Participation was voluntary for all the women who were permitted to be involved in the

study. Before the interview, I informed the study participants in detail about the purpose of the research verbally and in writing to understand clearly.

Further, I emphasized the confidentiality of participants' responses and the free choice to participate, including the option to withdraw from the study at any time. At the same time, the final decision regarding anonymity rested with the study participants. Further, confidentiality was preserved by conducting the interview in privacy and coding each data with numbers. As the researcher, I maintained masking partner organization in published reports, including ProQuest.

A written and signed consent was obtained from all the study participants and included information on all data collection devices and activities. Verbal authorization to record the session was requested and consented to prior to the interview. If anyone had refused, I would have only taken down notes. The data material (paper and electronic) was also treated with confidentiality. It was secured in my locked file cupboard at home, which will be destroyed through burning after 5 years, and on a password-protected laptop computer, backed up on a goggle-cloud drive.

Implications for Practice

A renewed focus is needed to facilitate companionship during labor and birth. Training in RMC needs to be prioritized to change behavior and support leadership. Candor regarding facilities' ability to structurally meet standards should be encouraged. Companionship during labor and birth should be promoted for all stages of labor; working with communities to raise expectations may be required. Non-verbal and caring behaviors are critical to women and are best assessed by the woman's experience.

Supportive leadership is crucial in improving care and raising expectations without providing staff with the support or resources to meet their increased distrust. Women are supposed to have a better experience of good quality care. Thus, their care should be addressed not just by the language of 'respect and rights' but also in a way that the emotional experience is enhanced, and fear reduced.

Summary and Transition

In Chapter 3, I presented the research design for the study on the childbirth experiences and perceptions of Sierra Leonean women relating to their basic maternal rights. A qualitative approach allowed for a more in-depth understanding and a more detailed explanation of the complex issues of the experiences and perceptions of childbirth. In this phenomenological study, semi-structured interviews using an interview protocol as the primary form of data collection have been designed to reference other publications. A small sample size of 21 women who have recently delivered up to two months postpartum was interviewed in a religious setting outside their birthing health facility to allow adequate time to get detailed information on the phenomenon. The researcher ensured that the data collected was stored well and coded by hand and computer using NVivo software. NVivo is helpful for data management and analysis, with useful conceptual mapping features for presentation and analysis (Hilal & Alabri, 2013). Finally, this chapter presented the ethical standards that met the research study's approval through the rights mechanisms. It ensured that all the rights of participants were protected by maintaining the confidentiality and voluntary consent to participate in this study.

The following chapters (4 and 5) included an overview of the study and a presentation of findings from the analysis of collected data. The results are presented in a descriptive, narrative form rather than as a scientific report since the study is naturalistic. It also discusses the applications of the research findings to the conceptual/ theoretical framework and the implications for practice. Finally, I presented the discussions, conclusion, and recommendations resulting from the conduct of the study.

Chapter 4: Results

Overview of the Study

In the present research study, I sought to understand and describe the childbirth experiences and perceptions relating to the basic rights of childbearing women during facility-based intrapartum care, with a specific focus on Northern Sierra Leone. The problem identified in this study is that, even though an increasing proportion of women are giving birth in health facilities globally, maternal, and newborn mortality and morbidity reductions have not necessarily been met (WHO, 2019a). Evidence has suggested that in countries with high maternal mortality, the fear of D&A those women often encounter in facility-based maternity care is a more powerful deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance (Bohren et al., 2014). There is a strong relationship between childbearing women's experiences and their influence on maternal health outcomes (Redshaw et al., 2019). Research findings of Betron et al. (2018) showed that D&A affect maternity care quality and persist as an obstacle to safe motherhood, violating the rights of childbearing women.

Although so much is well-known about D&A in many Sub-Saharan African countries, there is limited or no qualitative evidence on the lived childbirth experiences and perceptions of basic maternal rights in Sierra Leone. This lack of evidence concerning women's lived experiences can lead to mismanagement of the birthing process, which is negatively traumatizing (SMFAI, 2017). Therefore, this research aimed to describe the lived childbirth experiences of Sierra Leonean women relating to their

fundamental rights alongside their perceptions of childbirth experiences relating to the principles of RMC. Notably, the following research questions guided this study:

Research Question 1: What are the lived childbirth experiences of Sierra Leonean women relating to their fundamental maternal rights?

Research Question 2: How do Sierra Leonean women perceive their childbirth experiences relating to the principles of RMC?

These research questions addressed Sierra Leonean women's childbirth experiences and perceptions. This chapter presents the results that aided in answering the above research questions. These results were obtained from a sample of 21 women between the ages of 18 to 45 from three districts in Northern Sierra Leone, namely Kambia, Makeni in Bombali district, and Kabala in Koinadugu district.

Research Setting

This qualitative research study was undertaken in three districts of Northern Sierra Leone. The study participants were purposefully selected to form a sample size of 21 to 24, depending on the saturation point. This sample size was adequate, given that it was within the recommended range of a minimum of 12 participants to achieve data saturation (see Clarke & Braun, 2013). This study reached data saturation by ensuring that no new information emerged during the interviews. Thus, the sample of 21 participants helped in ensuring that data saturation was achieved. A more comprehensive description of the study participants selected for this study, is provided in Table 3.

Table 3

Demographic Information of Study Participants

Participants	Ethnicity	Number of children	Marital status	Level of education	Employment status (occupation)
1	Themne	2	Married	Senior Secondary school	Self-employed
2	Themne	5	Married	Primary School	Self-employed
3	Limba	4	Married	Junior secondary school 2	working
4	Limba	1	Married	Senior secondary school 3	Not working
5	Susu	3	Married	Senior Secondary School 4	Not working
6	Themne	2	N/A	Junior secondary school 1	Working
7	Limba	4	Married	Junior Secondary 3	Working
8	Limba	1	Married	WASSCE	
9	Limba	1	Not married	WASSCE	Not working
10	Limba	1	Married	Senior Secondary school 1	Not working
11	Limba	2	Married	Senior secondary school 2	Not working
12	Limba	1	Not married	Senior secondary school 3	Not working
13	Limba	1	Not Married	Senior secondary school 3	Not working

14	Limba	1	Not Married	Senior secondary school 3	N/A
15	Themne	1	Married	Form 2	Not working
16	Themne	1	Not Married	Senior Secondary School 3	Not working
17	Themne	3	Married	Junior Secondary School 3	Not working
18	Themne	2	Married	Senior Secondary School 3	Not working
19	Themne	1	Married	Junior Secondary School 1	Working
20	Themne	1	Married	Senior Secondary School 1	Not working
21	Limba	1	Not Married	Senior Secondary School 3	Not working

Table 3 depicts the demographic characteristics of the participants of the present research study. There was a total of 21 women who participated in the study. The demographic information assessed included participants' ethnicity, the number of children each had their educational level, marital status, employment status, and the time of their last childbirth. Eleven participants were Limba, nine Themne, and one was Susu by ethnicity. The highest number of parities was five, and the lowest was one, which accounted for about half of the participants interviewed. Most of the women interviewed were married (14), whereas six were not married, and one of the women did not disclose her marital status. The highest educational level attained was West African Senior School

Certificate Examination **(**WASSCE) (two participants). Few women interviewed were gainfully employed (4), whereas most were unemployed (17). However, about 15 of these women who are unemployed claimed they are involved in petty businesses, such as trading, while two were self-employed and involved in hairdressing.

Data Collection

Before embarking on the actual study, a pilot study was undertaken to test the interview protocol's validity, credibility, and reliability. According to Malmquist et al. (2019), a pilot study plays a vital role in designing a research design that can be effectively implemented in the main study because it justifies the proposed research methods. Thus, it was essential to undertake a pilot study to ensure the reliability of the research methods outlined in the methodology chapter.

I identified three women from social connections to participate in the pilot study. I ensured that these women met the eligibility criteria to enhance the reliability of the pilot study's findings. Semi-structured interviews with open-ended questions were applied to collect data from these identified women. The pilot study outlined that the internal consistency and the questions' acceptability of the interview protocol was met. It further outlined that the interview questions were valid and reliable enough to collect the intended data.

The main study was undertaken to ensure the interview questions' reliability, acceptability, and validity. Twenty-one Sierra Leonean women of childbearing age participated in this study. The study participants signed a consent form to indicate that they fully accepted to participate in the study. After I clearly explained to them the

purpose of the study, the interviews began. These interviews were conducted between 27th May and 6th June 2022 and lasted 60 to 90 minutes per participant. The study participants were assured confidentiality, and no personal information that may link the responses shared in this study to the participants was asked or recorded.

The information collected from the study participants underwent data processing entailing the conversion of the raw data into written format through transcription. Data processing was done by transcribing the audio-recorded data into MS word format. After transcription, I keenly listened to the audio records to ensure that no words were misspelled, and no information was left out during the transcription process. The data were then ready for analysis.

Data Analysis

This study involved in-depth face-to-face interviews on the childbirth experiences and perceptions of women who have given birth in a health facility between May and June 2022 in Northern Sierra Leone. The interview transcripts were analyzed using NVIVO software to develop the themes. The transcribed interview files were uploaded to the software, where the responses were grouped into various codes based on the research question. After that, the patterns of the answers based on the established codes were used to come up with themes.

Presentation of Findings

This section outlines the presentation of the results of the analysis of the collected data. The generated themes are discussed with reference to the research questions and the study's conceptual framework. The coding made using NVIVO software as per the

data obtained from three districts (Kambia, Koinadugu, and Bombali) is shown in Figures 4 to 6.

