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POSTNATAL WOMEN'S ASSESSMENT OF CARE RECEIVED DURING CHILD BIRTH AT SELECTED FACILITIES IN LA-NKWANTANANG MADINA MUNICIPALITY, ACCRA.

BY

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DECLARATION

I, Agnes Asare, do hereby declare that apart from references to other people's work which have been duly acknowledged, this dissertation is the result of my own research work conducted under the supervision of Dr. Philip Teg-Nefaah Tabong. I further declare that no part of the dissertation has been submitted for the award of any degree in any University.

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DEDICATION

This dissertation is dedicated to God Almighty for His grace and faithfulness throughout the programme.

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ABSTRACT

Encouraging women to deliver in facility settings is one strategy to improve maternal outcomes in developing countries. However, fear of maltreatment, as well as dissatisfaction with care during labour and delivery, have been reported as barriers to facility delivery. This study was therefore conducted to assess postnatal women's level of satisfaction of care received during delivery and their choice for facility-based in subsequent births at La-Nkwantanang Madina Municipality (LNMM).

The study adopted a cross-sectional design ina, Simple random sampling was used to select 313 women who reported at Madina Polyclinic (RC), Alpha Medical Centre and Madina Polyclinic Kekele six weeks after delivery. A structured questionnaire was used for data collection. The data was analysed using STATA 15. Bivariable data analysis using Pearson's Chi-square aws used tp determine the association between socio-demographic characteristics, reproductive history and wein satisfaction with care as well as experience fo maltreatment. Logistic regression analysis was done to determine the strengths of association between the variables was done. A p-value for <0.05 was deemed to be statistically significant.

The forms of support received during childbirth were, 54.3 percent of the women encouraged to have support persons at delivery, 76.7 percent were interested in the idea of labour companion with 22.4 percent of labour companions as husbands or partners. Postnatal women who experienced at least a form of disrespectful care during childbirth were 75.7 percent and 57.5 percent of women were satisfied with the care received at the health facilities. There was a significant association between the level of satisfaction and sociodemographic factors, the facility where childbirth occurred, forms of support received and the experience of disrespectful care. The preference for facility-based delivery at subsequent births was significantly associated with the level of satisfaction with care received and the experience of disrespectful care during labour and delivery.

The concludes that a woman's satisfaction with care received whilst pregnant or during child birth affects subsequent decision to seek health care in a facility. Improving quality of care and the birth experience of women can increase uptake of health facility-based delivery.

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
ANC	Antenatal Care
EmNC	Emergency Neonatal Care
EmOC	Emergency Obstetric Care
GDHS	Ghana Demographic and Health Survey
HIV	Human Immunodeficiency Virus
LNMM	La- Nkwantanang Madina Municipality
MPK	Madina Polyclinic Kekele
MPR/C	Madina Polyclinic Rawlings Circle
OPD	Out-Patient Department
PHM	Pentecost Hospital Madina
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

DEFINITION OF TERMS

Postnatal: is the period beginning immediately after the birth of the child and extends to six weeks after delivery.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Globally, an estimate of eight hundred and thirty mothers die each day during labour and childbirth. The majority (99%) of these avoidable deaths occur in low-income countries (US Census Bureau, 2015). Maternal death has disastrous outcomes for families, communities and country with significant economic effect resulting in broken homes and motherless children (Floyd et al., 2015). The crucial hurdle to the utilization of health services for women that contributes to maternal death is a delay in the decision to seek care, delay in arrival at a health facility and lack of provision of satisfactory care (Bohren et al., 2014). The lack of provision and adequate care buttress the need to improve women's access to maternity care and promote birth in health facilities with skilled attendants (WHO, 2015).

According to Souza et al., (2014), the majority of maternal deaths have been found to be avoidable. Maternal and neonatal health can be enhanced and complications avoided when women access skilled respectful care during pregnancy and childbirth from health care providers (Rosen et al., 2015). Women's experiences and their perceptions of maternity care are formed principally on client-provider interpersonal relationship (WHO, 2007). The major drawback to accessing skilled care for routine and complicated births is poor interactions between the patient and the health provider (Knight et al., 2013; Nair et al., 2014). Furthermore, the Respectful Maternity Care Charter as published by White Ribbons Alliance recognizes that women's perceptions to childbirth are an essential component of quality health care and their autonomy, dignity, feeling, choices and preferences must be respected (Windau-Melmer, 2013).

The Universal Rights on Childbearing Women, is enshrined with international human rights and comprises of right to information, informed consent, privacy and confidentiality, dignity and respect, physical abuse, freedom and discrimination. The care received during childbirth must emphasize these and not solely on the prevention of death of mother and baby (White Ribbon Alliance, 2011).

> *"Disrespect and abuse during childbirth has been defined as interactions or facility conditions that local consensus deem to be humiliating and undignified and those interactions or conditions that are experienced as or intended to be humiliating and undignified"*(Lynn P Freedman et al., 2014 page 916).

They also expected that the definition must fall under national and human rights standards, good quality and respectful maternity care. Disrespect and abuse during pregnancy and childbirth have been identified as an important indicator of poor quality care and a barrier to improved maternal outcomes with inadequate data on the scope and magnitude, especially in urban areas of low-income countries (Sando et al., 2016).

According to Abuya et al., (2015), disrespect and abuse are common among twenty per cent of women during labour and childbirth. In Ghana, some nurses show unacceptable behaviours in their line of duty to clients which is a serious problem expressed by the public, Ministry of Health, Ghana Health Service and Nurses and Midwives Council (Korsah, 2011).

This study is set out to assess the care postnatal women receive during childbirth and their preference for facility birth at subsequent deliveries at La-Nkwantanang Madina Municipality.

1.2 Problem Statement

Many women fail to seek delivery services at facilities with skilled birth attendants regardless of proven medical advantages (Yakubu et al., 2014). Globally, skilled attendants at delivery have increased from 62 percent to 80 percent with some births not supervised by health personnel. In Sub-Saharan Africa, skilled personnel assisted over 50 percent of deliveries (WHO, 2020). In Ghana, according to the Ghana Demographic and Health Survey (GDHS) (2014), the overall percentage of skilled delivery has improved remarkably from 59 percent from 2008 to 74 percent in 2014. However, facility-based delivery occurring in 2008 was 57 percent to 73 percent in 2014. The percentage of birth supervised by skilled personnel lags behind the percentage of clients receiving antenatal care from skilled attendants of 82 percent and 97 percent respectively over the same period.

According to Bohren et al., (2014), the facilitator and barrier to future facility-based delivery are dependent on future pregnancy outcomes. Also, women who experience negative interactions in a facility are reluctant to report back for subsequent deliveries. Low facility delivery has been attributed to poor quality service, perceived cost, permission to access service, the proximity of service, fear of male birth attendants and disrespectful health workers (Asefa & Bekele, 2015).

According to Okafor et al., (2014), high rates and contribution of disrespect and abuse continue to favour home deliveries with no skilled attendance in Nigeria. This can lead to poor maternal and neonatal outcomes and encourage the use of traditional birth attendants. Women in a rural community in Ghana experienced maltreatment during delivery and denied traditional birth practices in the facility (Moyer et al., 2013). Such an encounter can be a barrier to future facility-based delivery in a setting where women view TBAs as more

dependable than health facility personnel, as providing high-quality care in terms of supportive care, skill and emotional help during childbirth (Bohren et al., 2014).

At La-Nkantanang Madina Municipality in Accra, supervised deliveries have marginally improved from 45.3% to 62.8% for the first half of the year from 2012 to 2017. However, this is below 92.1% reported in the Greater Accra by GDHS (2014). Therefore; the need to assess the level of satisfaction with the care received by postnatal women during childbirth and their choice for facility-based delivery in subsequent deliveries.

1.3 Conceptual framework

The framework for this study was adapted from the Bowser and Hill (2010) and Respectful Maternity Care by United Nations Agency for International Development (USAID) (Reis et al., 2012), (see figure 1.1). It shows the factors that contribute to respectful or disrespectful care during labour and delivery as a result of client and provider interactions.

Patient factors which include the socio-demographic factors such the age, marital status, level of education, financial as well as the health status contribute to the care received during childbirth. Siraj, Teka and Hebo (2019), shows the association of marital status, parity, educational level to disrespect and abuse.

Disrespect and abuse experienced during labour and delivery often become a hindrance to subsequent or future utilization of facility-based deliveries (Bowser & Hill, 2010).

Research recommends. that having a companion at birth and especially, continuous support during childbirth can enhance women's experience and delivery outcomes. Companions amongst others are necessary to aid continuous support during labour and delivery (Afulani et al., 2018). When emotional support such as choice of companion, intake of fluids and food,

ambulating and choice of birth position are guaranteed during labour and delivery enhances the experience of quality care (Perkins et al., 2019).

Women provided with analgesia during labour and delivery would have significant satisfaction of the overall birth experience (Geltore et al., 2018). D'Ambruoso, Abbey and Hussein (2005a), conducted a study in Ghana where the women anticipated compassionate, expert, respectful treatment from professionals and that interpersonal facets of care were prerequisite to patient satisfaction. Universal themes such as pain control and interaction with the caregiver are often remembered intensely and are associated with satisfaction that women have with their birth experience. Equally, if these themes are neglected and not attended to, negative feelings can stay with women over time that might influence their attitude toward future pregnancies (Murray et al., 2010).

According to Crissman et al., (2013), fear of mistreatment and absence of support during labour and childbirth, remain barriers to deliver care in a health facility in Northern Ghana. When women were offered companion of choice, food and fluids intake, as well as movement encouraged during labour, it improved the proportion of women having facility-based delivery (Perkins, et al., 2019).

This study will assess whether postnatal women were satisfied with the maternity care received, determine the proportion of women who experienced disrespectful care, the forms of support received and the preference for facility-based delivery at subsequent birth.

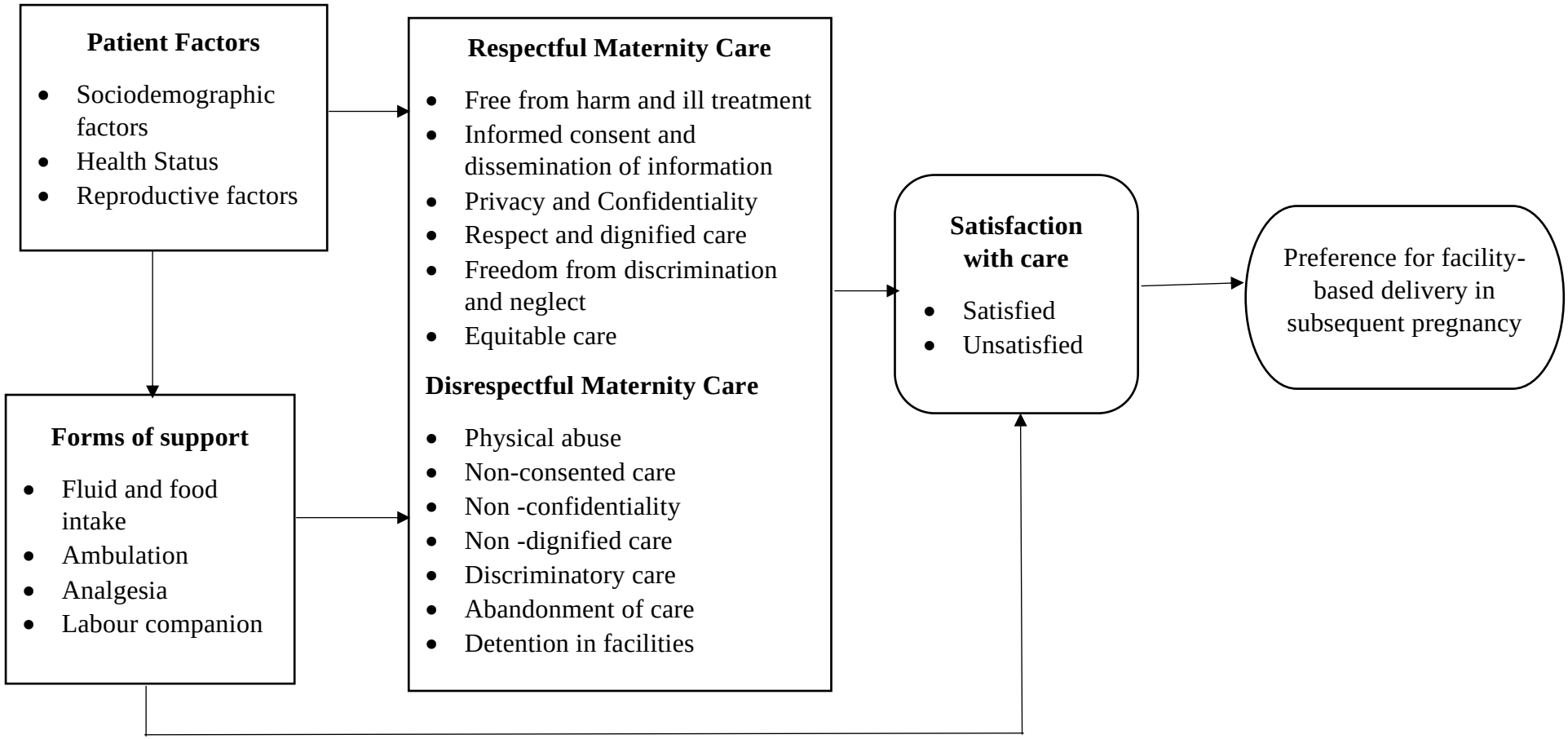


Figure 1.1 Conceptual framework on the assessment of care received by Postnatal women at LNMM 2019

1.4 Justification

There is widespread evidence that some women experience disrespect and abuse during childbirth. However, there is no internationally accepted definition of disrespect or abuse during childbirth, the extent and influence worldwide are unknown (Freedman et al., 2014).