Figure 4

Coding of Data From Kambia District

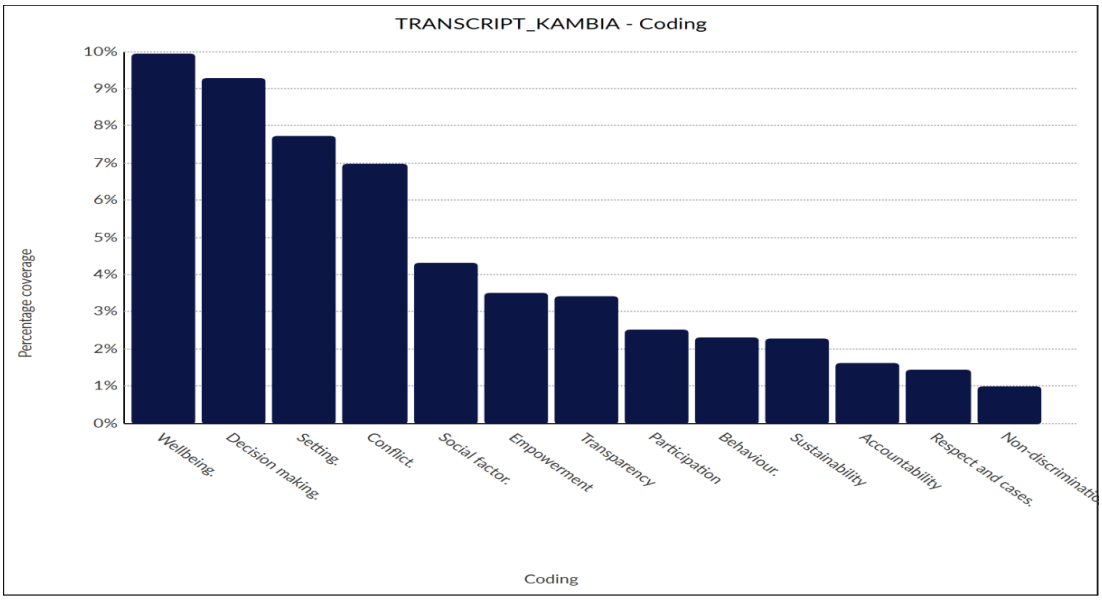


Figure 5

Coding of Data From Kabala District

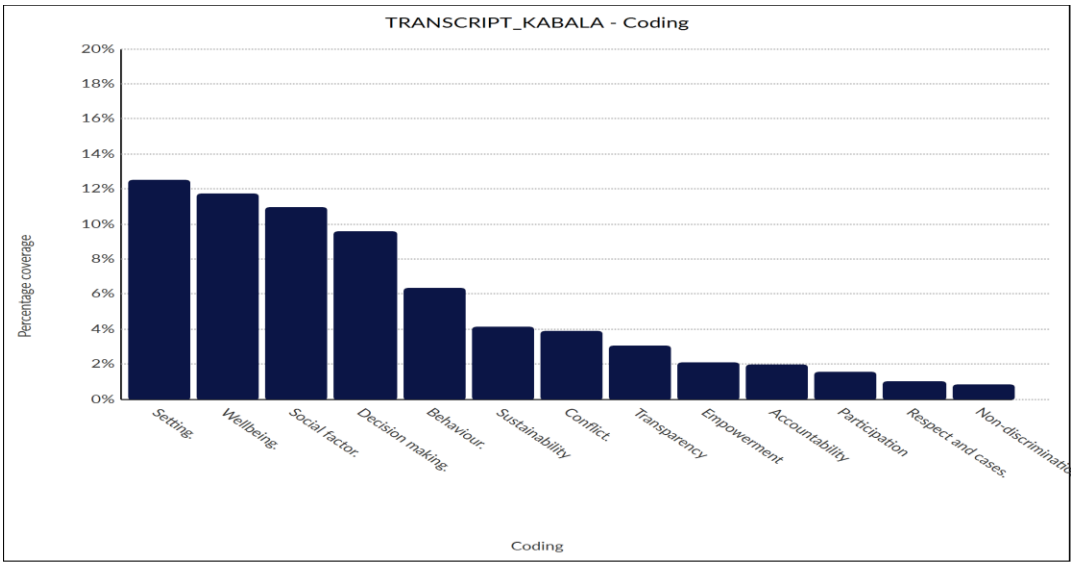
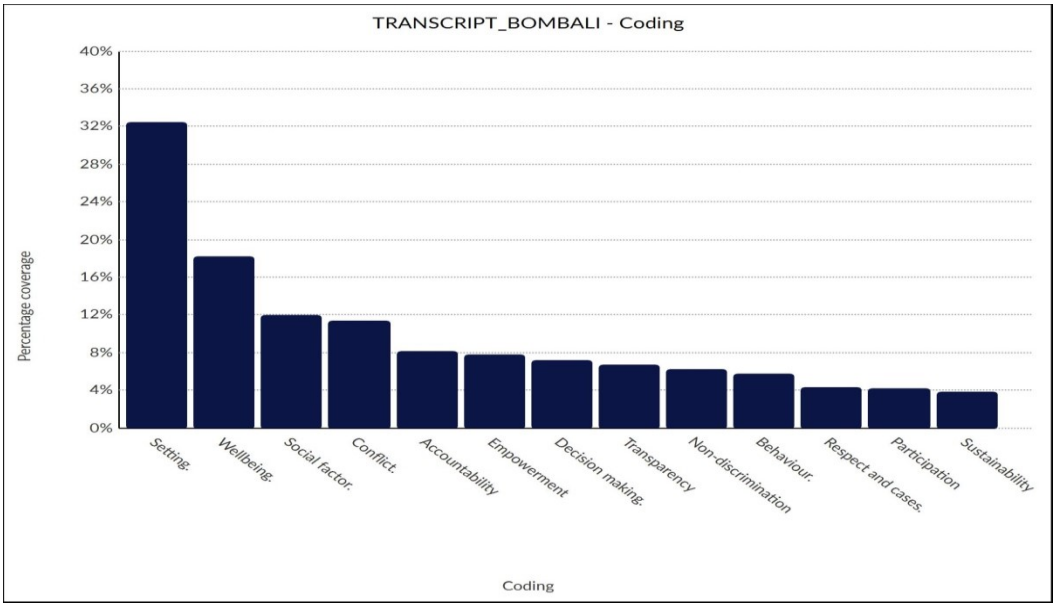


Figure 6

Coding of Data from Bombali District



The identified themes based on the first research question (What are the lived childbirth experiences of Sierra Leonean women relating to their fundamental maternal rights?) entailed accountability, empowerment, participation, sustainability, transparency, support factors, and maternal care setting.

The identified themes based on the second research question (How do Sierra Leonean women perceive their childbirth experiences relating to the principles of RMC?) entailed implications of health care providers' behavior, the role of social factor in maternal care, factors that lead to conflict in health care facilities, and factors that impact women's decision making. An overview of the themes, the research question alignment, and the number of supporting references are provided in Table 4.

Table 4

Overview of the Themes and Specific Research Question Alignment

Theme	Associated research question	Number of supporting references
Accountability	RQ1	21
Empowerment	RQ1	26
Factors that impact women's decision making.	RQ2	34
Factors that lead to conflict in health care facilities.	RQ2	22
Implications of health care providers' behavior.	RQ2	18
Non-discrimination	RQ2	12
Participation	RQ1	17
Respect and cases of abuse in facility-based childbirth.	RQ2	11
Support factor role in the wellbeing of women.	RQ1	53
Sustainability	RQ1	19
The relation between maternal care setting and quality of maternal care.	RQ1	56
The role of social factors in maternal care	RQ2	27
Transparency	RQ1	24

The codebook was generated from the NVIVO software to help describe each theme. Also, the codebook shows the number of files supporting each theme based on the three districts and the frequencies of each theme mentioned by the participants.

Table 5 shows the codebook describing each theme generated from the NVIVO software. An in-depth presentation of the respective themes is given below:

Table 5

Codebook

Name	Description	Files	References
Accountability	How women are treated in facility-based childbirth	3	21
Empowerment	The empowerment women receive during maternal care.	3	26
Factors that impact women's decision making.	Factors that impact women's decision making during maternal care.	3	34
Factors that lead to conflict in health care facilities.	Factors that lead to conflict in health care facilities regarding maternal care.	3	22
Implications of health care providers' behaviour.	Implications of Health care providers' behaviour while handling childbirth.	3	18
Nondiscrimination	The equality based on services offered to women during maternal care in a health facility.	3	12
Participation	The support women receive during maternal care	3	17
Respect and cases of abuse in facility-based childbirth.	The instances of cases that arise due to disrespect in facility-based childbirth.	3	11
Support factor role in the wellbeing of women.	Support factor role in the wellbeing of women during childbirth.	3	53
Sustainability	Improving maternal health to help save lives.	3	19
The relation between maternal care setting and quality of maternal care.	The relation between maternal care setting and quality of maternal care.	3	56
The role of social factor in maternal care	The role of social factors in maternal care	3	27
Transparency	The trustworthy and reliability of services offered at the health facility to help save lives.	3	24

Themes Relating to Research Question 1

Accountability

Accountability relates to the mechanisms put in place to ensure that the appropriate actions are taken to address how people's health rights are enacted through public health policies and practices and how failures are addressed (Riggirozzi et al., 2021). Thus, it entails putting the patient's best interests as priorities and justifying actions that tend to deviate from the expected standard in healthcare. This theme relates to the nature of women's treatment in facility-based childbirth. This treatment ranges from when the women got to the childbirth facility to when they were in the facility.

Most participants noted that they received a warm reception at the different facilities they visited. Some participants were physically given a helping hand by being held and supported, while others were politely addressed. For instance, Participant 1 pointed out the following: "As soon as we arrived in the hospital, I was held up from the gate to the maternity ward; I was very tired and weak."

Participant 8 further outlined that she was received politely: "I met one man and one woman upon my arrival at the health facility, they spoke politely to me. They asked me for the clinic card and gave it to them." Most of the participants also noted that the nurses at the facilities portrayed a polite and positive attitude towards them regarding their experiences at the facility. Participant 16 pointed out that the nurses that attended to her gave her urgent medical attention. She further added the following regarding the attitude of the nurses:

> The attitude of the nurses I met was positive; they spoke to me gently with encouraging words and assured me that I need not to be worried I would deliver safely. I felt good and pacified. I did not wait for a long time, and immediately after I arrived, I received good care and treatment. I was given much attention medically and emotionally. My case was very urgent. I was about to give birth to my baby. As soon as I arrived at the hospital, the baby was almost on the way to come out.

In agreement with the above sentiments, Participant 17 outlined the following:

> As soon as I arrived in the hospital, alighting from the motorbike, the nurses immediately received me. Knowing that my condition needed urgent attention, they treated me with great care. The midwives' and other workers' attitudes towards me were positive and well appreciated, with many thanks. No one shouted at me, no forceful command. I experienced very good treatment from the beginning (admission) to the end (discharged).

On the contrary, some participants noted that nurses' treatments were biased, given that some would offer better care to the patients they were familiar with. In agreement with this postulation, Participant 1 highlighted the following:

> Yes, there must be a difference, but they demonstrated to me the best of their nurse's moral ethics. There was no negative comment about me. I was their friend; I usually attend their clinics for check-ups and help plait their hair.

The nurses treated her well, owing to the familiarity they had. In line with these sentiments, Participant 3 shared the following: "I learned from other people before I

arrived in the hospital that pregnant women that go to deliver in the hospital are badly treated. But thank God I was not a victim. I was well received." The above sentiments were echoed by Participant 5 as follows:

> Shouting at patients, even spanking them, was not good. This is the worst disrespect. I felt so bad when I saw some nurses become so wicked to other women of low class. Another bad treatment was harassing for money, asking the women to pay for what is free for them anytime they go to the health facility to give birth; saying negative words of disrespect is very discouraging and embarrassing.

Participants 13, 18, and 21 cited incidences of negligence on the part of the healthcare providers attending them. This negligence resulted in nurses failing to stitch up the women after a tear or episiotomy and not effectively administering intravenous fluids. Participant 21 highlighted the following:

> They demanded money throughout, money for drip (IV fluids), money for delivery, money for stitches. You should pay the money before the work is done. I am not denying the fact that they don't know how to do their work, but the nurse who delivered me did not suture my perianal tear. Since it was my first pregnancy, I did not understand that I was supposed to be sutured. Until then, I returned home when I started bleeding. We had to return to the hospital.

Participants also reported instances of lacking privacy at the facilities they visited. This lack of privacy/confidentiality undermined their self-esteem since other people saw their nakedness and helplessness. Specifically, Participants 4, 6, 14, and 21 noted that

they lacked privacy when giving birth. For instance, Participant 6 pointed out the following:

> Upon arrival at the hospital, I was led into the labor room. I was not asked to pay for an admission card; no charges were levied on me. The labor room was clean and neat. There was no privacy maintained in the room. It was open that one could see everything around. I preferred to be treated privately. I was not happy most people watch at you when the doctor is viewing you.

Generally, the study participants reported they received diverse childbirth experiences at the facilities they visited for their last childbirths. While the majority claimed they received good care with nurses and healthcare providers offering good treatment characterized by positive attitudes, the others reported negative experiences militating against their maternal rights. Participants indicated that they were unhappy with the ill-treatment they received, courtesy of the negligence of the healthcare providers. The lack of privacy also added to the poor treatment meted out to these women. These findings constitute the experience of care as outlined by the framework.

Empowerment

This theme relates to the empowerment that women received during maternal care. This empowerment was in the form of providing information, material, and financial support to these women. This aspect of empowerment reflects the experience of care that women receive, as stipulated in the conceptual framework. From the interviews, the study participants noted that they received diverse forms of empowerment from different people. Firstly, most participants confirmed that they received a wide range of

information from nurses during the clinics they attended. This information helped them a great deal to prepare for childbirth and to make the right decisions regarding birth. Most of the study participants were empowered to attend antenatal clinics from where they acquired useful information as outlined by Participant 11: “In the antenatal clinic I attended, I was told to buy some baby items; like pampers, lappas, detail, soap, etc. My husband helped me by providing the money to purchase these baby items.”

Participants 5, 7, 9, and 10 added that attending antenatal clinics gave them insights into the need to give birth in healthcare facilities. Notably, the nurses at the facilities empowered them to make the right decisions regarding the places to give birth. This was elaborated by Participant 7 as shown below:

> I have been attending antenatal clinic during my last pregnancy, and the nurses advised me strongly to deliver my baby in a health facility. But I decided to go to the hospital because the doctors will help me if I have complications. Nothing would have prevented me from reaching the hospital. We have motorbikes around.

The participants also noted that they received material support from their families. Specifically, they received financial support to purchase items they needed for childbirth. Thus, this was a form of economic empowerment for them in the face of challenges associated with pregnancy and childbirth. For instance, Participant 7 shared,

> I went through a lot of constraints before the birth of this child. First, I didn’t know I was pregnant because I was seeing my menses. I became ill for some time. We were told in the clinic to bring to the hospital when in labor, burn oil,

> pampers, pad, baby clothes, and lappas. My husband helped me to provide the money to buy the items.

Generally, the participants unanimously noted that they received some form of empowerment from family, neighbors, or nurses during pregnancy and childbirth. This empowerment enabled them to go through pregnancy and childbirth quite well.

Participation

This theme presents the support that women receive during maternal care. This theme represents the care experience, as outlined by the conceptual framework. It is also in line with the ecological systems theory, given that women's experiences were impacted by their environments and, specifically, individuals surrounding them.

Participation entails the emotional and moral support that women also receive during this period. This type of support was offered right from when the women went to the hospital, before and after giving birth. Most participants pointed out that they had people such as their spouses and relatives who accompanied them to the healthcare facility where they gave birth. Participant 12 noted that she was accompanied to the hospital. She said the following:

> My labor pain started at 6:00 a.m. in my house. I was just walking aimlessly inside the house at about 6:00 p.m. I decided to go to the hospital. My mother, who was with me, accompanied me to the hospital.

Similarly, Participants 3, 9, 11, and 21 outlined that they were accompanied to the health facilities by their aunts and mothers because they were experienced with matters of

childbirth. Specifically, Participant 9 highlighted that her aunt was a nurse who also helped her:

> My aunt was with me in the labor room to help the other nurses, she too is a nurse, but she left abruptly to attend to an ambulance call in the hospital. I met other women in the labor room, we all received the same treatment, but after that, they went away.

Besides being physically there for them, the participants noted that they received emotional and moral support from the people surrounding them during labor. Participant 8 highlighted the following: “My aunt was in the labor room with me while waiting; she supported me with encouraging words and massaging my back when I was suffering severe labor pain.”

Furthermore, participants also reported that they received moral support from their relatives after giving birth. For example, Participant 17 said that she received moral support from her sister, who was allowed into the labor room.

> The sooner I arrived in the hospital, I received good care and treatment from the midwives and other workers. I was immediately augmented. Just after that, I quickly delivered a good and healthy baby. My baby was placed on a post-natal bed, and some hygiene work was done on me by the low-grade nurses. My sister, who accompanies me to the hospital, witnessed all that happened in the labor room. She was told to go out, but I insisted for her not to leave me, I held onto her clothes, and then the nurses accepted her to stay in to let me feel happy.

The participants also reported that they encountered kind staff who treated them well and gave them much-needed support to make them feel better. Most of them unanimously noted that the nurses attended to them and their newborn babies quite well, washed their babies while maintaining a high level of hygiene, and helped them to breastfeed their babies. This was elaborated by Participant 9 as follows: “As soon as I delivered, the nurses attended to me and my baby, throughout, hygiene was maintained, and I was transferred to the post-natal bed with my baby in good condition, early initiation of breastfeeding was done.”

Furthermore, in the instances where no relative was allowed to the labor room, the nurses stepped in and offered the much-needed moral and emotional support as pointed out by Participant 6 below:

> I needed someone to be by my side to support me, like my mother, but she was not allowed to come in the labor room. My father too was around but had no way to help me. However, the nurses greatly supported me; they massaged and injected me. I was comfortable in the hands of the health workers.

On the flip side, a few women reported not receiving the support they needed. For instance, Participant 15:

> When we alighted at the hospital, the nurse on duty took me inside the consultation room. The doctor immediately came into the room to examine me, but it was not yet time for the baby to come out. At exactly 12:00 noon, I delivered a bouncing baby boy. No one was me to support me when I was

> experiencing severe labor pain. The people I met in the labor room were asked to go out of the room. It was my wish for them to stay in to help support me.

The above was echoed by Participant 11, who said that no one offered her the support she needed in the labor room. She noted,

> I was comfortable with my position on the bed to deliver my baby. Even though I did not receive much support, it was all by myself pushing before the baby came out. I called for my sister, but she was not allowed to enter the labor room.

On a general note, most of the study participants received the moral, emotional, and physical support they needed at the facilities they were admitted. However, only a few were denied the support they required. Thus, the different treatments were reported from various facilities by the women.

Support Factor Role in the Wellbeing of Women

This theme explores the role that supports plays in the well-being of women during childbirth. Given that the prior theme of participants explored the kind of support the women received, this theme investigates the roles that the support received played in ensuring the well-being of women during childbirth. Most of the study participants noted that the help they received from the nurses in the healthcare facilities in the form of urgent medical attention, good care, and treatment made their deliveries safe and timely. This enhanced their well-being. Participant 1 reported that she called for an ambulance promptly sent to her, enabling her access to medical care at the health facility. She shared the following:

> I was walking aimlessly up and down as the pain became more severe, I alarmed and screened, I called for the ambulance for the emergency drive to the hospital. My sister was with me. I did not feel good. An IV fluid was set up upon my arrival in the hospital.

The promptness and quick care at the health facilities, which aided immediate medical care and child delivery, was further echoed by Participant 16 as follows:

> The attitude of the nurses I met were positive, they spoke to me gently with encouraging words and assured me that I need to be worried I will deliver safely. I felt good and pacified. In fact, I did not wait for long time. Immediately after I arrived, I received good care and treatment. I was given much attention medically and emotionally. My case was very urgent. I was about to give birth to my baby as soon as I arrived at the hospital the baby was almost on the way to come out.

The participants also pointed out that the good support they received during childbirth made them feel good, thus bolstering their well-being. Participants 2, 3, and 7 reported that the support and treatment they received during birth made them feel good. Participant 7 reported the following:

> After delivery, I was still bleeding. They said I needed a blood transfusion. I went to the lab to be checked, but they later said I just needed blood medication. So, the nurse advised me what to do when I got home. I felt good about the care they gave to me.

The support that the women received from senior staff, such as doctors at the facilities, also ensured that the women's healthcare rights were not violated, as outlined by Participant 2 below:

> The doctor was nice and caring, full of professional ethics. He did not allow any of the nurses to maltreat the patients. He makes rounds every morning and evening to give us medicine. Not a single person was asked to pay money for medicine.

Generally, from the lived experiences of the study participants, it is safe to note that the support they received during childbirth enhanced their well-being. This support makes them feel good about themselves, appreciate the good care, and guarantees safe and quick deliveries. Therefore, this improved their well-being. This theme conforms to the perception of care, as outlined by the conceptual framework. Notably, the aspect of wellbeing depends on the experience of care, which yielded the above perceptions, as described by the study participants.

Sustainability

This theme relates to the ways of improving maternal health to help save lives. It represents both the structure of maternal care and the experience of maternal care since the aspect of sustainability relates to the nature of respect women receive in healthcare facilities. The study participants shared their experiences at the hospitals they visited for deliveries regarding maternal health. When asked about the recommendations for enhancing improved maternal care for sustainability, the study participants narrated different aspects they would love to be upheld, corrected, or improved to bolster maternal

care in Sierra Leone. Some of these aspects encompassed the issue of health workers demanding money in public hospitals, rudeness of the nurses, lack of privacy, drugs, and failure of nurses and doctors to educate women on the use of the prescribed medications.

Some participants narrated that women at the facilities were asked to pay different fees to receive some services or treatments. Participant 19 highlighted that the healthcare provider at the facility she attended demanded money from her. Similarly, Participant 7 noted that she was asked to pay fees for soap at the hospital. Participant 2 further added that those women who did not have money were given poor treatment, unlike those with money. The following were her sentiments:

> Those who have no money are not well taken care of in the hospital; you will be molested, alter many negative words against you. You will be well attended if you have money. If you don't have money, you will be discouraged and suffer. If you have money, the best attention will be given to you, they provide whatever you request, and speak to you nicely. Cultural respect is only given to those that have money.

Thus, the participants opined that abolishing such fees in public facilities would enhance access to good maternal care. Participant 16 said, "Hospital workers demanding money from the patients is not realistic. According to government policy, treatment for pregnant women is free." In addition to the issue of fees, Participant 18 noted that the government should also avail sufficient drugs and supplies to discourage nurses from demanding money from women. This would ensure equal access to maternal care for sustainability. She stated,

> The only thing is that we are begging the nurses and the government to help us. Because the nurses are saying, there are no drugs in the hospital. If medicines are available, we will not pay much for many things except give them thank you gifts.

The nature of the treatment meted out to the women was another major issue of sustainability raised by most of the study participants. Although most of them noted that they received good care, they revealed that they witnessed other women being mistreated and recommended that nurses should cease these ill-treatments on women. Participants 6, 17, 11, and 20 strongly argued that the nurses at healthcare facilities should stop shouting at pregnant women and try to be polite to them. Participant 18 stated the following:

> My final word to the Government of Sierra Leone is to please warn the nurses that have bad attitudes towards pregnant women to desist. They should be polite and show complete cultural respect. This will motivate most women, if not all, to go to the hospital to deliver their babies, and risk factors will reduce.

Another major issue regarding improving maternal care to enhance sustainability raised by the study participants is privacy. Many of them noted that privacy is an essential pre-requisite during delivery. Participant 9 articulated that privacy is a promising treatment for women who visit health facilities to deliver their babies. Participant 6 further noted that lack of privacy, characterized by failure to cover women's nakedness, is considered a non-dignified treatment of women that violates the rights of childbearing women, and should be addressed. Participant 21 commented on privacy: "For me, the patient's privacy matters a lot. The nurses who are in the labor room are the

only ones who should be there. Those coming to learn should not be there when we are birthing."

The issues that the participants identified above are the recommendations for improvement. These improvements would guarantee the enhancement of maternal health to help save lives.

The Maternal Care Setting

This theme describes the relationship between the maternal care setting and the quality of maternal care offered. It represents the structure of care, experience of care, and the perceptions of care, as outlined in the conceptual framework. This is because the study participants gave accounts of their experiences and perceptions based on the structure and nature of the care, they received in the various health facilities they visited. This theme also conforms to the provider and facility factors' influence on RMC, as pointed out by this study's ecological systems theoretical framework.

The theme explores the relation between the setting of maternal care and the quality of maternal care offered per the study participants' lived experiences. All the participants of this study had their last childbirth at a health facility. Most women said they visited these facilities because they felt safe, citing that the health facilities guaranteed safe childbirths and complications could be handled promptly. This was elaborated by Participant 4 as follows:

> My intention or focus was to go to the health facility to give birth. Generally, I decided to give birth at the health facility for the safe delivery of my baby, and I was supported by my mother and other relatives in this decision. My main reason

> is that this was my first pregnancy; in the hospital, I will be free from the risk of death.

The above was echoed by Participant 4, who stated the following:

> The Kabala govt. Hospital is one of the best hospitals in Koinadugu District, and I was advised during my clinic days not to give birth in any other place but in the Govt. Hospital, I, therefore, decided to give birth at the government health facility, also, to enhance safety delivery, with the help of experienced midwives.

When asked about the nature of the support and treatment they received at the health facilities they attended, the participants had varied opinions. The majority of them noted that they received good care. Participants 4, 5, 6, 7, 8, 10, 12, 16, 17, and 20 reported that they received good treatment at the health facilities characterized by urgent medical attention, respect from the nurses, and polite treatment. Participant 4 stated the following:

> Upon arrival at the health facility, I met three ladies who offered me free medical treatment. I did not pay for the admission fee or charged to pay for a card or chart. I couldn't identify them, whether they were nurses or not. They did not do anything for me. They only told me to enter the labor room and wait there. Not too long, they attended to me quickly. The staff that helped me to deliver my baby comported well to me; they did not shout at me. They spoke so nice to me.

On the contrary, a few participants reported incidences of ill-treatment, abuse, and incidences of negligence from the health workers. Participant 13 said despite receiving good treatment, she witnessed a woman who was neglected by nurses and lying in a pool

of blood after the nurse who helped her deliver failed to remove the placenta. In another incident, Participant 18 noted that the nurses did not stitch up a tear she had while giving birth, causing her a lot of pain. She added the following:

> After delivery, I was soiled with blood. I was told to pay for the pad. I was not with money anymore, so they did not give me the pad until my husband came to pay for it. I was soiled in blood, but they refused. I was not treated well, especially after delivery. The nurse who delivered me knows her work. The rest of them are new nurses. One of them set up intravenous fluid and had my arm swollen. She did not know how to do it. I have had the pain up till now. My husband paid a delivery fee; I do not know how much he paid.

Some participants also reported that some health workers demanded money from the women in government health facilities, despite such services being deemed free. This was elaborated by Participant 16, who expressed the following: *"*Hospital workers demanding money from the patients is not realistic; according to government policy, treatment for pregnant women is free of charge."

The participants unanimously agreed that giving birth at home did not guarantee good maternal care since the traditional birth attendants were not competent enough. Participant 12 stated the following:

> My aunt helped me decide to give birth at a health facility; we thought that we would receive better care from trained and qualified nurses in the hospital than in the hands of Traditional birth attendants (TBAs) at home.

Participant 15 concurred with the above postulations by stating, "But to deliver at home, most of the TBA's are not well trained. Therefore, if a pregnant woman falls in their hands to birth her baby, it will be dangerous, and the risk factors will increase."

Overall, the study participants gave their diverse experiences regarding the maternal care they received per the settings of the facilities they visited. Most of them reported receiving good care from healthcare workers, while only a few reported incidences of ill-treatment and negligence. Notably, the participants stated that giving birth at home increased the chances of birth-related complications.

Transparency

This theme relates to the trustworthiness and reliability of services offered at the health facility to save lives. It exemplifies the structure of care, as presented in the conceptual framework. It describes the trustworthiness and reliability of these services per the study participants' lived experiences. Most of the participants highlighted they received reliable services that helped save their lives, alongside that of their babies. Participants 1, 3, 5, 8, 9, 10, 15, 16, and 17 agreed that they received reliable services that helped them have safe deliveries, thus saving their lives. Specifically, Participant 8 stated the following:

> Nurse... helped to deliver me, and I was much comfortable, the position I was in when giving birth to my baby. I felt cold and tried to cover myself with clothes, but I was not allowed to do so; nurse……. told me the hour had reached for the baby to come out, so needless to cover myself. Nevertheless, I felt good by then; all the nurses were alert to receive my baby.