In Ghana, some nurses show unacceptable behaviours in their duty of care to clients, which are serious problem expressed by public and professional bodies (Korsah, 2011). A study done in the Northern Region of Ghana where deliveries conducted by skilled birth attendants were low, all the respondents acknowledged disrespect and abuse during childbirth in a health facility (Moyer et al., 2013).

The La-Nkwantanang Madina Municipality in the Greater Accra Region for the first half of 2017, recorded more than half of the deliveries conducted by skilled birth attendants, which occurred outside the facility. Also, the percentage of deliveries conducted by skilled attendants at birth in the district, is lower than what was recorded as overall for the Greater Accra Region.

The district has identified improvement in institutional care among others, as the key priority for the year 2017, however, no study has been conducted by the facility on the satisfaction of care received during childbirth and the preference of facility-based deliveries births.

This study will assess the maternity care and forms of support women receive at childbirth from health personnel to help institute policies and interventions of improving facility-based delivery and maintaining the respect of human rights and ethics for optimum care of clients.

1.5 Research Questions

1. What forms of support did the women received during labour and childbirth at LNMM?
2. What proportion of women received disrespectful care during childbirth at LNMM?
3. Are postnatal women satisfied with the care they received during childbirth at LNMM?
4. What association exist between care received and preference of facility-based delivery at subsequent births?

1.6 Objectives

1.6.1 General objective

To assess postnatal women's level of satisfaction of care received during delivery and their choice for facility-based in subsequent births at LNMM.

1.6.2 Specific Objective

1. To assess the forms of support received during labour and delivery;
2. To determine the proportion of women who received disrespectful care;
3. To assess Postnatal women's level of satisfaction with the care received during childbirth; and
4. To identify the association that exist between care received, and the preference for facility-based delivery with subsequent births.

CHAPTER TWO

2.0 LITERATURE REVIEW

Introduction

This chapter reviews relevant literature appropriate to the study topic. The literature starts by providing a general background on facility-based delivery and factors that affect that. The review was done according to the objectives of the study and the conceptual framework.

2.1 Facility-based/Skilled Delivery

The WHO defines a Skilled Birth Attendant as "an accredited health professional – such as a midwife, doctor or nurse – who has been trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns" (WHO, 2004). The rate of maternal deaths is worsened by inadequate perinatal care, poor patronage of ANC and PNC services, and lack of skilled attendance at birth (Hogan et al., 2010). As more than 65% of maternal deaths occur during delivery, the importance of having a skilled attendant operating within a setting with adequate health care services during the time of birth cannot be overemphasized (Adegoke & Van Den Broek, 2009). Despite this, rural and poor urban dwellers in several countries, do not have a good chance of having access to skilled attendance at birth (Magoma et al., 2010).

Skilled delivery has been reported to reduce the probability of maternal mortality (Tarekegn et al., 2014), and recognized in Sustainable Development Goal 3 (UN, 2016). Generally, skilled delivery rates are high in developed countries, and are estimated to

about 99.5%, but the situation is different in the developing countries where only about 50% of women use the services of a skilled birth attendant with the rate in Africa as 46.5% (Nesbitt et al., 2013). Skilled birth rates are however low in developing countries. In Sub-Saharan Africa, skilled delivery is often less than 50% (Asamoah et al., 2014). Other challenges emanate from direct and indirect costs of accessing health care, poor transportation services, health facilities that are too far, lack of information and unsavoury precedent experiences with health care personnel (Yanagisawa et al., 2013).

More than 30% of births that occur worldwide happen in the homes, in the absence of a skilled attendant during delivery (WHO, 2008). In addition, data from twenty-three African countries indicate that, over 60% of births that occur in Sub-Saharan Africa take place at home (PMNCH, 2006). Underutilization of maternal health care services by women, have been associated with socio-cultural beliefs, and where a high premium is placed on the ability to deliver a child at home, women within these cultures will be wary of losing respect within their communities, or relinquishing control of the delivery process to a birth attendant (Asamoah et al., 2014; Bazzano et al., 2008). In a lot of cases, the decision concerning the place of delivery is made by family members, such as, husbands and mothers-in-law, or community leaders, village heads, soothsayers and traditional healers, with no regard to the pregnant woman's opinion (Crissman et al., 2013; Moyer et al., 2014).

Besides this, certain apprehensions within communities concerning facility-based deliveries, such as fear of invasive procedures, like caesarean sections, infertility and

death also result in women preferring home deliveries over facility-based deliveries (Bailey et al., 2002; Prata et al., 2011). A study carried out by Khan et al. (2012), in Indian slums established that 'family tradition', financial challenges and rude treatment by health care facility workers were all reasons given by female slum dwellers for preferring home delivery over health facility delivery. Quality of care has also been reported as one of the barriers to facility-based delivery.

2.2 Definition, elements and factors that affect the quality of care during childbirth

Quality of care is defined according to a systematic review, as preventive and supportive care with effective treatment for problems when they arise (Renfrew et al., 2014). It also reviewed that, women prefer healthcare personnel who incorporate clinical skills with interpersonal capacity. This includes safety, privacy and dignity, the use of interventions only, when they are indicated and strengthening the capacity of women to care for themselves and their infants. This review also discovered the key elements that result in the quality of care such as respect, good communication and customised care that enhances the biological, physical and socio-cultural processes. Women like health professionals who have clinical knowledge, good interpersonal skills with relevance to culture in their practice (Renfrew et al., 2014).

In recent times, quality of maternal health care has emerged as an area of intense interest among scholars, founders and health care providers. This has therefore, generated interest among researchers who have attempted to conduct researches in some aspects of quality across the world. One such studies, were conducted in southern India to elicit information on the clients' expectations of the quality of maternal health care and what was received at the facility. The results of this study showed that the quality of antenatal care received was lower than clients expectation, though the quality of care was significantly better in south India than north India, especially among the disadvantaged women (Rani et al., 2008).

In Tanzania, a study on the quality of maternal health care found shortages of staff, equipment and supplies as common complaints in the community hindering the quality of care (Mrisho et al., 2009). In Eritrea, a study on the quality of maternal health care showed that there was considerable pressure on the infrastructure and health providers at hospitals. Compliance with clinical care standards and availability of supplies were also reported to be optimal (Sharan et al., 2011).

Regarding the quality of care during childbirth, it has also been reported that quality of care during birth, vary across various stages of the birth process, from the first stage of labour to hours after birth. One such study, found clients rated the quality of care in the first stage of labour as 71.4%, the second stage of labour (63.0%), the third stage of labour (80.6%) and first 2 hours after labour (70.5%). The lowest scores were related to the domains of emotional support, hand washing and assessment of vital signs (Simbar et al., 2009) which were generally neglected by providers. Another study in Ghana showed that only 3-13% of services received by clients fulfilled the requirements for the highest quality category in any dimension. Quality was lowest in the emergency care dimensions, with 63% and 58% of facilities categorised as "low" or "substandard" for EmOC and EmNC, respectively (Nesbitt et al., 2013). A study on the quality of care during delivery in Ghana, also showed that examination and monitoring of mother and newborn during childbirth are inadequate and partographs are often not used. Equipment required to provide assisted vaginal deliveries (vacuum extractor or forceps) were absent in all surveyed facilities (Duysburgh et al., 2013, 2014). One form of quality of care is the form of support women receive during childbirth which is germane in this study.

2.3 Forms of support at childbirth

Birth is a vital outcome for all cultures. The remembrance of birth experiences, can be long-lasting and some specific encounters may not disappear. Women desire to be supported during labour apart from valuing clean and peaceful surroundings (Mensah et al., 2014) Intrapartum support has been defined as:

> '… *non-medical care that is intended to ease a woman's anxiety, discomfort, loneliness and exhaustion, to help her draw on her own strengths and to ensure that her needs and wishes are known and respected. It includes physical comfort measures, emotional support, information and instruction, advocacy and support for the partner*' p721(Simkin, 2002).

A notable number of randomised controlled trials have recognised a connection between continuous support of women at childbirth and enhanced birth results (Hodnett et al., 2012).

An agreement subsists in the literature, describing three subdivision of labour support namely; emotional, physical and informational support (Bryanton et al., 1994; Hodnett, 2002; Sauls, 2017). Emotional support is defined as "expressions of love, admiration, liking, reassurance and respect, spending time with the client and making them feel cared for. Physical support includes direct assistance and informational support includes advice, information and feedback"(Callaghan & Morrissey, 1993; Lakey & Orehek, 2011). Over the period, advocacy and partner support have been included in some studies to review research findings (Hodnett et al., 2012).

According to Hodnett et al., (2012), the pain women experience at birth has an effect on their clinical and psychological state as a result of fear, anxiety and absence of support during childbirth. He revealed that women reporting in labour when assigned to continuous support, were more probable to experience vaginal birth without constraint and less likely required pain relief during childbirth.

Afulani et al., (2018), identified that male spouses formed part of the companion at childbirth and although women were supported with non-clinical task, others disliked the companionship at childbirth on grounds of privacy denied and encouraging gossips. When women were offered companion of choice, food and fluids intake as well as movement encouraged during labour, it improved the proportion of women having facility-based delivery (Perkins, et al., 2019). World Health Organization (WHO) (2018), recommends that at childbirth, where there are no complications, mother and baby should be put together within an hour of birth to establish skin-to-skin contact, encouraging bonding and promotes breastfeeding. Despite, advocacy for support to be provided to women, during childbirth, disrespect during childbirth is widely reported.

2.4 Prevalence of disrespect during childbirth

Disrespect and abuse describes any interaction, facility condition or behaviour of service provider that is deemed to be humiliating or undignified (Freedman et al., 2014). Bowser and Hill (2010), ‘identified seven categories of disrespect and abuse during childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care and detention in facilities (p.9).

Studies done in Tanzania and Kenya have also shown that disrespect and abusive treatment are common with a frequency of 20-28% during childbirth depending on the type of research and area (Abuya et al., 2015; Kruk et al., 2018). A study conducted by Abuya et al. (2015), indicated that about twenty per cent of women in Kenya felt embarrassed during childbirth. With six of the categories of disrespect and abuse experienced. Women with multiple births were thrice likely to be detained, for not able to settle delivery bills and five times probable to be manipulated for money, compared with those of a single birth.

According to Asefa and Bekele (2015), 78.6% of the women at childbirth soberly experienced disrespect and abuse with 16.2% instinctively affected. Every woman who delivered at the hospital, as well as 89.4% of those at the health centres experienced non-consented care with 39.3%, felt abandoned during labour. A study by Asefa et al. (2018) where health professionals with midwives constituting 43.9% of filled questionnaires which revealed that, fifty per cent of the respondents confirmed that provider failed to seek the consent of mothers during childbirth, a quarter experienced physical abuse, three out of ten had a breach of privacy and five out of ten respondents attested to the fact that the women had experienced disrespect and abuse during the birthing process.

A study conducted in Ghana by Moyer et al (2013), women recounted being physically and verbally abused as well as the occurrence of neglect, discrimination and the denial of their traditional practices. Moyer et al., (2016) in their study in Ghana, about seven out of ten final year midwifery students (72.0%) responded that

maltreatment was a problem in Ghana and the forms it observed were shouting (68.8%), scolding for not reporting with birth supplies (54.5%). Educated women were treated better than less educated women as revealed by about forty per cent of the respondents.

Certain individuals who report for childbirth are discriminated by health care providers based on race, ethnicity, age, HIV status, financial and educational status among others. Adolescent girls may be victims of discrimination based on young age at childbirth (Bowser & Hill, 2010). Mistreatment is observed at childbirth, especially with the adolescents, when delivery is imminent and they fail to push or unable to report at labour with items for confinement. The significant forms the mistreatment took include verbal abuse, physical abuse, neglect and lack of support (Maya et al., 2018). These maltreatments and abuse affect a client's level of satisfaction with care and the likelihood of uptake of facility delivery.

2.5 Satisfaction with care during childbirth

A relevant intent and execution of maternity services globally is the function of providing acceptable, accessible and respectful services that women require and mandated to indicate important things necessary for their care (Redshaw & Heikkilä, 2010; ten Hoope-Bender et al., 2014). Women satisfaction during labour and delivery is a principal part of the quality of reproductive health care. Satisfaction with the birthing process has an instant and permanent effect on the health of the woman and the calibre of association with the baby (Goodman, Mackey & Tavakoli, 2004). Women with the enjoyable occurrence of childbirth have significant self-regard and

close relationship with the newborn and definite presumption of future deliveries (Rostampey, Khakbazan & Golestan, 2010).

Satisfaction with labour and delivery is a complex idea with some elements and constituent which lack concurrence (Goodman, Mackey & Tavakoli, 2004; Ford, Ayers & Wright, 2009). Personal control has been advocated as a principal element of childbirth. Nonetheless, the antecedent to maternal dominance at childbirth is not completely acknowledged (Schempf & Strobino, 2009; Fair & Morrison, 2012).

A study conducted by Jafari, Mohebbi and Mazloomzadeh (2017), revealed that women's satisfaction with the birthing process is guaranteed on her knowledge of labour and delivery process, application of nonpharmacological use of analgesics and vital participation and supporting control of delivery. Encompassed by correct, safe and serene atmosphere constitute the most important requisite to ascertain the satisfaction of childbirth. Murray et al., (2010), identified pain control and the relationship of the caregivers to the women in childbirth are not easily forgotten and is related to the satisfaction of the mother during delivery. D'Ambruoso, Abbey and Hussein (2005), conducted a study in Ghana where the women anticipated compassionate, expert, respectful treatment from professionals and that interpersonal facets of care were prerequisite to patient satisfaction. According to Burrowes et al., (2016), women experienced a good relationship with health professionals when they were respected and most women responded satisfied with the care received because, the interventions instituted by health practitioners for primary partum haemorrhage could not have been managed effectively, if the delivery occurred at home. On the contrary, dissatisfaction with labour and delivery may result in an increased risk of

Postpartum depression, anxiety (Mohammad, Gamble & Creedy, 2011; Bertucci et al., 2012) posttraumatic stress disorder (Ford, Ayers & Wright, 2009) compromised maternal and neonatal bonding (Bertucci et al., 2012) anxious of subsequent delivery (Mohammad et al., 2014) and the option of subsequent caesarean delivery (Rostampey, Khakbazan & Golestan, 2010). Pain is amongst the exigent factors (Goodman, Mackey & Tavakoli, 2004), its severity and relief contribute to dissatisfaction in the birthing process (Hodnett, 2002; Goodman, Mackey & Tavakoli, 2004; Christiaens, Verhaeghe & Bracke, 2010).

A study was done by Floyd et al., (2015) in Ghana at a tertiary hospital in Accra showed that women were satisfied or dissatisfied based on clinical care, monitoring, prompt management, operative intervention as well as emotional support, courtesy, affection and consolation experienced. Satisfaction with care received during delivery has the tendency to influence preference for subsequent facility-based delivery.

2.6 Preference for subsequent facility-based delivery

Research has indicated that women are discouraged from seeking services from facilities when they have experienced disrespectful care. In addition, "women choose where to deliver based in large part, on the way they will be treated in the facilities available to them" (Freedman and Kruk, 2014,p 1). According to Crissman et al., (2013), fear of mistreatment and absence of support during labour and childbirth remain barriers to delivery care in a health facility in rural Ghana. Social factors play an essential role in the extent to which women are able to access facility-based care (Moyer et al., 2013; Yakong et al., 2010). The reasons why women and their families are dissatisfied with facility-based delivery or facility-based care for

complications include rudeness, uncaring health provider attitudes, lack of privacy and discrimination against cultural practices, physical abuse, dirty facilities and delay in seeking care (Bohren et al., 2014; Gabrysch & Campbell, 2009; Kruk et al., 2009; Mselle et al., 2013; Shiferaw et al., 2013).

A systematic review of qualitative studies of maternity care in Sub-Saharan Africa unveiled the negative attitudes women conveyed towards health care workers whose behaviour has been abusive or rude (Brighton et al., 2013) and that, this is likely to influence their decision to seek care in the future. The major stumbling block to acquiring skilled care for routine and complicated births is poor interactions between the patient and the health provider (Knight et al., 2013; Nair et al., 2014). According to Ethiopia Demographic and Health Survey (2011), ninety per cent of women did not receive facility-based assisted delivery, rather delivered at home as a result of provider attitude. Mistreatment and abuse by health providers are seen as poor patient-provider relationship and a barrier to seeking delivery care (Oyerinde et al., 2013)

2.7 Summary and Conclusion

Several studies have been conducted in Ghana on disrespect and mistreatment have extensively used qualitative methods to study the problem. These qualitative studies are useful as they provide the client's narrative of their experience, however, the magnitude remains unexplored. A quantitative study such as this is required to provide information on the prevalence as well as clients who are more likely to be mistreated. Again, some studies have reported on the forms of support women receive during childbirth and satisfaction with health care. However, there is a

paucity of data on the satisfaction with care and the likelihood of subsequent facility-based delivery in Ghana. This gap in literature will be filled with the current study.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter describes how the study was conducted and it consists of the following; the study design, the study location, data collection techniques, data collection tools, data processing and analysis, quality control measure employed and ethical issues.

3.2 Study Design

A quantitative cross-sectional study was conducted at three selected health facilities in LNMM. This type of design looks at data from a population at a specific point in time (snapshot). It describes characteristics that exist in the population but cannot determine cause and effect. Data were collected by a self-administered structured questionnaire. Siraj, Teka and Hebo (2019), used the same study design to determine the prevalence of disrespect and abuse during facility-based childbirth and associated factors in South West Ethiopia.

3.3 Study Location

The quantitative study was conducted at the three facilities mentioned earlier in La-Nkwantanang Madina Municipal Assembly. Pentecost Hospital, formally known as Alpha Medical Centre is a 56-bed facility (Mission) located in Madina Estates. It has 5 specialist doctors, 12 general medical practitioners, 4 medical assistants, 1 pharmacist, 5 Biomedical scientists, 24 midwives, 63 general nurses and 85 paramedical staffs. Madina Polyclinic Kekele is a government facility located in the Nkwantanang-Madina Sub-municipality with a bed capacity of 10. It has 1 Specialist, 4 Medical officers, 4 Medical assistants 2 Pharmacists, 114 nurses and 20 Midwives.

Services provided include General OPD, ANC/Postnatal, Family planning services and Specialised clinics.

The municipality is one of the twenty-one Metropolitan/Municipal/District Assemblies in the Greater Accra Region. Geographically it is a small municipality, which lies in the northeastern part of Greater Accra Region. It is bordered on the west by the Ga East Municipal Assembly (GEMA), on the east by the Adentan Municipal Assembly (AdMA), the south by Accra Metropolitan Assembly (AMA) and the north by the Akwapim South District Assembly. It is currently divided into five sub-municipals namely; Nkwantanang, Social welfare, Tataana, Danfa and Pantang (Figre 3.1). There are twenty-five communities comprising of mixed settlements thus urban, peri-urban and rural areas. The population of the municipality is 130,380 with an annual growth rate of 4.2% in 2015. The urban/peri-urban population constitutes 82% of the municipality's total population with 18% residing in rural settlements.

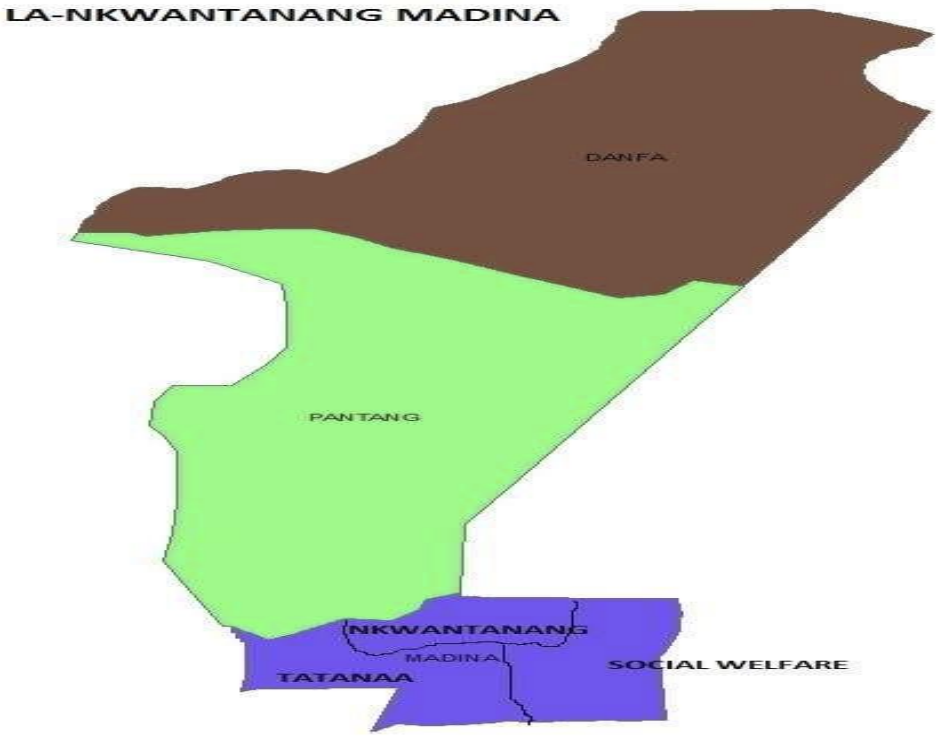


Figure 3.1: A map of La-Nkwantanang Madina Municipality in Accra, Ghana.

3.4 Study Population

This study was conducted among postnatal women within the reproductive ages of 15- 49years who delivered at these selected facilities and were attending postnatal clinic at the time of the study.

3.5 Study Variable

The study variables are divided into two: dependent and independent variables (3.1a and 3.1b).

Table 3.1a: Dependent and operational definition

Dependent Variable	Operation definition	Scale of measurement
Disrespectful care	Disrespct cover a wide range of experiences covering any of the following: Physical abuse: slapping/hitting or physical force on the mother Non-dignified care: mother experience rudeness, scolding or insults Non-consented care: No informed consent or information dissemination No privacy: curtains or other visual barriers not use Discrimiation: mother prejudiced on grounds of clinic state Neglect: mother was left alone or unattended to Detention: mother delayed in health facility against her will	Nominal

A woman is considered to have received disrespectful care if she experiences at least one of the seven categories of disrespect and abuse. For a specific category of abuse and disrespect with more than one verification criterion, a woman was labelled "abused and disrespected" in that category if she was abused and disrespected in at least one of the verification criteria during childbirth.

Table 3.1b: Independent variable and operational definition

Variable (independent)	Operational definition	Scale of measurement
Age	The number of years attained as at the last birthday celebrated.	Ratio
Marital status	This includes cohabitation, married, divorced and widowed.	Nominal
Educational level	The level of literacy of the respondent.	Ordinal
Occupation	The employment of the respondent.	Ordinal
Income	Amount of money earned monthly.	Ratio
Religion	Type of religion practised by the respondent.	Nominal
Parity	The number of children delivered by a woman.	Ratio
Mode of delivery	The route taken to deliver the baby.	Nominal
Companion at labour	Choice of someone to be present during childbirth	Nominal
Level of satisfaction	Overall impression made by the respondent from labouring and delivery. Process.	Ordinal
The decision for Facility-based delivery at subsequent birth	Respondents confidence in the patronage of the facility for future delivery.	Nominal

3.6 Inclusion Criteria

Women who have delivered either vaginally or by emergency caesarean section, reporting for their sixth-week postnatal review were included in the study.

3.7 Exclusion Criteria

Those who had a vaginal birth or emergency caesarean section after induction of labour as well as mothers in critical medical condition or experienced stillbirths nut attended postnatal for examination were excluded from the study. Women who had experienced stillbirth were excluded because they may be going through emotional distress which made it unethical to interview them.

3.8 Sample Size Determination

A single population proportion formula was used to estimate the sample size with an assumption of 5% precision and 95% confidence. An assumption that 72% of labouring mothers would face at least one form of disrespect and abuse during childbirth was undertaken. This figure was taken from a previous study conducted in Ghana in which final year midwifery students observed maltreatment of women at the labour wards (Moyer et al., 2016). This proportion was used to estimate the sample size. Therefore, the sample size of approximately 309 was derived using Fisher's formula.

$$n = z2\, p(1 - p)/e2$$

n = minimum sample size

z = standard normal deviate (1.96)

p = 72% of labouring mothers would face at least one form of disrespect (Moyer et al., 2016).

q=1-0.72= 0.28

e= degree of precision, set at 5% = 0.05

n= 309

In studies using postnatal women, it has been reported that a non- response rate of 2-10% should be expected. However, during the pilot study, no non-response was recorded. Nonetheless, the minimum response rate was adopted as advised. This, therefore, increased the sample size to 316.