Regarding the swiftness of the services at the health facility, Participant 10 had the following to share:

> I did not wait for too long, when I arrived at the health facility; The nurse said to me, 'We will soon attend to you when it is time for you to deliver. The nurses treated me with good care and talked to me politely with encouraging words.

On the flip side, some participants were unhappy about the money they were asked to pay for services provided. Thus, this act of demanding money from the women undermined the trustworthiness of services offered at the facilities. Participants 3, 12, 15, and 19 revealed that they were not happy that money was demanded from them for various services. Participant 12 stated the following:

> What I did not like was demanding soap and money from women after delivery of the baby. I was asked to pay Le. 30,000 discharge fees, and I paid. I paid against my wish, thinking that it was a free medical care hospital. It is not a private hospital.

Further, it emerged that those women who did not pay the needed money did not receive good treatment. This was elaborated by Participant 3, who noted that “another risk was lack of finances; if you have money, you will be taken care of, but no money, no one cares for you.”

Some nurses also collected money from the women but did not offer the treatment for which the money was intended. This was explained by Participant 15 as follows:

> After delivery, we were asked to pay Le 60,000 each for one injection, and I paid for it, but unfortunately, I was not injected, but money was collected. Nurses

collecting money from patients and never receiving what was paid for is absolute corruption.

The above narrations from the study participants explain the theme of transparency in maternal care. Some actions, such as offering quick and good treatment, enhance the reliability of maternal care services to save mothers' and babies' lives. On the contrary, demanding money downplays the reliability and trustworthiness of these services.

Themes Related to Research Question 2

Factors That Impact Women's Decision Making

This theme explores the factors that influence women's decision-making during maternal care. It represents the structure, experience, and perceptions of care, as pinpointed by the conceptual framework. Besides that, it conforms to the ecological systems theory, given it highlights the factors that impact women’s decision-making about maternal care. These factors all fall within an individual’s ecological system.

The study participants described various factors that made them arrive at the different decisions they made, including giving birth at a health facility. One outstanding factor was the fear of developing birth-related complications, which made them decide to visit health centers. Participants 4, 6, 9, 10, 15, 18, and 21 argued that they chose to give birth in a health facility because they feared that giving birth at home would expose them to risks related to childbirth. For example, Participant 6 stated the following:

> I decided to give birth at the health facility for fear of bleeding; I experienced severe bleeding when I gave birth to my first child. My mother endorsed this decision to give birth to my baby at the health facility.

Most of the study participants also noted that the good care they would receive at the health facilities made them opt to give birth in those facilities rather than delivering at home. This was highlighted by Participant 17, who stated: “With such a fear in me, I decided not to deliver at home but deliver at the government hospital to prevent any problems. In the hospital, I will surely receive greater assistance.” Participant 12 agreed with these views and revealed the following:

> My aunt helped me decide to give birth at a health facility; we thought that we would receive better care from trained and qualified nurses in the hospital than in the hands of Traditional birth attendants (TBAs) at home.

Other people's opinions also emerged as another key factor influencing women's decision-making. Most of the women outlined that they were supported by their relatives and people around them, such as neighbors, to decide to visit a health facility to give birth. To these women, the opinions of those around them mattered. Participants 3 and 19 noted that their husbands influenced their decision to give birth at a health facility. Participant 19 stated the following:

> My husband advised me to go to the hospital, even though I wanted to have my baby at home because I usually have shorter labor pains. He said I joined the clinic at the hospital, so I had the right to go there to have my baby. The only reason I would not have delivered at the hospital is faster and shorter labor.

Advice from health workers in the antenatal clinics that the women visited also influenced their decision-making during their maternal care. They unanimously pointed out that the nurses they met at the clinics advised them to ensure that they do not deliver at home but to visit the health facilities for their childbirths. The study participants stated that they took the nurses' warnings seriously, which informed their decision-making. This was comprehensively elaborated by Participant 10 as follows:

> Generally, the hospital is the only safe place to give birth to your baby. During my clinic days, the nurses gave very strict and strong warnings that no account pregnant woman should give birth in any other environment rather than the government health facility; this will help to avoid risks and future discouragement. With this in my memory, I decided to give birth in the government health facility. Nothing would have stopped me not to give birth to my baby in the government health facility.

Overall, diverse issues affect women's decision-making about childbirth and maternal care. Among the notable factors identified from the study participants' narration is the fear of developing birth-related complications if they delivered at home, the good care received in health care facilities during childbirth, opinions of people close to the women, and advice from health care providers. All these factors influenced the decision-making of the study participants. It was noted that the availability of finances was not a major factor that influenced the decision-making of the study participants. This was confirmed by Participant 1, who said that even if she did not have money, she would still visit a health facility to give birth. She stated the following: "No financial difficulty will

make me not to go to the hospital to give birth to my baby." Therefore, the financial factor did not emerge as an influence on women's decision-making during childbirth.

Nondiscrimination

This theme relates to the equality based on services offered to women during maternal care in a health facility. It reflects the structure and experience of care aspects of the conceptual frameworks. The theme explores the aspect of RMC with respect to equality in rendering maternal services as per the lived experiences of the study participants. The study participants narrated diverse experiences relating to the issue of equality and inequality in maternal care at the healthcare facilities they attended. Some reported that they received good and humane treatment, which is what was equally given to the other women they interacted with at the health facilities. For example, Participant 9 stated, "I met other women in the labor room, we all received the same treatment, but after that, they went away." In congruence with these observations, Participant 10 stated the following:

> I had a friendly treatment in the health facility just as I told you earlier, the attitude of the workers was good. They spoke to other women and me politely, encouraging words of motivation. I felt the same as if I were at home. Respected and privacy well maintained.

On the other hand, most participants noted that they witnessed discriminatory treatments being offered to some other women they interacted with at the healthcare facilities. Participants 1, 2, 5, 13, 14, and 16 revealed that they witnessed other women being discriminated against by being given poor quality care compared to other women.

Specifically, Participant 5 stated, “In the future, I would like to tell other women to go to this health facility, the care and treatment for pregnant women is good. However, not all are treated equally for reasons best known to them.”

Some study participants outlined some of the reasons disparate treatments were offered to different women. Amongst these reasons is familiarity with the nurses or other healthcare workers, records of clinic attendance, one's social class, and availability of money. Notably, those who did not attend antenatal clinics were humiliated and harassed by the nurses, as affirmed by Participant 13: "the women that did not attend complete clinic hours were humiliated.” Those familiar with healthcare workers in the facility were given good treatment and not asked to make any payments. This was revealed by Participant 16, who stated, “After delivering my baby, I did not pay for anything, it was free treatment, but all was through the influence of a friend of mine working in the hospital.” In line with these revelations, Participant 1 stated the following:

> Yes, there must be a difference, but they demonstrated to me the best of their nurse's moral ethics. There was no negative comment about me. I usually attend their clinics for check-up, and I always help to plait their hair. I was their friend.

Regarding one's social status, women from low-class backgrounds and who lacked money were given ill-treatments. Participant 15 outlined that any woman who did not have money to pay the discharge fee was not given a discharge paper. This was comprehensively elaborated by Participant 5 as follows:

> Shouting at patients, even spanking them, was not good. This is the worst disrespect. I felt so bad when I saw some nurses become so wicked to other

> women of low class. Another bad treatment was harassing for money, asking the women to pay for what is free for them anytime they go to the health facility to give birth; saying negative words of disrespect is very discouraging and embarrassing.

The above narrations outline the experiences of the study participants regarding the topic of non-discrimination in healthcare facilities. From these narrations, it is evident that instances of both non-discrimination and discrimination are witnessed in maternal healthcare facilities. The non-discrimination emanates from rendering equal services to all women without bias. On the contrary, discrimination is characterized by incidences of disparate treatment to the women on different grounds such as social status, familiarity, and failure to attend antenatal clinics.

Factors That Lead to Conflict in Health Care Facilities

This theme describes the factors that contributed to conflicts in healthcare settings regarding maternal care. It relates to the structure and experience of care as per the study's conceptual framework. Specifically, the factors brewing conflict relate to the nature of care that the healthcare providers give to the women and the behaviours of the healthcare providers and women during childbirth at the facilities. Moreover, the theme aligns with the ecological systems framework since these factors emanate from these women's social environments surrounding birth.

The participants of this study identified various factors that led to conflicts between the healthcare workers and the women who delivered their babies in these facilities. One of these factors is the failure of pregnant women to visit antenatal clinics.

It would cause the nurses to harass these women due to a lack of clinic records. This was elaborated by Participant 8 as follows*;* "they treated me so well when I produced my clinic card. It would have been difficult for me without my clinic card." Participant 13 further noted that the women who did not attend antenatal clinics were humiliated by the nurses. Adding to these sentiments, Participant 21 stated, "Yes, they were treated well. They were not shouting at them, except for one woman who did not attend her antenatal clinic at the hospital."

Another factor that contributes to conflicts in maternal healthcare facilities is the mistreatment by nurses and other healthcare workers. Specifically, this mistreatment was in the form of impoliteness and shouting at the women during delivery. These mistreatments made the women feel disrespected and highly disagreed with these nurses' treatments. Participants 6 and 11 outlined that they were highly displeased and disagreed with the disrespect they received from the nurses attending them. Specifically, Participant 6 made the following remarks:

> We don't like the midwives or nurses to shout or yell at us while giving birth. The idea of interactions is very good, they will ask us to dance, jump, and other exercise games to help ease out the pain and avoid prolonged pain.

Failure by the women to follow instructions given to them by the nurses at the facilities contributed to conflicts between themselves and these nurses. Participants 15, 17, and 18 stated that the nurses would get into serious disagreements with women who defied the instructions. Participant 17 comprehensively described this as follows:

> It is true that nurses are in the habit of shouting, disrespecting pregnant women that go to health facilities to deliver. According to my experience and observation, it depends on the cause or should be directed to some patients. Some patients are the causes of the misbehavior or bad attitude from the health workers, especially female nurses. Most of the pregnant women that go to the health facilities to deliver never dress decently, put on dirty and torn clothes, with stinky body odor that is offensive, never brush their teeth, etc. How can such women deserve respect in a public environment? These are the women the nurses always shout at and disrespect, particularly those with pride; they refuse simple correction and fail to listen and obey the teachings nurses give them during their clinic periods.

Another factor attributed to conflicts in health facilities by the study participants is a late arrival at the health facility. The participants narrated that the women who arrived late exposed themselves to disagreements with the nurses at the facilities. Participant 8 noted the following: “One of the risk factors for disrespect at the facility is shouting and too many commands by nurses in talking to women, especially women arriving late at the health facility. In agreement, Participant 15 said; “Going to the hospital late was not good; being a victim already, such attitude will cause the nurses to speak to you impolitely, even shouting at you.”

From the lived experiences of the study participants, diverse factors contribute to conflicts between women and the nurses at the health facilities they visit for maternal care. These factors include late arrival to the health facilities, failure by the women to attend antenatal clinics, failure by the women to follow instructions, and mistreatment by

the nurses. These factors often become the basis for conflicts, such as women being shouted at by the nurses.

Implications of Health Care Providers' Behavior

This theme describes the implications of the healthcare providers' behavior while handling childbirth as per the lived experiences of the study participants. From the description of the participants, it was clear that there were both good and ill treatments for women during childbirth. The study participants described the kind of care they received and the behavior the health care providers displayed while handling childbirth. Most of them narrated that the care given to them, and their babies and the attitudes and behavior of the healthcare providers impressed them. Participants 2, 3, 4, 5, 6, 9, 14, 17, and 19 stated that the treatment and behavior they observed from the healthcare providers made them feel good, happy, and impressed. For instance, Participant 6 stated that; *"*the nurses did their best to contain me. Overall, I felt good for the person that delivered me. She was very efficient.*"* This was further elaborated by Participant 17, who stated the following:

> The sooner I arrived in the hospital; I received good care and treatment from the midwives and other workers. I was immediately augmented. Just after that, I quietly delivered a good and healthy baby. My baby was placed on a post-natal bed, and some hygiene work was done on me by the low-grade nurses. My sister, who accompanied me to the hospital, witnessed all that happened in the labor room. She was told to go out, but I insisted for her not to leave me, I held onto her clothes, and then the nurses accepted her to stay in to let me feel happy.