3.9 Sampling Technique

The allocation of the sample to the three health facilities was made proportionately, based on the number of clients who received childbirth services at each facility in the month preceding the data collection period. The average number of deliveries per month in Pentecost Hospital, Madina Polyclinic (RC) and Madina Polyclinic Kekele were 310,40 and 108 respectively.

Health Facility	Population (N)	Population proportion P= (N/458) *100	Number selected N=(p*316)
Pentecost Hospital	310	0.68	215
Madina Polyclinic (RC)	40	0.09	28
Madina Polyclinic Kekele	108	0.23	73
Total	458	1.00	316

The postnatal clinic runs every week hence the sample size of mothers to be interviewed per week for Pentecost Hospital, Madina Polyclinic (RC) Madina Polyclinic Kekele were 36, 5, and 13 respectively. A simple random sampling without replacement was conducted at the selected facility to obtain the participants for the study. At each facility, a list of mothers attending postnatal clinic per week was obtained from the medical records and assigned numbers from one to the last number. Each number was written on a paper of the same size and put in a bowl with a blindfolded person to pick 36, 5, and 13 papers at Pentecost Hospital, Madina Polyclinic (RC) Madina Polyclinic Kekele respectively. The mothers whose names corresponded to the numbers selected at each facility were explained to, in detail, the study to be conducted to get their approval to become participants. If a client declined to become a participant, a replacement was done.

3.10 Data collection and Tools

A self-administered structured questionnaire was used for data elicitation. Participants who could not read, the Research Assistants interpreted the questions and helped them filled the questionnaire. The participants were reminded that their participation was voluntary and could stop at any time, and they could skip any questions they preferred not to answer. They were reminded that no identifying information would be recorded in their data. Upon completion of the consent process, questionnaires were administered on a one on one basis, to the participants. It took on an average of 40 minutes to administer each questionnaire. The questionnaire was divided into four parts (see appendix 2). The first part

sought to find out socio-demographic characteristics/ client-related factors. The second part assessed disrespectful care and forms of support during labour and childbirth. The tool was adapted from the Maternal and Child Health Integrated Program (MCHIP) tool kit instrument that assesses and improves respectful maternity care (Reis et al., 2012). An approach centred on the individual, touches on respect for beliefs, traditions and culture; the right to information and privacy; confidentiality; consent and preference in care; choice of a companion during labour and birth; freedom of movement during labour; non-separation of mother and newborn and prevention of institutional violence, including abusive and disrespectful care. The last part of the questionnaire assessed whether the participant was satisfied with the care or not. It also assessed the preference for facility-based delivery in subsequent births based on the care received.

3.11 Quality Control

Three research assistants were engaged in the study. They assisted in the administration of the questionnaire only. They were trained intensively for two days on the technique of questionnaire administration for the quantitative data collection on the ethical guidelines and data entry.

3.12 Pretesting

The developed questionnaire was pretested at the University of Ghana Hospital at Legon. Convenience sampling method was used to select ten postnatal women in that facility for pre-testing the questionnaire.

3.13 Data Processing and Analysis

Data was entered, cleaned and analysed using STATA software version15. Frequency and percentages were used to describe the demographic characteristics of the study participants.

The forms of support received and the various components of disrespectful care towards the women were also described using the frequency and percentages. The Pearson's chi-square test of association was used to assess socio-demographic factors and the forms of support that were significantly associated with the experience of at least one of the forms of disrespectful care practices towards women delivering at the health facilities. The multivariable logistic regression model was used to estimate the crude and adjusted odds ratio of the factors significantly associated with the experience of at least one form of disrespectful care from Pearson's chi-square test.

Also, the Pearson's chi-square test was used to assess the association between the socio-demographic characteristics, forms of support received during delivery and the various component of disrespectful care practices experienced among the women and as against their level of satisfaction. The level of satisfaction was dichotomized by putting those who were dissatisfied and those with a neutral level of satisfaction together and coded them as 0 whilst those who were satisfied were coded as 1. Based on the variables that were significant from the Pearson's chi-square test, the multivariate logistic regression model was used to estimate the crude and adjusted odds ratios of health care satisfaction among the women. All statistical tests with p-values below 0.05 were considered significant and a 95% confidence interval was estimated for all odds ratios in the study

3.14 Ethical Consideration

Approval was sought from the Ethical Review Committee of the Ghana Health Service (GHS), Research and Development Division, Accra. Informed consent of the respondent was sought before they participate in the study. The proposal also received ethical clearance from the University of Ghana, College of Health Sciences Research Ethics Committee.Permission was also obtained from the Municipal Health directorate at La-Nkwantanang Madina.

3.14.1 Access and approval of study area

The Municipal Health Directorate was notified of the intention to conduct the study. Subsequently, an introductory letter was obtained from the Head of Department, Social and Behavioural Science and sent to the Municipal Health Directorate. A copy of the approval letter from the Ghana Health Service Ethical Review Committee was also sent to the authorities.

3.14.2 Privacy, Confidentiality and Anonymity

All respondents were given assurance that any information they provide would strictly be used solely for academic purposes and their confidentiality was, therefore, assured. Participants' names were not mentioned in the report of the study and information gathered on participants was kept strictly confidential between the researcher and the study participants by storing data with a password known to only the researcher. Anonymity was ensured in the dissemination of findings from this study since participants were not identified by their names.

3.14.3 Compensation

No compensation was given to any study participant.

3.14.4 Risk and Benefits

Respondents were assured that the research would not come to them at any risk or cost except their precious time that they would use to fill the questionnaire. There were no direct benefits associated with taking part in the study. However, it is expected that the results of the study would contribute towards policy decisions making in order to improve facility-based delivery.

3.14.5 Voluntary withdrawal

Participants were at liberty to withdraw from the study at any point in time without posing a problem between the researcher and the respondent. Data collected on any participant who withdrew from the study at any stage was deleted.

3.14.6 Consenting process

Each respondent was approached individually to explain the objectives of the study to them before they gave their consent prior to participation. Before participants were interviewed, each was given a consent form to read and sign. For individuals who could not read, the purpose of the study was explained to them and when they accepted to partake, their thumbprints were taken.

3.14.7 Data storage and usage

The data collected was stored with passwords on electronic media and in a locked file cabinet and used strictly for the purposes of research. Anonymity would be ensured in dissemination of findings from this study with no identification of participants by their names.

3.14.8 Declaration of conflict of interest

The researcher as the principal investigator declared no conflict of interest in the study.

3.14.9 Funding for the study

This study is in partial fulfilment of requirements towards the award of a Master of Public Health (MPH) degree at the School of Public Health, College of Health Sciences, University of Ghana, Legon. Hence no funding from any source and all estimated cost of the study was borne solely by the researcher.

3.15 Dissemination of Findings

The result of the research is submitted to the School of Public Health in partial fulfilment of the requirements for the award of a Master of Public Health Degree. The findings will also be written for publication in a peer-reviewed journal.

3.16 Limitations of the study

The data was collected on the sixth week after delivery and could introduce recall bias in gathering their experiences. The health facility where delivery occurred was the settings used in gathering data. This may introduce information bias if the respondents are unable to express themselves for fear of victimization. Nonetheless, particiapntw are assured of anonymity. From observation during data collection, participants responded to the questions without fear of victimization.

CHAPTER FOUR

4.0 RESULTS

Introduction

This chapter of the study presents the results obtained in the analysis of the study. The chapter begins with the demographic profiles of the respondents, followed by the descriptive statistics of the study and the discussion of the results obtained from the study. The data were analysed using Stata version 15.0 as well as Microsoft Excel in creating frequency tables, charts and graphs. The results are presented according to the specific objectives and the conceptual framework

4.1 Socio-demographic characteristics of respondents

A total of 313 pregnant women were interviewed in the study. About half (49.8%, n=156) were within the age range 25 to 34 years, 22.0% (n=69) were single whilst 43.8% (n=137) were married, 17.9% (n=56) had no formal education whilst 12.5% (n=39) had tertiary level of education, 22.4% (n=70) were unemployed. Most (68.7%, n=215) of the women delivered at PHM. (Table 4.1).

Table 4.1: Background characteristics of Postnatal women at LNMM, 2019

Socio-demographic characteristics and reproductive history	Frequency (n=313)	Percentage (%)
Age group		
<25	111	35.46
25-34	156	49.84
35-44	46	14.70
Marital status		
Single	69	22.04
Married	137	43.77
Co-habiting	81	25.88
Divorced/Widowed	26	8.31
Highest education		
No education	56	17.89
Primary	107	34.19
Secondary	111	35.46
Tertiary	39	12.46
Employment		
Unemployed	70	22.36
Civil servant	44	14.06
Traders	146	46.65
Others	53	16.93
Income (GHS)		
None	18	5.75
<500	113	36.10
500-1000	88	28.12
>1000	94	30.03
Religion		
Muslim	115	36.74
Christians	198	63.26
Parity		
P1-2	229	73.16
P3-4	71	22.68
P4+	13	4.15
Mode of delivery		
Emergency Caesarean Section (Em. CS)	68	21.73
Spontaneous Vagina Delivery (SVD)	245	78.27
Facility of delivery		
MPK	70	22.36
MPR/C	28	8.95
PHM	215	68.69

4.2 Forms of Support received during labour and childbirth at LNMM, 2019

Over half (54.3%, n=170) of the women were encouraged to have a support person present during delivery whilst 76.7% (n=240) liked the idea of support persons being present. A third (33.2%, n=104) had their mothers as labour companions, 22.4% (n=70) had their husband or partners present whilst 10 (3.2%) had no one present

during delivery. Less than half 34.5% (n=108) of the women had the freedom of movement during labour, 44.7% (n=140) were encouraged to eat foods, 50.2% (n=157) were encouraged to take fluids, 51.4% (n=161) had labour analgesia, 29.4% (n=92) had episiotomy done whilst 80.2% (n=251) had their babies given to them immediately after birth. (Table 4.2).

Table 4.2: Forms of Support received during labour and childbirth at LNMM, 2019

Forms of support	Frequency (n)	Percentage (%)
Woman encouraged to have support person		
No	143	45.69
Yes	170	54.31
A woman likes the idea of a support person		
No	73	23.32
Yes	240	76.68
Labour companion		
Mother	104	33.23
Husband/partner	70	22.36
Friend	31	9.90
Others	98	31.31
None	10	3.19
The woman had freedom of movement during labour		
No	151	48.24
Yes	108	34.50
Don't know	54	17.25
Encouraged to eat food		
No	173	55.27
Yes	140	44.73
Encouraged to take fluids		
No	156	49.84
Yes	157	50.16
Labour analgesia		
No	152	48.56
Yes	161	51.44
Episiotomy/laceration		
No	221	70.61
Yes	92	29.39
The baby was given to the mother immediately after birth		
No	62	19.81
Yes	251	80.19

4.3 Self-reported experience and forms of disrespect experienced during labour and childbirth at LNMM, 2019

Fig. 4.1 shows the frequency distribution of the number of women who experienced the various forms of disrespect during the delivery at the health facilities. About a fifth (19.8%, n=62) of the women experienced physical abuse and 9.3% (n=29) were

discriminated against. 38.9% (n=122) of the women experienced undignified care, 7.7% (n=24) of the women were detained or confined against their will, 60.4% (n=189) did not receive consented care, the

privacy or the confidentiality of 109 (34.8%) women were not protected and 17.9% (n=56) of the women were left unattended to when they needed care. (Fig. 4.1)

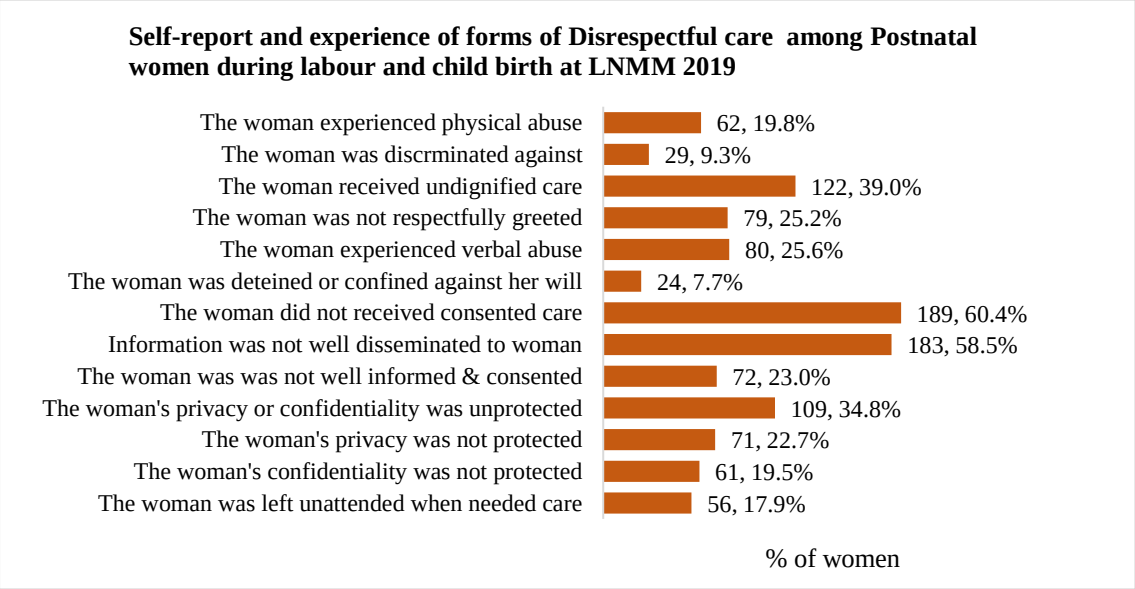


Fig. 4.1: Self-reported and experience and forms of disrespect experienced during labour and childbirth at LNMM, 2019