The study participants also noted that the good behavior and treatment they received satisfied them. Thus, this was an indication of a positive implication. Participants 4, 5, and 14 expressed that the nurses' and midwives' behavior was satisfactory. For example, Participant 5 stated, “I was satisfied with the support I received from the health workers at the facility, it helped me so much, did not prolong my labor pain, and I delivered quickly.” Participant 4 further noted that she would refer other women to the facility due to her satisfactory services and observed behavior. She stated the following:

> Yes, I will tell other women to go to the health facility to deliver. I will always go to the health facility to deliver my baby because it is safe for me and there is much caring; the attitude or behavior of the nurses is satisfactory.

On the contrary, some participants reported that they were not impressed with the behavior of some healthcare providers. This is because some nurses shouted at patients and mistreated them. This exemplifies the negative implications of healthcare providers’ behavior as perceived by the study participants. Participants 6, 13, and 15 pointed out that they were not impressed with some negative behaviors depicted by the health care providers. For instance, some nurses could not cover the women to protect their privacy, which was not impressive to some women, such as Participant 6, who stated the following:

> The labor room was clean and neat. There was no privacy maintained in the room. It was open so that one could see everything around. I preferred to be treated

privately. I was not happy most people watch at you when the doctor is viewing you.

Generally, there were negative and positive implications of the health care providers' behaviors during childbirth. The good behavior and treatment made the women happy, impressed, and satisfied to the extent that some were willing to recommend other pregnant women to deliver in those health facilities. On the other hand, the ill-treatment and negative attitudes led to the women being less than impressed. The above implications conform to the ecological systems theory. This is because the healthcare facilities represent the ecologies of the women, while the healthcare providers are the factors who impact their experiences and whose actions cause the discussed implications. These implications also relate to the experience and perceptions of care outlined in the conceptual framework.

Respect and Cases of Abuse in Facility-Based Childbirth

This theme explores cases arising due to disrespect in facility-based childbirth as per the experiences of the study participants. It relates to the experiences and perceptions of care per the study's conceptual framework. The study participants said they experienced respect, disrespect, and abuse during childbirth at the health facilities. The instances of D&A resulted in women being shouted at and some being beaten by the nurses. Many of the participants reported that even though they did not experience abuse and disrespect themselves, they witnessed other women being shouted at, as narrated by Participant 5, who stated, "Shouting at patients even spanking them was not good, this is the worst disrespect, I felt so bad when I saw some nurses become so wicked to other

women of low class." Participant 10 further stated that some nurses beat women. She described the following scenario:

> Many times, nurses become arrogant to women when helping to deliver their babies; they abuse and disrespect them so much. They beat them if they fail to put more force to push the baby to come out instead of being nice to women in severe labor pain. This kind of behavior is very inhuman.

Another form of disrespect, as given in the accounts of the study participants, was being denied privacy. Some of the study participants highlighted that giving birth while other people witnessed them and saw their nakedness as a sign of great disrespect to them. Participants 3, 6, 14, and 16 highlighted that they did not like the lack of privacy during childbirth. For instance, Participant 3 stated,

> "You are completely exposed out all people see you and what is being done with you, no privacy. This was kind of disrespect to the patient." She further added, "when they ask you to open your legs to view you is disrespect. I did not like to open my legs for viewing me. It was shameful and disrespectful".

Failure to seek the patients' consent before undertaking any procedure on them was another case of disrespect to the women, as narrated by Participant 6, who stated the following:

> Some bad treatments we don't like done to us at the health facility are treatment given to us without our consent (they inject you at any time against your wish) and there is no privacy in the rooms, they will ask you to open your legs for viewing nothing to cover your nakedness.

On the positive side, some women showed utmost respect at the childbirth facilities. Participants 2, 4, 6, 10, 13, 15, and 17 reported that they experienced much respect and no abuse from the healthcare providers at the facilities they visited for their last childbirths. For instance, Participant 4 said; that the staff that helped me to deliver my baby comported well to me. They did not shout at me; they spoke so nicely to me. Participant 10 further elaborated that she felt respected as per her account as follows:

> I had a friendly treatment in the health facility just as I told you earlier, the attitude of the workers was good. They spoke to other women and me politely, encouraging words of motivation. I felt the same as I was at home. Respected and privacy well maintained.

From the narrations of the study participants presented above, D&A often occur during facility-based childbirths. As per the above narrations, disrespect was in the form of shouting and beating women, denying them privacy, and performing treatments without their consent. On the positive side, some women noted that they experienced respect. Thus, respect and disrespect cases are bound to occur during facility-based childbirth.

The Role of Social Factors in Maternal Care

This theme describes the roles that the social factor plays during maternal care as narrated by the study participants. Under this theme, the accounts of the study participants relating to the roles of social factors in maternal care are presented. Participants 2 and 4 noted that women from low socio-economic backgrounds received ill-treatment, including being shouted at. Specifically, Participant 2 highlighted, “ Most

people in the hospital are not given equal treatment, as others receive good treatment others do not, especially if you do not have money to pay. This was one of the sad events I experienced." Participant 4 further noted that these women were given ill treatment because they came from low social backgrounds. She stated the following: "shouting at patients, even spanking them, was not good; this is the worst disrespect. I felt so bad when I saw some nurses become so wicked to other women of low class." The above sentiments were echoed by Participant 14, who narrated the following:

> Well, like some nurses will shout at you when you are in labor, they will curse you: "get out of my, when you were enjoying, I was not there." Also, if you do not have money, you will not be prioritized to put on the bed since there are only three beds in the labor room. I was not treated this way, but some women were treated this way.

Marital status was another factor that emerged as a social factor and played a role in maternal care. Specifically, most of the participants who stated that they were married outlined that they received much support from their husbands. Participants 1, 2, 3, 7, 11, and 14 reported that their husbands provided them with the money they needed to prepare for childbirth and paid any money that was asked for at the health facilities. For example, Participant 14 stated, "Well, during my ANC clinic, the nurses to us to prepare cotton lappas (5), burn oil, baby clothes, etc. My husband gave me money to buy the items, and I packed them in a bag." Participant 11 stated the following:

> I did not wait for long when I arrived at the health facility; one of the nurses injected me immediately to reduce my pain, and my husband paid money for it. I

> was tested for my blood percentage; it was low, and my husband donated blood, which was transfused in me.

On the other hand, the women who were not married did not receive much support during preparation for childbirth, as narrated by Participants 13 and 21. Specifically, Participant 13 stated, "I am a student; I did not prepare for my delivery, as I said, I am a student, I got pregnant by accident, it was not my wish and never planned it."

The number of children one has was another social factor that played a role in maternal care. For instance, the women who had delivered other children quickly understood the procedures at the health facilities and what required them. On the other hand, the women who were first-time mothers did not quite well understand some things and processes during childbirth. This was elaborated by Participant 21 as follows:

> I do not deny that they don't know how to do their work, but the nurse who delivered me did not suture my perianal tear. Since it was my first pregnancy, I did not understand that I was supposed to be sutured. Until then, I returned home when I started bleeding. We had to return to the hospital.

From the above accounts given by the study participants, the social factors identified included socio-economic status, marital status, and the number of children one has. Women from low socio-economic backgrounds received ill-treatment, while those with money received good treatment during childbirth. Married women received support from their husbands, while those who were not married received little to no help. First-time mothers were also not conversant with procedures undertaken during childbirth. The identified social factors exemplify the individual aspect of the ecological systems theory.

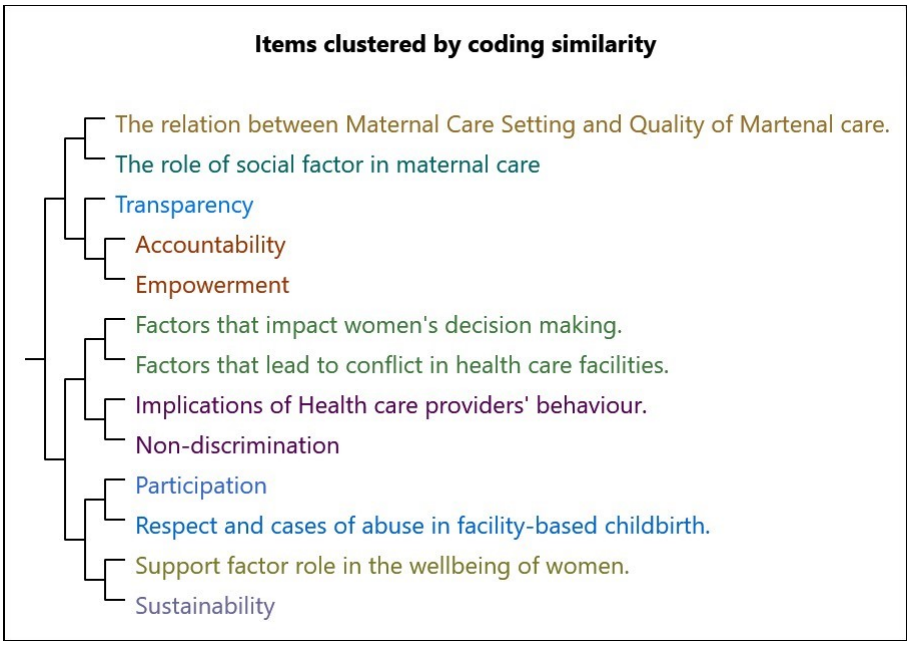
Notably, the identified social factors affect an individual and influence maternal care. Similarly, these social factors represent the personal characteristics highlighted in the study's conceptual framework.

Summary

This study described Sierra Leonean women's experiences in childbirth and perceptions of basic maternal rights. Thus, to this end, this chapter contains the results of the qualitative study conducted with 21 Sierra Leonean women from the three districts in Northern Sierra Leone. Generally, the study participants narrated various experiences about the quality of the facilities they attended and the quality of the maternal care they received. The cluster of the themes is presented in the following Figure 7.

Figure 7

Items Clustered by Coding Similarity



The figure above represents the items clustered by word similarity. These items are the different themes under which the analysis of results was presented in this chapter. The study findings will be thoroughly discussed in the next chapter while relating them to the literature. The next chapter also contains discussions of the conclusions presented in contrast to the literature review, implications, limitations, recommendations, and findings of this study.

Chapter 5: Discussion, Recommendations, and Conclusion

Introduction

The problem identified in the present study emanated from the fact that despite global efforts, Sierra Leone faces immense challenges in supporting good maternal health and quality of care, and, hence, it has one of the world's highest maternal mortality ratios. High rates of avoidable maternal and newborn mortality and morbidity are often due to poor quality of care (Kruk et al., 2018). Evidence has suggested that in countries with high maternal mortality, the fear of D & A women often encounter in maternity care is a more powerful deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance (Bohren et al., 2014). Tuncalp et al. (2015) identified respect, dignity, equity, and emotional support as essential components of high-quality maternal care. However, these factors are often overlooked or ignored in childbirth. The Universal Rights of Childbearing Women has demonstrated how fundamental human rights apply to maternal health (White Ribbon Alliance, 2011). RMC interventions could improve women's labor and childbirth experience and address health inequalities.

The WHO framework for improving the quality of care for women during childbirth highlights that women's care experiences are equally important to clinical care provision (Tuncalp et al., 2015). In Sub-Saharan Africa (Eastern and Southern Africa), there has been increasing evidence of rude, disrespectful, abusive treatment and a lack of responsiveness to women's needs during labor and childbirth (Rosen et al., 2015). However, there is a lack of qualitative evidence on Sierra Leonean women's experiences during labor and birth, and the extent to which they perceive these experiences. This lack

of evidence concerning women's experiences can lead to mismanagement of the birthing process, which can have an adverse and traumatizing effect (Rodríguez-Almagro, 2019). Therefore, in this research, I sought to explore the lived experiences of Sierra Leonean women and their perceptions of facility-based intrapartum care. This study aimed to understand these women's experiences better to contribute to the existing body of knowledge relating to the status of D&A in Sierra Leone and form the basis for lobbying for policies to ensure effective maternal care in the country. Pursuant to these objectives, 21 women from Northern Sierra Leone participated in the interviews. The results of the analysis of the data collected were presented in Chapter 4. To this end, this chapter addresses the findings of the results while making a comparison with existing literature.

This chapter presents the findings of the results presented in Chapter 4. The major themes from the analysis were given according to each theme's research question. After the results are discussed and contextualized, the limitations of the present study are laid out. Consequently, the recommendations for implications are presented. The chapter ends with a summative conclusion covering the entire research study.

Discussion

Presenting the meaning of the results from in Chapter 4, it is essential to synchronize them with the literature. In this regard, the discussion considered the literature review to establish the extent to which the results differ or concur with the literature. The discussion is as follows.

Research Question 1

The central focus of the first research question was on the lived childbirth experiences of Sierra Leonean women relating to their fundamental maternal rights. Seven themes emerged from the data analysis: accountability, empowerment, participation, sustainability, transparency, support factors, and maternal care setting.

Accountability

This theme assessed the aspect of prioritizing women's interests and offering them the best care in facility-based childbirths. The findings indicated that some healthcare workers gave the women good care and depicted polite and positive attitudes towards them while offering these treatments. Furthermore, those who needed urgent medical attention were immediately attended to, thus saving their lives and those of their babies. These findings exemplified the positive childbirth experiences as described in the literature review. Specifically, they were in line with Downe et al.'s (2018) and Hajizadeh et al.'s (2020) findings, which indicated that positive childbirth experiences emanated from good care given to women in facilities.

On the contrary, this research established a lack of accountability in childbirth facilities. It was in the form of discriminatory treatment given to women in the facilities. Those who had money were treated well, while those who did not have money received ill-treatment. Moreover, nurses and other health workers' behaviors of demanding money from the women despite being in public health facilities indicated a lack of accountability during intrapartum care. These findings were congruent with those in the literature because many studies, including those of Shimoda et al. (2018) and Sando et al. (2016),

established a lack of accountability in health care facilities. This lack of accountability was characterized by a lack of respect and ill-treatment of women birthing in health facilities.

Empowerment

This theme explored the kind of empowerment that women receive during maternal care. The present study's findings outlined that they received information from nurses during antenatal clinics they attended. This information acted as a form of empowerment to the women because it enabled them to prepare adequately for their childbirths. These findings conformed with those of Mordal et al. (2021), who outlined that women develop feelings of control upon receiving continuous information. Similarly, Solnes Miltenburg et al. (2016) established that giving women appropriate information indicated good treatment offered in healthcare facilities. In this sense, information is a form of empowerment that women highly need during maternal care.

Another form of empowerment described in this study's findings was financial empowerment. This emerged as women were given financial support by their spouses and relatives to purchase the necessary items to facilitate smooth childbirth. These findings resonated with those of Hosseini Tagbaghdehi et al. (2020), who stated that support from relatives and husbands was a form of empowerment for women during maternal care. Thus, it can be noted that empowerment is a significant factor for women during childbirth and maternal care.

Participation

Under this theme, women's support during maternal care was considered participatory. The study findings revealed that the women received emotional and moral support from their spouses and relatives right from when they visited the hospital, during labor, and after giving birth. This support was in the form of physical presence and encouraging words. Besides the emotional and moral support, the women also received support from the kind health care workers who attended to them with utmost professionalism and politeness. These findings supported those outlined in the literature that indicated that the women in Tagbaghdehi et al.'s (2020) study narrated that the presence of their husbands during childbirth was a form of support that played vital roles during this period. The findings relating to the support women received from healthcare providers supported Namujju et al.'s (2018) study highlighted in the literature, which established that healthcare provider support and care positively affect women's childbirth experiences. The authors found that physical and psychological support leads to a positive experience, and inappropriate communication and care guide to negative experiences. Therefore, it is safe to conclude that support from women's relatives is a form of participation that is pivotal in ensuring positive childbirth experiences by women. Moreover, support from healthcare providers is an essential element of participation in delivering positive childbirth experiences for women who visit health facilities to give birth.

On the negative side, the study findings revealed that some women did not receive the support they needed due to nurses denying them what they requested. For instance,

some were left in the labor room on their own and could not find anyone to give them support. This implies that incidences of lack of participation in maternal care exist in healthcare facilities. These findings supported Mukamurigo et al. (2017), who argued that women being abandoned and denied support and help in health facilities during childbirth are rampant. Mukamurigo et al. further pointed out that lack of support and negligence for women poses challenges to maternal care and subjects the women to ill-treatment. Therefore, these findings support the postulation that a lack of support exists in maternal care in modern health care facilities.

Support Factor Role in the Wellbeing of Women

This theme described the roles that support played in women's well-being as per the study participants' lived experiences. The findings of this study revealed that quick and urgent medical attention and support are given to women, ensuring safe deliveries, and thus saving the lives of the mothers and their babies. These findings agreed with those of Afulani et al. (2017), who reported that supportive care given to women during childbirth positively influenced their perceptions regarding the quality of healthcare.

The study findings also established that the moral and emotional support they received from their relatives and healthcare workers made them feel good, enhancing their overall well-being. It was also confirmed that the support women received ensured that their maternal rights were not violated. These findings supported the requirements of effective maternal care in health care facilities as outlined by Oladapo et al. (2015) and WHO (2015). These requirements include effective communication, respect, and emotional support, which enhance women’s well-being. Therefore, it can be noted that

support offered to women during childbirth and maternal care enhances their overall well-being.

Sustainability

This theme presented the experiences of Sierra Leonean women concerning ways that help enhance sustainability in maternal care to save lives. The participants described diverse scenarios and aspects they would love to be upheld and others to improve. The major issue under this theme is demanding women pay money to obtain some services. What was peculiar was that some nurses even asked patients to pay for services in public health care facilities where such services were considered free. This was a negative experience and indicates that the sustainability of maternal care was still largely lacking in the country. Notably, the participants recommended that this issue of fees should be eradicated to make maternal care in health facilities affordable to every woman. These findings supported those in the literature by Ratcliffe (2013) and SMFA (2017), which outlined that financial barriers were a significant barrier to achieving the sustainability of maternal care. These financial barriers lead to women not receiving good care and reduced access to clinical interventions for needy women (SMFAI, 2017).

Another aspect was the lack of privacy in maternity wards and labor rooms. The women viewed this as disrespect because their nakedness was paraded to other people. These findings regarding the lack of privacy in health care facilities resonated with those of Garnett (2018), which indicated that women cited a lack of privacy that led to negative childbirth experiences in health facilities. Thus, these negative treatments downplayed the sustainability of maternal care in health care facilities.

On the positive side, the majority of the study participants reported that the good care they received during intrapartum care should be enhanced in order to make maternal care accessible to all. As described by the study participants, this good care was characterized by politely addressing the women, listening to their concerns, and providing privacy during delivery. This would thus enhance sustainability in maternal care. These findings supported the recommendations of Lambert et al. (2018), O'Donnell et al. (2014), and Tuncalp et al. (2015) regarding good quality care for sustainability.

The Maternal Care Setting

This theme presented findings relating to the relationship between maternal care settings and the quality of maternal care offered in these facilities. This study revealed that women visited health facilities to deliver because they felt safe and that the facilities guaranteed safe deliveries. Most women said they received good care in the health facilities they visited. It was in the form of urgent medical attention, respect from the health care workers, and polite treatment from the nurses and midwives. This exemplifies the good quality given to women in health care facilities. These findings supported those of Mgawadere et al. (2019) and O'Donnell et al. (2014). The authors described quality care in health care facilities as positive relationships with caregivers and professional care given to women.

On the flip side, some participants revealed they received ill-treatment at the health facilities where they were birthed: This was characterized by being shouted at and some women being beaten. Incidents of negligence on the part of the healthcare workers were also reported. For instance, one participant revealed that the doctor failed to stitch

up a tear she experienced during birth. This exemplifies poor quality care in health care facilities. These findings also aligned with Mgawadere et al.'s (2019) and O'Donnell et al.'s (2014) description of poor-quality care given to women in health care facilities. The authors described poor quality care as women receiving unwelcome reception and physical and verbal abuse alongside non-consented care.

Transparency

Under this theme, the participants' experiences in relation to the trustworthiness and reliability of the services offered in health facilities were presented. Most of the study participants outlined that they received reliable services that helped save their lives and those of their babies. For instance, some revealed that they arrived at the health facilities needing urgent assistance and were swiftly assisted by the health care workers at the health facilities. This finding indicates that there exist facilities that offer trustworthy and reliable services to women during childbirth. These research findings were in line with those described by O'Donnell et al. (2014) and SMFA (2017) in the literature review. These authors outlined that availability of resources, good relationships with caregivers, and good treatment for women characterize reliable and trustworthy services that result in good quality care in health facilities.

It also emerged that there were participants who were unhappy with the services they received at the health facilities. Specifically, the issue of finances led to questioning the transparency of the services at these health facilities. Participants who were asked to pay money to receive services and yet were in public facilities felt that they were robbed. For instance, a participant narrated a scenario where she was asked to pay for a service

that was later not delivered even after paying. These findings exemplify a lack of reliability and trustworthiness of maternal care services rendered in healthcare facilities. These research findings added to Ratcliffe (2013) and SMFAI (2017) in the literature outlining that financial factors deny women access to quality care. The results also provide newer insights that economic factors encompassing healthcare workers demanding money downplay maternal care transparency in health facilities.

Research Question 2

The second research question was focused on describing how Sierra Leonean women perceive their childbirth experiences relating to the principles of RMC. The themes identified concerning this research question include implications of health care providers' behavior, the role of social factors in maternal care, factors that lead to conflict in healthcare facilities, and factors that impact women's decision making.

Factors That Impact Women's Decision Making

Various factors were identified to influence women's decision making. Among the factors identified by the study participants were fear of risk characterized by the fear of developing birth-related complications, good care received in health care facilities, opinions of other people close to the women, and advice from health care providers.

Specifically, the quality of care given in healthcare facilities dictates whether women visit these facilities to birth. This finding supports Hajizadeh et al.'s (2020) postulation that negative aspects of maternity care can influence women’s decision not to use health facilities during birthing. These findings are also supported by Tunçalp et al.'s (2015) opinions that women's experiences in healthcare facilities, alongside the quality of

care they receive, influence their health-seeking behaviors. They also supported Ishola et al.'s (2017) postulations that the negative behaviors of healthcare workers towards women undermined the utilization of health facilities for delivery. The factors not identified in the literature but revealed the analysis include the information from healthcare workers and people's opinions about women. Therefore, these factors add to the existing literature on the factors that influence women's decision making during maternal care.

One major factor that stood out from the factors influencing women's decision-making was the issue of finances. Contrary to SMFAI's (2017) argument that financial costs associated with maternity care reduce women's access to clinical interventions, the present study established that the availability of finances does not influence women's decision to give birth in a health facility. Specifically, one participant noted that even if she lacked money, she would still visit a health facility to birth. In this regard, finance does not play a critical role in influencing women's decision-making.

Nondiscrimination

This theme explored equality in service provision to women during intrapartum care. This study revealed that instances of non-discrimination and discrimination existed in healthcare settings. Non-discrimination was evidenced by women narrating that they received equal treatment and care with the other women they interacted with at the health facilities. These findings were in line with Bante et al. (2020) and Mousa and Turingan (2018), which reported that women in their studies received a high degree of discrimination-free care during delivery. They were also in conformity with OHCHR's

(2012) and WHO's (2014) recommendations for non-discriminatory care to women during childbirth and maternal care.

On the other hand, discrimination was evidenced by women narrating instances where disparate treatments were given to other women. For example, some were shouted at because they did not have money to pay for some services, while those with money were given good treatment. Similarly, those who knew someone in the facilities were treated better than those who were strangers. These findings supported Miller's and Lalonde's (2015) arguments that despite the increase in access to health facility-based maternal care, women still reported incidences of discriminatory care in these facilities. In this regard, it can be noted that both non-discriminative and discriminative consideration is given to women in modern healthcare facilities.

Factors That Lead to Conflict in Health Care Facilities

Various factors were identified to cause conflicts in health care facilities. These factors include failure to follow healthcare workers' instructions, women's late arrival to healthcare facilities, failure to attend antenatal clinics, and mistreatment of women by healthcare workers. These factors bred a lot of conflicts between the women and the healthcare workers in the healthcare facilities. For instance, the failure of the women to follow instructions and their late arrival at the healthcare facilities caused nurses to quarrel and shout at them. The major factor identified in the literature as a cause of the conflict was disrespect to women occasioned by verbal and physical abuse, as outlined by Afulani et al. (2017), Mesenburg et al. (2018), and Sethi et al. (2017). The literature did not identify the other factors encompassing failure to follow healthcare workers'

instructions, late arrival to healthcare facilities, and failure by women to attend antenatal clinics. Therefore, this research study provides newer insights into the factors causing conflicts in healthcare facilities.

Implications of Health Care Providers' Behavior

This theme assessed the implications arising from health care providers' behaviors and actions. The present study established positive and negative implications of healthcare providers' behaviors. Good quality care, polite language, and healthcare workers' good attitudes towards women have positive implications. Examples of these positive implications are feelings of impression and satisfaction from women. These findings supported Afulani et al. (2017) and Namujju et al. (2018), which revealed that the women who received good care in their studies were left with positive impressions.

On the contrary, negative implications arose from poor quality care, mistreatments, and abuse of women alongside healthcare workers' negligence. These ill-behaviors of healthcare workers resulted in dissatisfaction and displeasure among the study participants. These findings agree with Afulani et al. (2017) and Ishola et al. (2017), which outlined that the women in their studies who were given ill treatments developed negative impressions and consequently made them reconsider their decisions of birthing in those facilities in their subsequent pregnancies.