4.3.1 Prevalence of disrespectful care among the Postnatal women during delivery and childbirth

In overall, 75.7% (n=237) of the women experienced at least one form of disrespectful care during their delivery at the health facility. (Fig. 4.2)

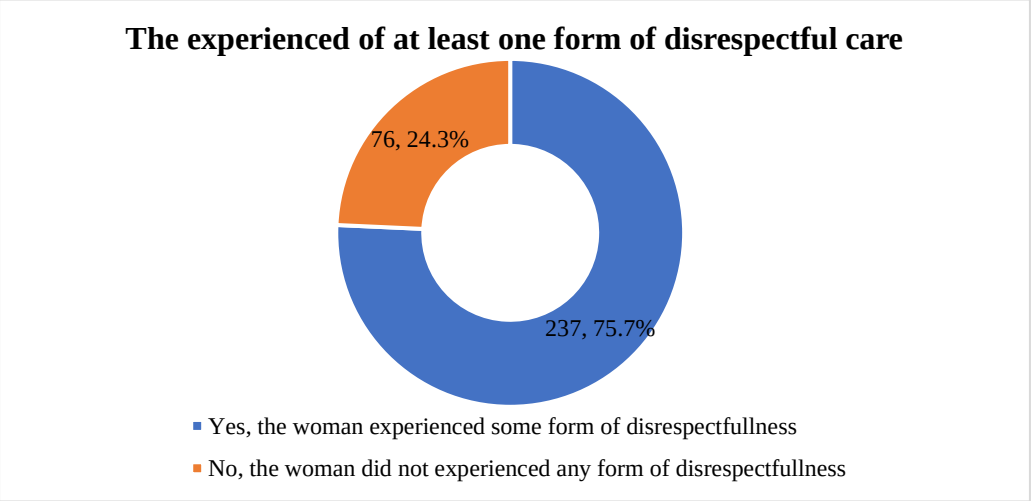


Fig. 4.2: Prevalence of disrespectful care among Postnatal women during labour and delivery.

4.4 Association between socio-demographic characteristics (SCD) and reproductive factors (RH) and experience of disrespectful care

Pearson's chi-square test was used to assess the association between socio-demographic characteristics of the women and experience of some form of disrespectful care. The experience of at least one form of disrespectful care was 85.5% (59/69) among single women, 64.9% (89/137) among married women, 80.3% (65/81) among cohabiting women, and 92.3% (24/26) among divorced or widowed women. There was significant association between marital status and the experience of at least one form of disrespectful care (χ^2=17.01, p=0.001).

Experience of some form of disrespectful care was higher among women who visited PHM (86.5%, 186/215) compared to those who visited MPK (58.6%, 41/70) and MPR/C (35.7%, 10/28). There was a significant association between health facility delivered at and the experience of at least one form of disrespectful care (χ^2=49.19, p<0.001). Highest level of education (χ^2=15.05, p=0.002), employment (χ^2=10.97, p=0.012), religion (χ^2=10.63, p=0.001) and mode of delivery (χ^2=13.54, p<0.001) were also significantly associated with the experience of at least one form of disrespectful care. (Table 4.4).

Table 4.4: Association between Socio-demographic characteristics (SCDs) and reproductive history (RH) and experience of disrespectful care, 2019

SCDs/RH Variables	Total n	Experience of any form of disrespect: No n (%)	Experience of any form of disrespect: Yes n (%)	χ^2-value	p-value
Age group				4.14	0.126
<25	111	20 (18.02)	91 (81.98)		
25-34	156	45 (28.85)	111 (71.15)		
35-44	46	11 (23.91)	35 (76.09)		
Marital status				17.01	0.001**
Single	69	10 (14.49)	59 (85.51)		
Married	137	48 (35.04)	89 (64.96)		
Co-habiting	81	16 (19.75)	65 (80.25)		
Divorced/Widowed	26	2 (7.69)	24 (92.31)		
Highest education				15.05	0.002**
No education	56	7 (12.50)	49 (87.50)		
Primary	107	33 (30.84)	74 (69.16)		
Secondary	111	20 (18.02)	91 (81.98)		
Tertiary	39	16 (41.03)	23 (58.97)		
Employment				10.97	0.012*
Unemployed	70	7 (10.00)	63 (90.00)		
Civil servant	44	15 (34.09)	29 (65.91)		
Traders	146	40 (27.40)	106 (72.60)		
Others	53	14 (26.42)	39 (73.58)		
Income				3.71	0.294
None	18	2 (11.11)	16 (88.89)		
<500	113	32 (28.32)	81 (71.68)		
500-1000	88	23 (26.14)	65 (73.86)		
>1000	94	19 (20.21)	75 (79.79)		
Religion				10.63	0.001**
Muslim	115	16 (13.91)	99 (86.09)		
Christians	198	60 (30.30)	138 (69.70)		
Parity				1.19	0.552
P1-2	229	52 (22.71)	177 (77.29)		
P3-4	71	20 (28.17)	51 (71.83)		
P4+	13	4 (30.77)	9 (69.23)		
Mode of delivery				13.54	<0.001***
Emergency Caesarean Section (Em. CS)	68	5 (7.35)	63 (92.65)		
Spontaneous Vagina Delivery (SVD)	245	71 (28.98)	174 (71.02)		
Facility of delivery				49.19	<0.001***
MPK	70	29 (41.43)	41 (58.57)		
MPR/C	28	18 (64.29)	10 (35.71)		
PHM	215	29 (13.49)	186 (86.51)		

χ^2: Pearson's chi-square. P-value Notation: *: p<0.05. **: p<0.01. ***: p<0.05

4.5 Association between forms of supports received and the experience of any form of disrespect among Postnatal women during labour and childbirth at LNMM 2019.

Table 4.5 shows the Pearson's chi-square test of association between the various form of support received and the experience of at least one form of disrespectful care. The woman is encouraged to have a support person (χ^2=17.31, p<0.001), the woman liking

the idea of a support person (χ^2=24.03, p<0.001), the labour companion present (χ^2=13.56, p=0.009), having the freedom of movement during labour (χ^2=23.92, p<0.001), encouraged to eat food (χ^2=22.79, p<0.001), encouraged to take fluids (χ^2=15.39, p<0.001), having labour analgesia (χ^2=20.32, p<0.001) and the baby given to mother immediately after delivery (χ^2=11.06, p=0.001) were the forms of support significantly associated with the experience of at least one form of disrespectful care. Also, the number of staffs present during labour (χ^2=8.93, p=0.003) was significantly associated with the experience of at least one form of disrespectful care. (Table 4.5)

Table 4.5: Association between forms of supports received and the experience of any form of disrespect among Postnatal women during labour and childbirth at LNMM.

Variables	Total n	Any form of disrespectful care		χ^2-value	p-value
		No n (%)	Yes n (%)		
Support person encouraged				17.31	<0.001***
No	143	19 (13.29)	124 (86.71)		
Yes	170	57 (33.53)	113 (66.47)		
Likes the idea of a support person				24.03	<0.001***
No	73	2 (2.74)	71 (97.26)		
Yes	240	74 (30.83)	166 (69.17)		
Labour companion				13.56	0.009**
Mother	104	20 (19.23)	84 (80.77)		
Husband/partner	70	24 (34.29)	46 (65.71)		
Friend	31	3 (9.68)	28 (90.32)		
Others	98	29 (29.59)	69 (70.41)		
None	10	0 (0.00)	10 (100.00)		
Had the freedom of movement during labour				23.92	<0.001***
No	151	33 (21.85)	118 (78.15)		
Yes	108	41 (37.96)	67 (62.04)		
Don't know	54	2 (3.70)	52 (96.30)		
Encouraged to eat food				22.79	<0.001***
No	173	24 (13.87)	149 (86.13)		
Yes	140	52 (37.14)	88 (62.86)		
Encouraged to take fluids				15.39	<0.001***
No	156	23 (14.74)	133 (85.26)		
Yes	157	53 (33.76)	104 (66.24)		
Labour analgesia				20.32	<0.001***
No	152	54 (35.53)	98 (64.47)		
Yes	161	22 (13.66)	139 (86.34)		
Episiotomy/laceration				0.59	0.441
No	221	51 (23.08)	170 (76.92)		
Yes	92	25 (27.17)	67 (72.83)		
The baby was given to the mother immediately after birth				11.06	0.001**
No	62	5 (8.06)	57 (91.94)		

Table 4.5: Association between forms of supports received and the experience of any form of disrespect among Postnatal women during labour and childbirth at LNMM continued.

Variables	Total n	Any form of disrespectful care		χ^2-value	p-value
		No n (%)	Yes n (%)		
Staffs present during labour				8.93	0.003**
Less than three (< 3)	227	45 (19.82)	182 (80.18)		
Three or more (≥ 3)	86	31 (36.05)	55 (63.95)		
Staffs present during delivery				1.26	0.262
Less than three (< 3)	223	58 (26.01)	165 (73.99)		
Three or more (≥ 3)	90	18 (20.00)	72 (80.00)		
Staff overwhelmed				3.07	0.216
No	125	36 (28.80)	89 (71.20)		
Yes	43	7 (16.28)	36 (83.72)		
Don't know	145	33 (22.76)	112 (77.24)		

χ^2: Pearson's chi-square. P-value Notation: *: p<0.05. **: p<0.01. ***: p<0.05

4.6 Determinants of the experience of disrespect during labour and delivery

Table 4.6 shows a multivariate analysis of the factors associated with the experience of at least one form of disrespectful care towards women delivering at the health care facility. The simple logistic regression model was used to estimate the unadjusted odds ratio whilst the multiple logistic regression model was used to estimate the adjusted odds ratio.

From the adjusted logistic regression model, the odds of a woman experiencing at least one form of disrespectful care was 5 times significantly high for those visiting PHM compared to those visiting MPR/C (AOR: 5.01, 95% CI: 1.18-21.35, p=0.029). The odds of experiencing at least one form of disrespectful care was 2.5 times among women who were not encouraged to have a support person present compared to women who were encouraged to have a support person present during delivery (AOR: 2.48, 95% CI: 1.12-5.49, p=0.026). Also, women who did not like the idea of support person present during labour had 5-times increased odds of experiencing at least one form of disrespectful care compared to those who did not like the idea of support person present (AOR: 5.38, 95% CI: 1.08-26.81, p=0.040). Also, women who had less than 3 health care providers present during labour had 3-times increased odds of experiencing at least one form of disrespectful care compared to those who had at least three health care workers present (AOR: 3.31, 95% CI: 1.47-7.42, p=0.004). (Table 4.6)

Table 4.6: Multivariate analysis of factors influencing the experience of any form of disrespect towards Postnatal women during labour and delivery, 2019