Generally, the behaviors of healthcare workers have an impact on women in healthcare facilities. Positive attitudes, quality care, and support given to women leave positive impressions on the women. On the contrary, poor-quality care and ill-treatment

result in women having negative implications, which may discourage them from seeking maternal care in healthcare facilities.

Respect and Cases of Abuse in Facility-Based Childbirth

From the study participants' experiences, both respect and abuse incidents were reported. D&A occurred in the form of shouting and beating women, denying them privacy, and undertaking non-consented procedures. There were cases of extreme disrespect where women were physically abused by being hit by the nurses. These findings were in line with those of Bohren et al. (2017), Mukamurigo et al. (2017), Mesenburg et al. (2018), and Shimoda et al. (2018). They reported verbal and physical abuse of women, non-consented care, unwelcoming reception, abandonment, and neglect. Asefa et al. (2020) attributed the reasons women are mistreated during childbirth to lack of knowledge and misunderstanding, normalization of mistreatment, punitive action against uncooperative and emotional women; gaining compliance with critical examinations to achieve good birth outcomes; and structural issues.

On the positive side, the study participants reported incidences of respect. These incidences were characterized by scenarios of women’s privacy being upheld, consent being sought before performing any procedures, and women being addressed in polite language. These findings supported Afulani et al. (2017) and Namujju et al. (2018), which reported that some women in their studies received good quality treatment and respect. Therefore, it is safe to note that cases of abuse and respect can be observed in health facilities in the modern age of improved healthcare access.

The Role of Social Factors in Maternal Care

Social factors were identified to influence maternal care. These factors included socio-economic status, marital status, and the number of children that one has. The first-time mothers were unaware of many procedures, while those who had initially given birth to other children were familiar with maternal care procedures. Unmarried women did not receive much support, while married ones received immense support from their spouses. Women from low-socioeconomic backgrounds did not receive quality care and were susceptible to humiliation and harassment from healthcare workers. These findings agreed with those of Ishola et al. (2017). They revealed that the low socio-economic status of women, alongside their lack of education, contributed to disrespect during maternal care. The other factors not identified in the literature include marital status and the number of children one has. Thus, these factors add new knowledge to existing literature pertaining to the role of social factors in maternal care.

Limitations

Limitations encompass the possible weaknesses, which are commonly not controlled by the researcher, and relate to the research method and design used (Theofanidis & Fountouki, 2018). To fully contextualize the study results, it is also essential to address their shortcomings. There were not many limitations of this present study.

Firstly, the present research setting was in Northern Sierra Leone, whose healthcare facilities might differ from those in other parts of the country. In this sense, the findings of this research may not be generalized and applied to other facilities in other

parts of the country. This is because the study was only focused on Northern Sierra Leone. The researcher provided detailed information about the participants, data collection methods, and data analysis procedures to address this limitation. Besides that, the researcher collected data from three different districts in the North of Sierra Leone. Therefore, this might help other researchers to replicate the study.

Secondly, the study was only limited to the use of interviews with only 21 participants. This prevented data collection from other sources, such as questionnaires and other people who might have been more knowledgeable about the phenomena under this study. To address this limitation, the researcher ensured that the participants chosen for this study were within the set eligibility criteria and were aware of the topic of study.

Finally, the study was purely qualitative and narrative. This prevented the collection of numerical data to validate the qualitative findings. Nonetheless, the researcher undertook a pilot study to test the research methods' validity, which helped downplay this limitation.

Implications for the Study

Theoretical Implications

This study provides value to the existing literature on women's experiences and perceptions regarding their basic maternity rights. The first theoretical implication is that the findings enhance understanding of women's lived experiences and perceptions about basic maternal care.

This research demonstrated that quality care is necessary to uphold accountability of maternal care in healthcare facilities Downe et al. (2018) and Hajizadeh et al. (2020).

In addition, support, and empowerment of women during childbirth enhances their overall well-being, as outlined by Afulani et al. (2017) and Oladapo et al. (2015). The study also revealed the existence of discriminative care (Bante et al., 2020) and non-discriminative care (Miller & Lalonde., 2015) alongside cases of respect (Namujju et al., 2018) and abuse (Bohren et al. (2017) of women seeking maternal care in hospitals. Furthermore, the study demonstrated that social factors influence the quality of maternal care given to women. Further, the study revealed that the quality-of-care women receive influences their satisfaction and decision to seek maternal care in health facilities in their subsequent pregnancies.

The present study also provided newer insights into diverse aspects of maternal care. Specifically, it offered new knowledge pertaining to other pertinent factors, including information from healthcare workers and opinions of people around women, which affect women's decision-making. Furthermore, the study provided newer insights into the influence of marital status and the number of children one has on maternal care.

Implications for Practice

The present study also provided several implications for practice. To this effect, several recommendations can be derived from the findings of this study. Equitable care should be provided to all women regardless of their social status. The issue of healthcare workers demanding money to render services that are supposed to be free should also be addressed by the relevant authorities. This will help in ensuring that all women access quality maternal care. This will also enhance the transparency and accountability of maternal care offered in healthcare facilities in Sierra Leone.

Secondly, women's empowerment should be enhanced, and can be achieved through wide dissemination of information regarding maternity care to inform women and make them seek maternal care. Besides that, material, moral, and emotional support should be rendered to the women. Specifically, healthcare workers should ensure to give women the support they need. This will help in ensuring that their overall well-being is bolstered.

Most importantly, healthcare workers should maintain utmost professionalism when handling women in maternal care. Specifically, they should enhance women's privacy and ensure to seek their consent before performing any procedures on them. Besides, these workers should politely address women and avoid shouting at them or abusing them. This will create positive impressions and experiences and make women always visit healthcare facilities during pregnancy and childbirth.

Implications for Social Change

This research has depicted that, in some instances, women receive disparate treatment in health facilities. Some women from low socio-economic backgrounds are discriminated against. Therefore, nurses and healthcare workers in health facilities should desist from discrimination and ensure that they give equal treatment to women during maternal care. Women should never be discriminated against since health facilities are deemed places where people seek help and expect to receive good quality care.

Healthcare workers should also and always maintain a good work ethic and professionalism. They should uphold this by depicting positive attitudes, polite language, and respectful behaviors toward the women they attend at the health facilities. This will

help ensure they dispense respectful and ethical treatment to women during maternal care. It will also ensure that they earn respect from these women.

Furthermore, the Sierra Leone government has to ensure that maternal care is free in public healthcare facilities. This will help ensure that quality maternal care is accessible to all women in the nation. Besides that, it will help ensure that women from low socioeconomic backgrounds can afford quality maternal care to bolster the country's maternal health outcomes.

Recommendations

Recommendations for Further Research

To this end, important directions for further research are identified in the present research. One of these is that the study could be replicated in another setting in Sierra Leone to determine the extent to which the results obtained are specific to Sierra Leone and whether they can be duplicated elsewhere.

Given that the present study utilized a qualitative research method, future research employing quantitative or mixed methods could be undertaken to validate the findings of this research. Furthermore, a purposive sampling technique was used in this study, which might have resulted in some form of selection bias. Therefore, a future study employing other sampling techniques could be undertaken to validate or complement the present research findings. Finally, the current research only focused on healthcare facility-based childbirth experiences. Future research exploring traditional birth methods could be undertaken to compare the two and provide further recommendations. With this challenge, there is also a need to explore negative experiences and understand the reasons

behind them and whether there are any factors related to health care that can be improved.

Recommendations for Action

Besides the recommendations for future research, there are also recommendations for practices. These recommendations target primarily national and local policymakers, implementers, and managers of Maternal health, health care professionals (including nurses, midwives, general medical practitioners, and obstetricians), and academic staff in health training institutions.

Addressing RMC through a lens of strengthening health systems that promotes a rights-based approach to maternal health services for both women and staff is most likely to mitigate women's mistreatment during facility-based childbirth. The national systems of Sierra Leone should develop and enforce policies that can help enhance access to respectful maternal care and bolster the quality of care given to women. Besides that, these systems should provide channels for reporting any mistreatment of women during maternal care to ensure that healthcare providers comply with the set policies.

The healthcare providers should also ensure to adhere to the stipulated maternal rights. In this sense, they should avoid abusing and mistreating women during childbirth. Interventions to promote RMC will include training on RMC, the introduction of wallpapers and pamphlets, and post-training facility-based quality improvement sessions. Maternity care providers should optimize the quality of labor and childbirth care through a holistic, human rights-based approach, recognizing, among others, RMC throughout labor and birth.

Health training institutions should ensure that the RMC Charter is integrated into the curriculum so students can practice RMC before graduation and prepare for workplace maternity care.

The community members should also ensure that women in their communities visit healthcare facilities for maternal care. They should also sensitize women on maternal care and childbirth issues. Furthermore, women should ensure they visit healthcare facilities and attend antenatal clinics to get the necessary assistance from healthcare providers. These women should also adhere to the healthcare providers' instructions and advice to render good quality care by the relevant providers. A renewed focus is needed to facilitate companionship during labor and birth.

Reflections

Undertaking this research has given me in-depth insights regarding childbirth and maternal care. I have understood that women undergo diverse experiences characterized by good and bad treatment and care. Those who receive good care are not mistreated, and their rights are respected often have positive perceptions and experiences relating to maternal care in healthcare facilities. On the other hand, those who are given ill-treatments, disrespected, and have their rights violated often perceive childbirth and maternal care in healthcare facilities with negativity.

In essence, the above insights have enabled me to understand that irrespective of social status, women deserve good quality care during childbirth. Moreover, women receiving good treatment are highly likely to return to the healthcare facility for subsequent childbirths. Besides that, they become ambassadors of those facilities by

referring other women. In this regard, advocating for good quality maternal care for women is essential. Thus, I seek to educate women on their rights and encourage them to visit healthcare facilities to receive quality maternal health care during and after childbirth.

Conclusion

In conclusion, the present research sought to understand and describe the childbirth experiences and perceptions relating to the basic rights of childbearing women during facility-based intrapartum care. To this effect, the following research questions were formulated: (1) What are the lived childbirth experiences of Sierra Leonean women relating to their fundamental maternal rights? (2) How do Sierra Leonean women perceive their childbirth experiences relating to the principles of RMC?

The two research questions gave rise to thirteen themes based on qualitative semi-structured interviews with 21 Sierra Leonean women. The themes included the following: accountability, empowerment, participation, sustainability, transparency, Support factor, maternal care setting, implications of Health care providers' behavior, the role of social factors in maternal care, and factors that lead to conflict in health care facilities, and factors that impact women's decision making. In exploring these themes vis-à-vis the literature, they all reaffirmed that women’s experiences and perceptions of health facility-based childbirth are diverse and could be positive or negative. The most critical establishment of this study is that enhancing maternal health and quality care is essential to bolster transparency, accountability, and sustainability of maternal health outcomes in the country.

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Appendix A: Sample-Participant Recruitment Flyers

Women who have given birth in a hospital in Bombali District Needed!!!

I want to hear your childbirth story!

I am a Ph.D. student in Public Health at Walden University in Minneapolis, Minnesota, USA conducting graduate research on the:

"Childbirth Experiences and Perceptions of Sierra Leonean Women Relating to their Basic Maternal Rights."

Who can Participate?

-Women aged 18-45 years whose gestational age was 28-40 weeks.

-Admitted for no reasons other than labor and delivery.

-Delivered in a hospital in the past two months.

Participation in this Research Involves:

-About 90 minutes audio recorded private interview.

-Receiving a snack during the interview and transportation refunds at the end of the interview.

Confidentiality is my priority.

Contact Information: For more information or to become a participant, please call Francess Fornah at 076679424

Research is conducted through Walden University-Minneapolis Walden University IRB Approval # **04-13-22-0758841.** It expires on **April 12, 2023,** and Sierra Leone Ethics and Scientific Review Committee Approval for this study is valid for the period 18th May 2022- 17th May 2023.

Appendix B: Participant Recruitment Form – Screening Questions for Eligibility Criteria

1. What is your age category?

a. Less than 18 years b. Above 18 -45 years

2. What is the age of your last baby?

a. 0-2 months b. Above 2 months

3. Where did you deliver your last baby?

4. a. Clinic b. Hospital

5. If hospital, what is the name of the hospital?.....

6. What was the main reason for visiting the facility where you delivered?

a. Illness b. Labor and Delivery

7. What was the gestational age of your last baby on delivery?

a. Less than 28 b. 28-40 weeks

8. Was your birth a vaginal delivery?

a. No b. Yes

9. Do you have any relative working in the facility where you gave birth?

a. Yes, b. No

If yes, what is the relation? ----------

If the answer to these questions does not meet the criteria, thank the potential participant for her time and explain she is not eligible for the study. If the participant is eligible, then the researcher sought consent for administering the consent form at an agreed date.