Any form of disrespect	Unadjusted logistic regression		Adjusted logistic regression	
Variables	**UOR [95% CI]**	**P-value**	**AOR [95% CI]**	**P-value**
Marital status				
Single	1.00 [reference]		1.00 [reference]	
Married	0.31 [0.15-0.67]	0.003**	1.10 [0.39-3.06]	0.857
Co-habiting	0.69 [0.29-1.64]	0.398	1.90 [0.60-5.96]	0.272
Divorced/Widowed	2.03 [0.41-9.98]	0.382	2.91 [0.50-17.02]	0.236
Highest education				
No education	4.87 [1.76-13.46]	0.002**	3.70 [0.78-17.64]	0.101
Primary	1.56 [0.73-3.33]	0.251	1.97 [0.55-6.97]	0.295
Secondary	3.17 [1.42-7.05]	0.005**	2.72 [0.81-9.16]	0.107
Tertiary	1.00 [reference]		1.00 [reference]	
Employment				
Unemployed	1.00 [reference]		1.00 [reference]	
Civil servant	0.21 [0.08-0.58]	0.003**	0.50 [0.12-2.17]	0.354
Traders	0.29 [0.12-0.70]	0.005**	0.65 [0.22-1.94]	0.434
Others	0.31 [0.11-0.83]	0.020*	1.16 [0.31-4.35]	0.830
Religion				
Muslim	1.00 [reference]		1.00 [reference]	
Christians	0.37 [0.20-0.68]	0.001**	0.88 [0.38-2.02]	0.764
Mode of delivery				
Emergency Caesarean Section	1.00 [reference]		1.00 [reference]	
Spontaneous Vagina Delivery	0.19 [0.08-0.50]	0.001**	0.63 [0.17-2.33]	0.486
Facility of delivery				
MPK	2.54 [1.03-6.31]	0.044*	1.36 [0.42-4.41]	0.611
MPR/C	1.00 [reference]		1.00 [reference]	
PHM	11.54 [4.85-27.46]	<0.001***	5.01 [1.18-21.35]	0.029*
Woman encouraged to have support person				
No	3.29 [1.85-5.87]	<0.001***	2.48 [1.12-5.49]	0.026*
Yes	1.00 [reference]		1.00 [reference]	
A woman likes the idea of a support person				
No	15.83 [3.78-66.24]	<0.001***	5.38 [1.08-26.81]	0.040*
Yes	1.00 [reference]		1.00 [reference]	
Labour companion				
Mother	1.00 [reference]		1.00 [reference]	
Husband/partner	0.46 [0.23-0.91]	0.027*	1.28 [0.45-3.65]	0.645
Friend	2.22 [0.61-8.05]	0.224	1.12 [0.22-5.60]	0.891
Others	0.57 [0.29-1.09]	0.088	0.72 [0.30-1.76]	0.475
The woman had freedom of movement during labour				
No	1.00 [reference]		1.00 [reference]	
Yes	0.46 [0.26-0.79]	0.005**	0.84 [0.39-1.79]	0.642
Don't know	7.27 [1.68-31.44]	0.008**	3.66 [0.70-19.30]	0.126
Encouraged to eat food				
No	1.00 [reference]		1.00 [reference]	
Yes	0.27 [0.16-0.47]	<0.001***	0.68 [0.24-1.91]	0.467
Encouraged to take fluids				
No	1.00 [reference]		1.00 [reference]	
Yes	0.34 [0.20-0.59]	<0.001***	0.88 [0.31-2.46]	0.806
Labour analgesia				
No	1.00 [reference]		1.00 [reference]	
Yes	3.48 [1.99-6.09]	<0.001***	2.05 [0.82-5.10]	0.123

4.7 Level of satisfaction of health care service received during labour and delivery among Postnatal women at LNMM 2019

Of the 313 women interviewed in the study, 14.1% (n=44) were dissatisfied, 28.4% (n=89) were neutral and 57.5% (n=180) were satisfied with the health care services they received during their labour and delivery at the health facilities. (Fig. 4.3)

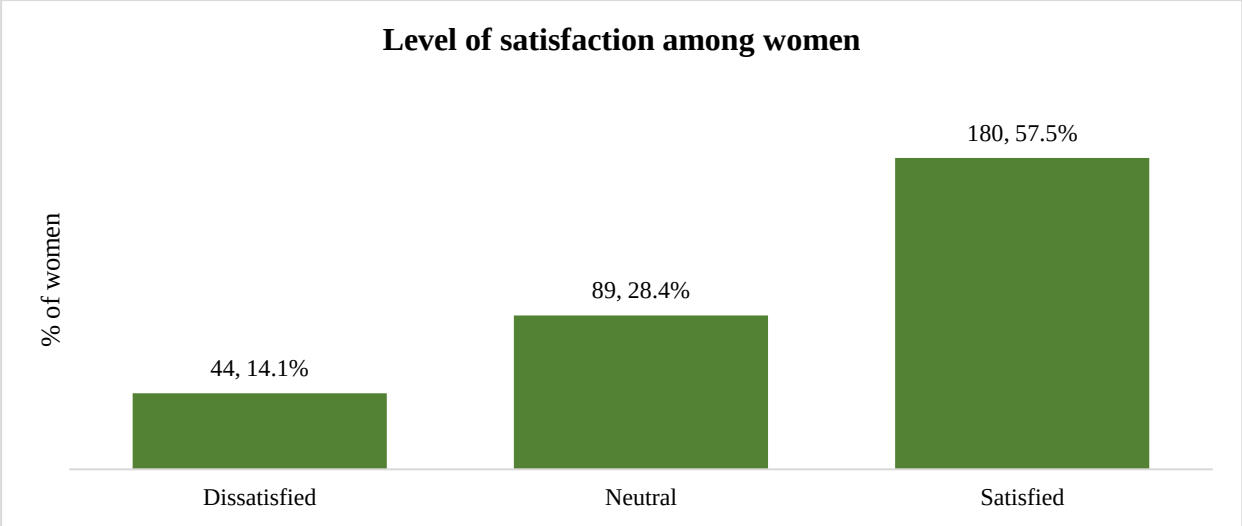


Fig. 4.3: Level of satisfaction towards health care received during labour and delivery among Postnatal women in LNMM 2019

4.8 Association between Socio-Demographic characteristics and reproductive history and Patients' satisfaction with health care service

Pearson's chi-square test was also used to assess the association between the socio-demographic characteristic of the women and their level of satisfaction. Health care satisfaction was 45.7% (32/70) among unemployed women, 54.6% (24/44) among civil servants, 60.3% (88/146) among traders and 67.9% (36/53) among those with other jobs. The occupation of the women was significantly associated with the level of satisfaction (χ^2=18.98, p=0.004). Health care satisfaction was 88.6% (62/70) among women who visited MPK, 82.1% (23/28) among those who visited MPR/C and 44.2% (95/215) among those who visited PHM. The health care facility was significantly associated with the level of satisfaction among women (χ^2=50.3, p<0.001). The income level (χ^2=24.91, p<0.001), religion (χ^2=10.41, p=0.005), parity (χ^2=9.78, p=0.044) and mode of delivery (χ^2=8.92, p=0.12) were also significantly associated with the level of satisfaction among the women. (Table 4.8)

Table 4.8: Association between Socio-demographic characteristics and reproductive factors and patients' satisfaction with health care service

SCDs/RH Variables	Total n	Level of satisfaction			χ^2-value	p-value
		Dissatisfied n (%)	Neutral n (%)	Satisfied n (%)		
Age group					4.09	0.394
<25	111	20 (18.02)	27 (24.32)	64 (57.66)		
25-34	156	19 (12.18)	45 (28.85)	92 (58.97)		
35-44	46	5 (10.87)	17 (36.96)	24 (52.17)		
Marital status					12.35	0.055
Single	69	16 (23.19)	23 (33.33)	30 (43.48)		
Married	137	19 (13.87)	36 (26.28)	82 (59.85)		
Co-habiting	81	5 (6.17)	22 (27.16)	54 (66.67)		
Divorced/Widowed	26	4 (15.38)	8 (30.77)	14 (53.85)		
Highest education					8.36	0.213
No education	56	11 (19.64)	20 (35.71)	25 (44.64)		
Primary	107	16 (14.95)	23 (21.50)	68 (63.55)		
Secondary	111	13 (11.71)	36 (32.43)	62 (55.86)		
Tertiary	39	4 (10.26)	10 (25.64)	25 (64.10)		
Employment					18.98	0.004**
Unemployed	70	20 (28.57)	18 (25.71)	32 (45.71)		
Civil servant	44	4 (9.09)	16 (36.36)	24 (54.55)		
Traders	146	14 (9.59)	44 (30.14)	88 (60.27)		
Others	53	6 (11.32)	11 (20.75)	36 (67.92)		
Income					24.91	<0.001***
None	18	6 (33.33)	4 (22.22)	8 (44.44)		
<500	113	13 (11.50)	21 (18.58)	79 (69.91)		
500-1000	88	6 (6.82)	30 (34.09)	52 (59.09)		
>1000	94	19 (20.21)	34 (36.17)	41 (43.62)		
Religion					10.41	0.005**
Muslim	115	24 (20.87)	37 (32.17)	54 (46.96)		
Christians	198	20 (10.10)	52 (26.26)	126 (63.64)		
Parity					9.78	0.044*
P1-2	229	36 (15.72)	71 (31.00)	122 (53.28)		
P3-4	71	8 (11.27)	17 (23.94)	46 (64.79)		
P4+	13	0 (0.00)	1 (7.69)	12 (92.31)		
Mode of delivery					8.92	0.012*
Emergency Caesarean Section	68	9 (13.24)	29 (42.65)	30 (44.12)		
Spontaneous Vagina Delivery	245	35 (14.29)	60 (24.49)	150 (61.22)		
Facility of delivery					50.30	<0.001***
MPK	70	3 (4.29)	5 (7.14)	62 (88.57)		
MPR/C	28	2 (7.14)	3 (10.71)	23 (82.14)		
PHM	215	39 (18.14)	81 (37.67)	95 (44.19)		

χ^2: Pearson's chi-square. P-value Notation: *: p<0.05. **: p<0.01. ***: p<0.05

4.9 Association between forms of support received and patients' satisfaction with health care service

Table 4.9 shows the Pearson's chi-square association between forms of support received and the level of satisfaction among the women. The woman being encouraged to have a support person (χ^2=17.63, p<0.001), the woman liking the idea of a support person (χ^2=17.78, p<0.001), having the freedom of movement during labour (χ^2=10.30, p=0.036), encouraged to eat food (χ^2=6.26, p=0.044), having labour analgesia (χ^2=15.84, p<0.001) and the baby given to mother immediately after delivery (χ^2=13.18, p=0.001) were the forms of support significantly associated with

the level of satisfaction of the women towards the health care services they received. Also, the staff being overwhelmed (χ^2=26.06, p<0.001) and the preference for the health facility visited during the woman's next delivery (χ^2=142.90, p<0.001) were also significantly associated with the experience of at least one form of disrespectful care. (Table 4.9).

Table 4.9: Association between forms of support received and patients' satisfaction with health care service

Variables	Total n	Level of satisfaction			χ^2-value	p-value
		Dissatisfied n (%)	Neutral n (%)	Satisfied n (%)		
Support person encouraged					17.63	<0.001***
No	143	27 (18.88)	52 (36.36)	64 (44.76)		
Yes	170	17 (10.00)	37 (21.76)	116 (68.24)		
Likes the idea of a support person					17.78	<0.001***
No	73	21 (28.77)	20 (27.40)	32 (43.84)		
Yes	240	23 (9.58)	69 (28.75)	148 (61.67)		
Labour companion					12.43	0.133
Mother	104	16 (15.38)	24 (23.08)	64 (61.54)		
Husband/partner	70	7 (10.00)	17 (24.29)	46 (65.71)		
Friend	31	4 (12.90)	15 (48.39)	12 (38.71)		
Others	98	14 (14.29)	30 (30.61)	54 (55.10)		
None	10	3 (30.00)	3 (30.00)	4 (40.00)		
Had the freedom of movement during labour					10.30	0.036*
No	151	18 (11.92)	52 (34.44)	81 (53.64)		
Yes	108	17 (15.74)	19 (17.59)	72 (66.67)		
Don't know	54	9 (16.67)	18 (33.33)	27 (50.00)		
Encouraged to eat food					6.26	0.044*
No	173	26 (15.03)	58 (33.53)	89 (51.45)		
Yes	140	18 (12.86)	31 (22.14)	91 (65.00)		
Encouraged to take fluids					5.04	0.080
No	156	22 (14.10)	53 (33.97)	81 (51.92)		
Yes	157	22 (14.01)	36 (22.93)	99 (63.06)		
Labour analgesia					15.84	<0.001***
No	152	21 (13.82)	28 (18.42)	103 (67.76)		
Yes	161	23 (14.29)	61 (37.89)	77 (47.83)		
Episiotomy/laceration					3.34	0.188
No	221	28 (12.67)	69 (31.22)	124 (56.11)		
Yes	92	16 (17.39)	20 (21.74)	56 (60.87)		
The baby was given to the mother immediately after birth					13.18	0.001**
No	62	13 (20.97)	26 (41.94)	23 (37.10)		
Yes	251	31 (12.35)	63 (25.10)	157 (62.55)		
Number labour					1.29	0.525

Table 4.9: Association between forms of support received and patients' satisfaction with health care service continued.