Appendix C: Participants Interview Protocol

Location (Site) Code: ----------

District Code: ----------

Participant Code: ----------

Interview Date: ----------

File Code of audio-recording: ----------

Start Time: ----------

End Time: ----------

Interviewer: ----------

Introduction (use complete introduction if being done sometime after the consent form is signed)

I want to introduce myself again. I am Francess Fornah, a doctoral student in Public Health at Walden University. Thank you for consenting to participate in this interview. As I mentioned when you completed the consent form, this research is part of my doctoral studies, which I am conducting in 3 districts (Bombali, Koinadugu, and Kambia) of the Northern province of Sierra Leone. This research focuses on women's experiences and perceptions while using health facilities for childbirth relating to basic maternal rights. I would also like to remind you that you can decline to answer any question. All responses will be confidential.

The findings from this research could help improve services for other women coming to hospitals and other maternity facilities to give birth, including yourself, if you

are going to have another baby. This interview will take between 60 and 90 minutes. If you feel tired or would like to stop the discussion, please let me know, and we can stop and continue the next time at your convenience. I will also use a voice recorder to capture all the information you provide correctly. I will now begin this interview.

A. Personal Characteristics

1. Tell me about yourself. *(Probe if not provided: How old are you? Where do you live? How many children do you have? When did you have your last child? What is your marital status? What ethnic tribe do you belong to? Are you working? What level of education did you complete)?*

B. Experience of Care

Section 1: Preparing to give birth

2. Tell me about any preparations you made before regarding the last delivery of your child. *(Probe if not provided: What preparations did you make before your baby was delivered? Who helped you (if anyone) with these preparations)?*
3. Tell me about when you started experiencing labor pains *(Probe if not provided: When did it begin? Where were you? What were you doing? Who were you with (if anybody)? What did you do? What were your feelings at that time)?*

Section 2: Decision to give birth at a health facility

4. Tell me about the decision to go to the health facility. *(Probe if not provided: How did you decide to go to the facility? Who helped you make that decision? How long did it take to decide to go to the health facility to give birth)?*

5. Tell me more about the general situation related to your decision to give birth at a health facility. (*Probe if not provided: What would you say helped you or your family with the decision to go to the health facility for you to give birth? What factors could have prevented you from deciding to go to the facility for childbirth)?*

Section 3: Arrival at a health facility to give birth

6. Tell me about the experience of getting to the health facility to give birth. *(Probe if not provided: How did you get to the facility? Who helped you? What other factors contributed to you reaching the health facility? What factors could have prevented you from reaching the facility? What were your feelings on the way to the health facility)?*
7. Tell me about your experience on arrival at the health facility. *(Probe if not provided: Whom did you meet at the health facility? What did they say to you? How would you describe the attitude of the health worker whom you met on arrival at the health facility)* Describe your feelings on arrival at the health facility)?

Section 4: Admission procedures and experiences giving birth, including waiting time

8. Tell me about the health facility itself. *(Probe if not provided: How would you describe the rooms where you were and where you delivered your baby? How comfortable were you with the rooms, bed, and other facilities)?*
9. Tell me about your experience while in the facility waiting to give birth? *(Probe if not provided: Describe your feelings during this time? What support did you get from*

health workers at the facility? Did you feel that it helped? Did you get any other support)?

10. Tell me about other women you met at the health facility waiting to give birth. *(Probe if not provided: What were your interactions with any other women you met at the health facility)?*

11. Tell me what you remember about your experience giving birth)? *(Probe if not provided: What happened (physical, emotional/psychological, consented care, privacy, confidentiality, financial implications)? How do the incidents/incidents affect family and relatives/friends? Who delivered you? How would you describe the experience? Were you comfortable with the position in which you delivered? Were there any special requests that you made with regard to your delivery? Were these granted? Tell me more about your feelings at that time. How would you describe the skills of the midwife or health worker who attended to you?)*

Section 5: Management immediately after delivery.

12. Tell me, what happened after you delivered your baby? *(Probe if not provided: Describe your feelings after the birth of your baby. What support did you receive after the baby's birth, and from whom? How would you describe your experience at the health facility where you deliver? What words would you use or say)?*
13. Tell me about your newborn baby. *(Probe if not provided: What baby did you get? How is your baby? How would you describe the care given to your baby)?*
14. Tell me about your experience when you were ready to leave the hospital. *(Probe if not provided: What happened? Who assisted you? Who came to collect you? What*

were your feelings about how prepared you were with regard to taking care of your baby? How would you describe this experience)?

C: Perception of Care

Section 6: Factors that contribute to /Risk factors for disrespect and abuse in health facilities

15. Please narrate your experience of the ***friendly/bad treatment*** you received during your last childbirth. (*Probe if not provided:* What happened (Dignity, respect, physical, emotional/psychological, consented care, privacy, confidentiality, financial implications)?
16. How did the ***incident(s) of friendly/bad treatment*** you experienced during your last childbirth in the facility affect you and your immediate relatives*? (Probe if not provided: Dignity, respect, Physical, emotional/psychological, financial implications? How the incident(s) affected family and relatives/friends? Did the incident affect your future use of the facility).*
17. Is there any notable event during your stay in the facility during your last childbirth that you may want to share with me? *(Probe if not provided: What was the nature of the event? How did you feel about it? Why was the event memorable?*

Section 7: Future plan for fertility and delivery

18. Tell me whether you will come again or tell anyone to come to this health facility to give birth if they are pregnant. Tell me about the reasons for your answer.

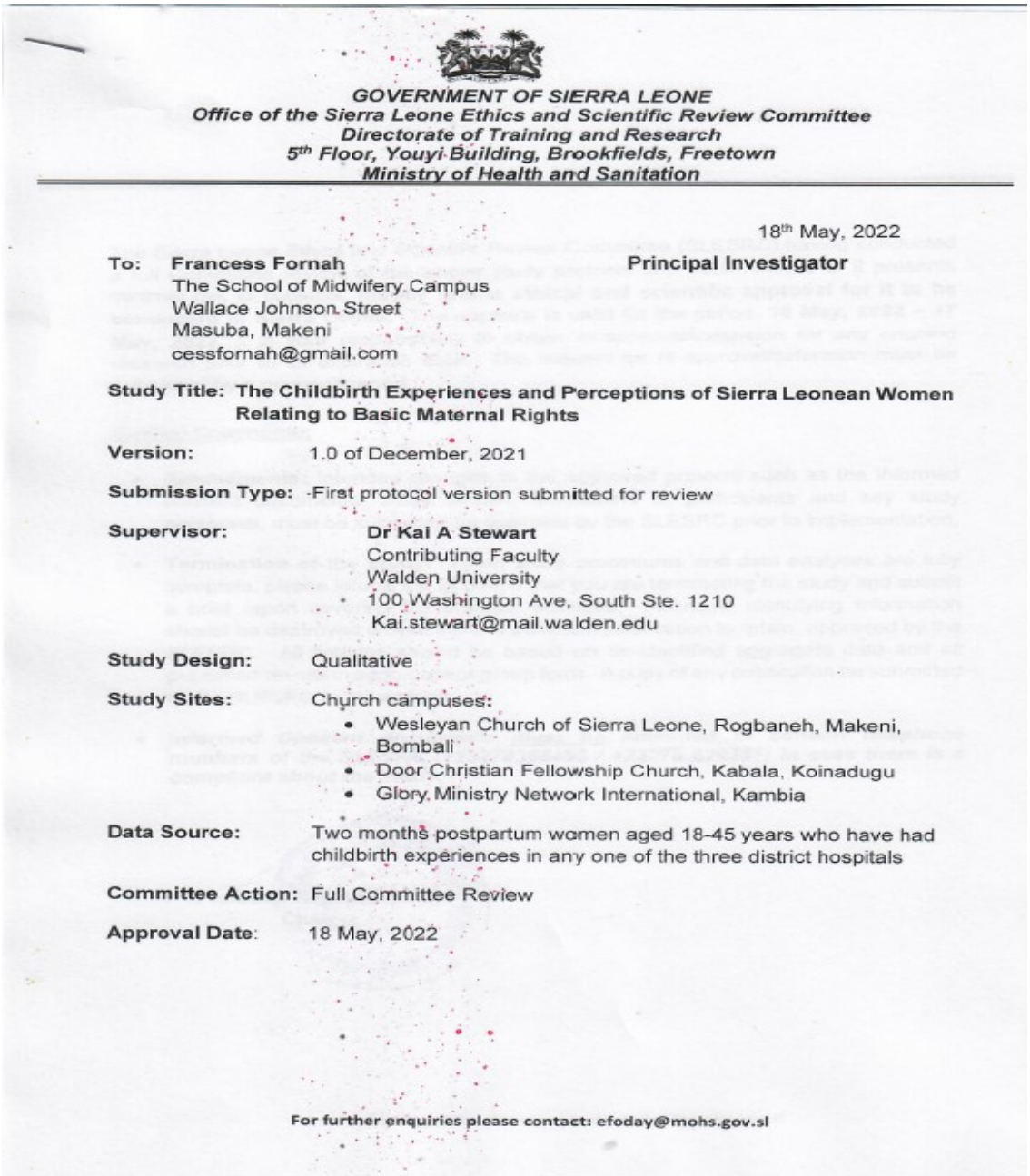
19. Tell me about your future regarding future child deliveries. *(Probe if not provided: Desired number of children, where they would go for delivery; reasons for the choice of plans, the place of delivery, an alternative to the hospital delivery).*
20. Is there anything else you would like to add or share about this topic that you feel is important for me to know?

D. Conclusion

This brings us to the end of the interview. I know it has been a long time, and I would like to thank you for participating in this research. I will transcribe the information on the recording, and in case I need to clarify any answer you provide, I would like to contact you again on this. Please let me know if I can do this and if I can do this by telephone or other means. This information will be put together with the other interviews that I will collect, and I will do a report and submit it to Walden university. Please do remember if you have any questions later, you can contact me by telephone number or by email, which will be made available to you. This information is also in the copy of the consent form that I gave you earlier.

Thank you again for participating in the interview.

Appendix D: Sierra Leone Ethics and Scientific Review Committee Approval Letter



GOVERNMENT OF SIERRA LEONE
Office of the Sierra Leone Ethics and Scientific Review Committee
Directorate of Training and Research
5th Floor, Youyi Building, Brookfields, Freetown
Ministry of Health and Sanitation

18th May, 2022

To: **Francess Fornah** — **Principal Investigator**
The School of Midwifery Campus
Wallace Johnson Street
Masuba, Makeni
cessfornah@gmail.com

Study Title: **The Childbirth Experiences and Perceptions of Sierra Leonean Women Relating to Basic Maternal Rights**

Version: 1.0 of December, 2021

Submission Type: First protocol version submitted for review

Supervisor: **Dr Kai A Stewart**
Contributing Faculty
Walden University
100 Washington Ave, South Ste. 1210
Kai.stewart@mail.walden.edu

Study Design: Qualitative

Study Sites: Church campuses:
- Wesleyan Church of Sierra Leone, Rogbaneh, Makeni, Bombali
- Door Christian Fellowship Church, Kabala, Koinadugu
- Glory Ministry Network International, Kambia

Data Source: Two months postpartum women aged 18-45 years who have had childbirth experiences in any one of the three district hospitals

Committee Action: Full Committee Review

Approval Date: 18 May, 2022

For further enquiries please contact: efoday@mohs.gov.sl

GOVERNMENT OF SIERRA LEONE
Office of the Sierra Leone Ethics and Scientific Review Committee
Directorate of Training and Research
5th Floor, Youyi Building, Brookfields, Freetown
Ministry of Health and Sanitation

The Sierra Leone Ethics and Scientific Review Committee (SLESRC) having conducted a full Committee review of the above study protocol and determined that it presents minimal risk to subjects, **hereby grants ethical and scientific approval for it to be conducted in Sierra Leone.** The approval is valid for the period, **18 May, 2022 – 17 May, 2023.** It is your responsibility to obtain re-approval/extension for any ongoing research prior to its expiration date. The request for re-approval/extension must be supported by a progress report.

Review Comments:

- **Amendments:** Intended changes to the approved protocol such as the informed consent documents, study design, recruitment of participants and key study personnel, must be submitted for approval by the SLESRC prior to implementation.
- **Termination of the study:** When study procedures and data analyses are fully complete, please inform the SLESRC that you are terminating the study and submit a brief report covering the protocol activities. Individual identifying information should be destroyed unless there is sufficient justification to retain, approved by the SLESRC. All findings should be based on de-identified aggregate data and all published results in aggregate or group form. A copy of any publication be submitted to the SLESRC for its archive.
- ***Informed Consent documents must be amended to contain telephone numbers of the SLESRC (+23278366493 / +23276 629251) in case there is a complaint about the study.***

Professor Heckert Morgan
Chair

For further enquiries please contact: efoday@mohs.gov.sl