<Three	227	35 (15.42)	63 (27.75)	129 (56.83)		
>Two	86	9 (10.47)	26 (30.23)	51 (59.30)		
number delivery					0.41	0.813
<Three	223	33 (14.80)	62 (27.80)	128 (57.40)		
>Two	90	11 (12.22)	27 (30.00)	52 (57.78)		
Staff overwhelmed					26.06	<0.001***
No	125	13 (10.40)	19 (15.20)	93 (74.40)		
Yes	43	9 (20.93)	15 (34.88)	19 (44.19)		
Don't know	145	22 (15.17)	55 (37.93)	68 (46.90)		
Preference for health facility					142.90	<0.001***
No	81	31 (38.27)	28 (34.57)	22 (27.16)		
Yes	151	2 (1.32)	15 (9.93)	134 (88.74)		
Don't know	81	11 (13.58)	46 (56.79)	24 (29.63)		

χ^2: Pearson's chi-square. P-value Notation: *: p<0.05. **: p<0.01. ***: p<0.05

4.10 Association between forms of disrespect experienced and Patients' satisfaction with health care service

Table 4.10 shows the association between the level of satisfaction and the various form of disrespectful care among women during labour and delivery at the health facilities.

Table 4.10: Association between forms of disrespect experienced and Patients' satisfaction with health care service

Disrepect variables	Total N	Level of satisfaction			χ^2-value	p-value
		Dissatisfied n (%)	Neutral n (%)	Satisfied n (%)		
The woman experienced physical abuse					7.93	0.019*
No	251	31 (12.35)	66 (26.29)	154 (61.35)		
Yes	62	13 (20.97)	23 (37.10)	26 (41.94)		
The woman was discriminated against					1.12	0.573
No	284	39 (13.73)	79 (27.82)	166 (58.45)		
Yes	29	5 (17.24)	10 (34.48)	14 (48.28)		
The woman received undignified care					35.96	<0.001***
No	191	10 (5.24)	52 (27.23)	129 (67.54)		
Yes	122	34 (27.87)	37 (30.33)	51 (41.80)		
The woman was not respectfully greeted					21.17	<0.001***
No	234	22 (9.40)	63 (26.92)	149 (63.68)		
Yes	79	22 (27.85)	26 (32.91)	31 (39.24)		
The woman experienced verbal abuse					16.93	<0.001***
No	233	23 (9.87)	63 (27.04)	147 (63.09)		
Yes	80	21 (26.25)	26 (32.50)	33 (41.25)		
The woman was detained or confined against her will					12.81	0.002**
No	289	35 (12.11)	82 (28.37)	172 (59.52)		
Yes	24	9 (37.50)	7 (29.17)	8 (33.33)		
The woman did not receive consented care					17.93	<0.001***
No	124	6 (4.84)	32 (25.81)	86 (69.35)		
Yes	189	38 (20.11)	57 (30.16)	94 (49.74)		
Information was not well disseminated to woman					19.82	<0.001***
No	130	6 (4.62)	34 (26.15)	90 (69.23)		
Yes	183	38 (20.77)	55 (30.05)	90 (49.18)		
The woman was not well informed & consented					8.00	0.018*
No	241	28 (11.62)	65 (26.97)	148 (61.41)		
Yes	72	16 (22.22)	24 (33.33)	32 (44.44)		
The woman's privacy/confidentiality was not well protected					2.61	0.272
No	204	26 (12.75)	54 (26.47)	124 (60.78)		
Yes	109	18 (16.51)	35 (32.11)	56 (51.38)		
The woman's privacy was not protected					0.76	0.684
No	242	34 (14.05)	66 (27.27)	142 (58.68)		
Yes	71	10 (14.08)	23 (32.39)	38 (53.52)		
The woman's confidentiality was not protected					11.88	0.003**
No	252	29 (11.51)	67 (26.59)	156 (61.90)		
Yes	61	15 (24.59)	22 (36.07)	24 (39.34)		
The woman was left unattended when needed care					7.86	0.020*
No	257	30 (11.67)	72 (28.02)	155 (60.31)		
Yes	56	14 (25.00)	17 (30.36)	25 (44.64)		
The woman experienced some form of disrespectful care					17.73	<0.001***
Respectful	76	1 (1.32)	18 (23.68)	57 (75.00)		
Disrespectful	237	43 (18.14)	71 (29.96)	123 (51.90)		

χ^2: Pearson's chi-square. P-value Notation: *: p<0.05. **: p<0.01. ***: p<0.05

4.11 Multivariate analysis of factors influencing patients' satisfaction with health care services.

The level of satisfaction was dichotomized with those who were not satisfied combined with those with a neutral level of satisfaction. The logistic regression model was then used to estimate both the crude odds and adjusted odds of satisfaction of health care services among the women. From the adjusted logistic regression model, women who were encouraged to have a support person present had about 3-time significant odds of satisfaction of health care services compared to women who were not encouraged to have a support person present (AOR: 2.83, 95% CI: 1-44-5.56, p=0.003). Also, the odds of health care satisfaction was 15 times significant among women who preferred the health facility for the next delivery compared to those who will not use the health facility for the next delivery (AOR: 15.06, 95% CI: 6.26-36.19, p<0.001). (Table 4.11)

Table 4.11: Multivariate analysis of factors influencing Postnatal women's' satisfaction with health care services

	Unadjusted logistic regression		Adjusted logistic regression	
Variables	**UOR [95% CI]**	**P-value**	**AOR [95% CI]**	**P-value**
Employment				
Unemployed	1.00 [reference]		1.00 [reference]	
Civil servant	1.43 [0.67-3.04]	0.359	0.84 [0.26-2.76]	0.777
Traders	1.80 [1.01-3.20]	0.045*	0.74 [0.30-1.83]	0.517
Others	2.51 [1.19-5.29]	0.015*	0.59 [0.18-1.96]	0.389
Income				
None	1.00 [reference]		1.00 [reference]	
<500	2.90 [1.05-8.00]	0.039*	1.51 [0.29-7.79]	0.620
500-1000	1.81 [0.65-5.02]	0.257	0.83 [0.14-4.78]	0.835
>1000	0.97 [0.35-2.67]	0.948	0.75 [0.13-4.48]	0.756
Religion				
Muslim	1.00 [reference]		1.00 [reference]	
Christians	1.98 [1.24-3.15]	0.004**	1.70 [0.84-3.45]	0.139
Parity				
P1-2	1.00 [reference]		1.00 [reference]	
P3-4	1.61 [0.93-2.80]	0.089	1.64 [0.71-3.79]	0.245
P4+	10.52 [1.35-82.28]	0.025*	13.45 [0.96-188.02]	0.053
Mode of delivery				
Emergency Caesarean Section	1.00 [reference]		1.00 [reference]	
Spontaneous Vagina Delivery	2.00 [1.16-3.44]	0.012*	1.37 [0.57-3.30]	0.488
Facility of delivery				
MPK	9.79 [4.47-21.44]	<0.001***	1.13 [0.34-3.80]	0.842
MPR/C	5.81 [2.13-15.86]	0.001**	1.14 [0.18-7.26]	0.887
PHM	1.00 [reference]		1.00 [reference]	
Support person encouraged to woman (ref: No)	2.65 [1.67-4.21]	<0.001***	2.83 [1.44-5.56]	0.003**
Woman likes idea of support person (ref: No)	2.06 [1.21-3.50]	0.008**	1.24 [0.58-2.66]	0.586
The woman had freedom of movement during labour				
No	1.00 [reference]		1.00 [reference]	
Yes	1.73 [1.04-2.88]	0.036*	1.12 [0.50-2.52]	0.789
Don't know	0.86 [0.46-1.61]	0.646	1.68 [0.65-4.32]	0.285
Woman encouraged to eat food (ref: No)	1.75 [1.11-2.77]	0.016*	0.84 [0.40-1.76]	0.643
Woman received labour analgesia (ref: No)	0.44 [0.28-0.69]	<0.001***	0.79 [0.38-1.66]	0.531
Baby given to mother immediately after birth (ref: No)	2.83 [1.59-5.03]	<0.001***	1.35 [0.59-3.11]	0.475
Staff overwhelmed				
No	1.00 [reference]		1.00 [reference]	
Yes	0.27 [0.13-0.56]	<0.001***	0.43 [0.16-1.21]	0.110
Don't know	0.30 [0.18-0.51]	<0.001***	0.51 [0.24-1.12]	0.094
Preference for health facility during the next delivery				
No	1.00 [reference]		1.00 [reference]	
Yes	21.14 [10.46-42.70]	<0.001***	15.06 [6.26-36.19]	<0.001***
Don't know	1.13 [0.57-2.24]	0.728	0.92 [0.39-2.17]	0.857
The woman experienced physical abuse (ref: No)	0.45 [0.26-0.80]	0.006**	0.80 [0.32-2.04]	0.644
The woman experienced verbal abuse (ref: No)	0.41 [0.24-0.69]	0.001**	0.68 [0.29-1.59]	0.375
The woman was detained or confined against her will (ref: No)	0.34 [0.14-0.82]	0.016*	0.55 [0.15-2.05]	0.376

Table 4.11: Multivariate analysis of factors influencing Postnatal women's' satisfaction with health care services continued.

Variables	**UOR [95% CI]**	**P-value**	**AOR [95% CI]**	**P-value**
The woman was not well informed & consented (ref: No)	0.50 [0.30-0.86]	0.011*	0.76 [0.33-1.73]	0.509
Information was not well disseminated to woman (ref: No)	0.43 [0.27-0.69]	<0.001***	1.02 [0.41-2.52]	0.967
The woman's confidentiality was not protected (ref: No)	2.77 [1.66-4.63]	<0.001***	0.40 [0.16-1.03]	0.058
The woman was left unattended when needed care (ref: No)	0.53 [0.30-0.95]	0.033*	0.55 [0.23-1.35]	0.194
The woman experienced some form of disrespectful care (ref: No)	0.43 [0.27-0.68]	<0.001***	1.23 [0.40-3.74]	0.716

UOR: unadjusted odds ratio. AOR: adjusted odds ratio. CI: confidence interval.

4.12 Association between disrespectful care and preference of current health facility for the next delivery

The preference for the health facility visited during the woman's next delivery was significantly associated with the experience of at least one form of disrespectful care from the Pearson chi-square test (χ^2=17.54, p<0.001). Of the 81 that will not use the health facility for their next delivery, 92.6% experienced at least one form of disrespectful care. Of the 151 that will use the current health facility for their next delivery, 68.2% experienced at least one form of disrespectful care. And of the 81 that do not know if they will use the current health facility for their next delivery, 72.8% experienced some form of disrespectful care. (Fig. 2). The percentage of Postnatal women who experienced some form of disrespectful care, among those who will not use the current health facility for their next delivery, was higher when compared to the women who will use the current health facility for their next visit or those who don't know if they will use the facility or not.

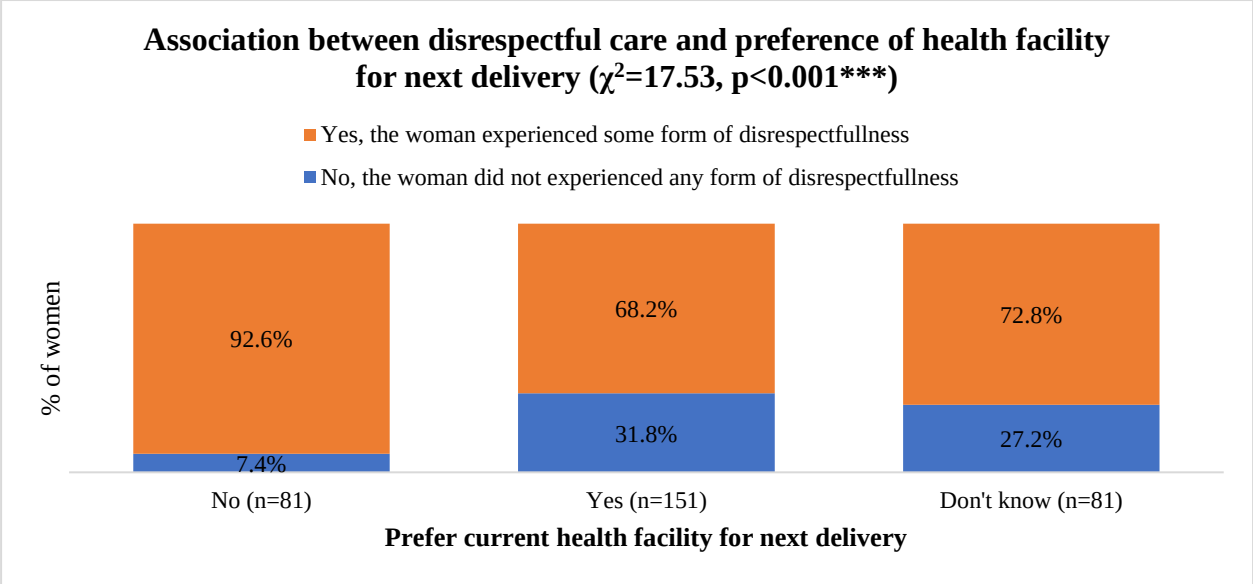


Fig. 4.4: Association between disrespectful care and Preference of current health facility for the next delivery

CHAPTER FIVE

5.0 DISCUSSION

5.1 Forms of support received during labour and childbirth at LNMM 2019

More than half (54.3%) of the postnatal women were encouraged to have support persons during labour and delivery. This may be as a result of inadequate space at the labour wards to allow effective execution of labour companion at these facilities or the value of the labour support underestimated. More than two-thirds (76.7%) of the women confirmed their preference for the idea of a support person during labour and delivery. This affirms the assertion that women like to be supported during labour (Mensah et al., 2014). The companions may provide psychological support to endure labour and childbirth, but also provide logistics and assistance to the staff where necessary (Perkins, Ehsanur Rahman, et al., 2019). One out of every four (22.4%) labour companions were husbands or partners which reveals a low male involvement during labour and childbirth while their mothers formed a third (33.2%) of the support persons. About a third (34.5%) of the postnatal women had freedom of movement during labour which is not encouraging. This could be as a result of either the respectful maternity care guidelines are not complied or inadequate space available at the labour ward discouraged the practice of unrestricted movement during labour.

About half of the women were encouraged to drink fluids (50.2%) and eat food (44.7%) during labour. This is also not encouraging because the process of childbirth may lead to maternal exhaustion especially if the labouring women are denied this support. The woman starved and or dehydrated, may lack the energy to expel the baby at the second stage. As a result of exhaustion, increasing her risk of instrumental or caesarean deliveries. Mothers may become dissatisfied with service and may

influence their health-seeking behaviour at subsequent births when deprived of meals and food.

Half of the women (51.4%) received labour analgesia with a third (29.4%) having episiotomy or laceration at childbirth. This number is significant especially when an episiotomy is not a recommended routine procedure, the experience of pain may affect the overall birthing experience for the women. The majority (80.2%) of the postnatal mothers had their babies with them within an hour of birth as a recommended practice by WHO, and mothers who were denied, may have their babies requiring additional support or critically ill after delivery (WHO, 2018). The study revealed that women encouraged to have a support person, a woman interested with the idea of a birth companion, freedom of movement during labour, encouraged to eat during labour, labour analgesia and early bonding of mother and baby after delivery were significantly associated with the level of satisfaction of postnatal women towards the care received.

There was also a significant association on the forms of support received thus,the woman encouraged to have a support person, liking the idea of a support person, the presence of labour companion, freedom of movement during labour, intake of fluids and meals labour analgesia and early bonding of mother and baby immediately after delivery with the experience of at least one form of disrespectful care. Therefore, a woman in labour denied movement, intake of fluids, meals, pain relief support person and early bonding of mother and baby has not received respectful maternity care.

5.2 Prevalence of disrespectful care during labour and childbirth at LNMM

The majority (75.7%) of the women reporting for labour and delivery at LNMM 2019 experienced at least a form of disrespectful care. This is similar to what was identified in studies done earlier in some parts of the country (Asefa & Bekele, 2015; Moyer et al., 2016) One in five of the women (19.8%) experienced physical abuse, about one in ten (9.3%) were discriminated against, about four in ten (38.9%) had undignified care, six in ten (60.4%) received unconsented care, about four in ten (34.5%) received non-confidential care, about one in five (17.9%) felt neglected and one in ten (7.7%) experienced detention against their will. The high prevalence of disrespectful care coupled with the representation of all the seven categories of disrespect and abuse in the study indicates that it is a problem requiring strengthening of the policy of respectful maternity care and institutional reforms at LNMM. Failure to address this menace will cause clients to mistrust the healthcare system leading to poor health-seeking behaviour and the loss in battle against maternal morbidity and mortality.

There was a significant association between marital status, the highest level of education, employment, religion mode of delivery and health facility where childbirth occurred with the experience of at least one form of disrespectful care. The findings of significant association of marital status, educational level to disrespectful care confirms the study by Siraj, Teka and Hebo (2019). The experience of at least one form of disrespectful care was 1.3times higher among single women (85.5%) than the married women (64.9%) and 1.4times higher among the divorced/widowed (92.3%) than the married. There was no significant association observed in the study of adolescent girls and women less than 25years with the

experience of at least a form disrespectful care and hence contradicts with earlier studies of mistreatment among adolescent girls during childbirth (Bowser & Hill, 2010; Maya et al., 2018).

Experience of some form of disrespectful care was higher among women who visited PHM (86.5%) compared to those who visited MPK (58.6%) and MPR/C (35.7%). The determinants (odds) of experiencing disrespect during labour and delivery was 5 times significantly high for those visiting PHM compared to those visiting MPR/C, 2.5times among women who were not encouraged to have a support person present compared to women who were encouraged to have support person present, 5 times increased among women who did not have support person present and 3 times increased among women with less than three health care providers present during labour and delivery.

5.3 The level of satisfaction with care during labour and childbirth at LNMM 2019

More than half of the women (57.5%) were satisfied with the care received at the health facilities. There was a significant association between the level of satisfaction with the socio-demographic factors such as occupation, income level, religion, parity, mode of delivery and the facility where childbirth occurred. Those at the lower wealth quintile were more satisfied than the higher quintile, those with low parity were more satisfied than the higher parity. Those who had spontaneous vaginal birth were more satisfied than the emergency section and the Christians were more satisfied than the Muslim respondents. This observation is important

because when unsatisfied client, especially with the experience of multiple births (Grand multiparous), may have reduced uptake of health services at next delivery which may affect the proportion of births supervised by skilled birth attendants and the risk of severe maternal morbidity and mortality.

Health care satisfaction was 88.6% (62/70) among women who visited MPK, 82.1% (23/28) among those who visited MPR/C and 44.2% (95/215) among those who visited PHM. The PHM is a referral unit for all facilities in LNMM (includes MPR/C &MPK) and finding of less than half of the respondents satisfied with their services is a problem because women may be reluctant to report to that facility if referred for further management and may reduce the overall facility-based deliveries for LNMM. There was also a significant association between the forms of support received and the level of satisfaction among the women. The support forms include women encouraged to have support person, interest in the idea of a support person, freedom of movement in labour, intake of meals, labour analgesia and baby given immediately to mother after delivery. These factors enhance the experience of the quality of care as confirmed by the findings of choice of companion, intake of fluids and food, ambulating during labour and delivery (Perkins et al., 2019) and labour analgesia significantly affecting the satisfaction of the overall birth experience (Geltore et al., 2018).

It was also identified in the study that staff being overwhelmed at childbirth were significantly associated with the experience of at least one form of disrespectful care. This finding can be further probed into with qualitative research to confirm this assertion and pragmatic actions taken for strengthening the existing policy of

respectful maternity care and institutional reforms to improve the number of skilled birth attendants for the positive birth experience.

There was a significant association between the level of satisfaction with care received and various forms of disrespectful care except for discrimination and non-confidential care (lack of privacy/confidentiality). This may affect the maternal and neonatal bonding (Bertucci et al., 2012), increase the likelihood of postpartum depression (Mohammad, Gamble & Creedy, 2011; Bertucci et al., 2012) and the experience of poor quality of care by the client.

Factors influencing patients level of satisfaction with healthcare service received during labour and delivery were thrice significant odds among women who were encouraged to have a support person present compared to women who were not encouraged and 15 times significant odds among women who preferred the health facility for the next delivery compared to those who will not use the health facility for the next delivery. This means that encouraging women to have a birth companion of their choice and enforcing the various forms of support under respectful maternity care in the facilities will enhance their overall birth experience and the confidence of patronizing the health facility for subsequent births. This confirms the findings made by Freedman and Kruk (2014), that the previous experience of childbirth at a facility informs her decision of where to go at the next delivery.

5.4 Preference for facility birth at the next delivery

The preference for the facility visited at the woman's choice for the next delivery was significantly associated with the experience of at least one form of disrespectful care. Less than 1 in 10 women who will not use the facility for subsequent delivery had a majority (92.6%) of the women experiencing some form of disrespectful care while more than 3 in 10 women who will use the same facility for next delivery had more than half (68.2%) of them experiencing some form of disrespectful care. Again about 3 in 10 women (27.2%) who were not sure of using that facility for next delivery also had more than half (72.8%) of them experiencing some form of disrespectful care. These findings agree with a study done in the Northern part of Ghana where the fear of mistreatment prevented facility-based delivery at subsequent deliveries (Crissman et al., 2013). This could explain the reduction in facility-based delivery at LNMM compared to what was observed in GAR in 2017. The experience of poor client-provider relation may prevent women to seek skilled care for routine and complicated births (Knight et al., 2013; Murray et al., 2010; Nair et al., 2014). This may promote deliveries outside the facilities and delay in seeking healthcare during childbirth resulting in the poor quality of care.

CHAPTER SIX

6.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

The study was conducted to assess the level of satisfaction with care received by postnatal women during childbirth and the preference for facility-based delivery at subsequent births at selected facilities in LNMM. This study was found necessary when the proportion of facility-based births for the municipality was lower than what was observed for the region. The study was an exit interview conducted on 313 postnatal women who reported for their sixth-week review. The data were analysed using STATA version 15.0.

The key findings of the study are as follows;

1. The forms of support received were 54.3per cent of the women encouraged to have support persons at delivery, 76.7percent were interested in the idea of labour companion, 22.4 percent of labour companions were husbands or partners. Freedom of movement during labour was 34.5 percent, 50.2 percent encouraged to drink fluids, 44,7 percent ate during labour, 51.4 percent received labour analgesia and 80.2per cent women received their babies immediately after delivery.
2. More than seventy-five percent (75.7%) of the postnatal women experienced at least a form of disrespectful care during childbirth 19.8 percent experienced physical abuse, 9.3 percent were discriminated against, 38.9 percent had undignified care, 60.4 percent received unconsented care, 34.5 percent received non-confidential care, 17.9 percent felt neglected and 7.7 percent experienced detention against their will.

3. About fifty-seven percent (57.5%) were satisfied with the care received at the health facilities. There was a significant association between the level of satisfaction and the socio-demographic factors (occupation, income level, religion, parity, mode of delivery) the facility where childbirth occurred, forms of support received and the experience of disrespectful care.
4. The preference for facility-based delivery at subsequent births was significantly associated with the level of satisfaction with care received and the experience of disrespectful care during labour and delivery.

6.2 Conclusion

The study concludes that women received some forms of support during childbirth and labour but was marginally low especially in the area of partners presence during the birthing process. Most of the women experienced disrespectful care with all the categories represented. Some of the women were satisfied with the care received and their preference of the facility for subsequent deliveries were influenced by the level of satisfaction received and experience of disrespectful care at childbirth.

6.3 Recommendation

6.3.1 Recommendation for Practice

Based on the finding of the study, the following recommendation will improve the birth experience of women:

1. The Ministry of Health should strengthen and enforce the policy on Respectful Maternity Care through advocacy by the agencies of the Ministry of Health (Ghana Health Service and Christian Health Association of Ghana) in health service delivery.

2. The Ministry of Health should organize workshops on customer care for health workers in maternity units in the country.

3. Managers of health facilities should institute punitive measures for health workers who maltreat and disrespect women during labour and childbirth.

6.3.2 Recommendation for policy

2 There is the need to incorporate labour companions for all births into the policy and maternal care.

6.3.3 Recommendation for future research

1. There is a need for LNMM to further research into the preferred choice of labour companion for the women.
2. The facility must carry out client satisfaction surveys from time to time to evaluate their performance in rendering quality service during childbirth.
3. The head of facilities should sponsor further research on a qualitative study on clients and health provider factors, to gain an in-depth understanding and the insights drawn, to address the issues of disrespectful care.

REFERENCES

Abuya, T., Warren, C. E., Miller, N., Njuki, R., Ndwiga, C., Maranga, A., Mbehero, F., Njeru, A., & Bellows, B. (2015). Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS ONE*, *10*(4), 49422–00100. https://doi.org/10.1371/journal.pone.0123606

Adegoke, A. A., & Van Den Broek, N. (2009). Skilled birth attendance-lessons learnt. *BJOG: An International Journal of Obstetrics and Gynaecology*, *116*(SUPPL. 1), 33–40. https://doi.org/10.1111/j.1471-0528.2009.02336.x

Afulani, P., Kusi, C., Kirumbi, L., & Walker, D. (2018). Companionship during facility-based childbirth: results from a mixed-methods study with recently delivered women and providers in Kenya. *BMC Pregnancy and Childbirth*, *18*(1), 150. https://doi.org/10.1186/s12884-018-1806-1

Asamoah, B. O., Agardh, A., Pettersson, K. O., & Östergren, P. (2014). Magnitude and trends of inequalities in antenatal care and delivery under skilled care among different socio-demographic groups in Ghana from 1988 - 2008. *BMC Pregnancy and Childbirth*, *14*(1), 295. https://doi.org/10.1186/1471-2393-14-295

Asefa, A., & Bekele, D. (2015). Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. *Reproductive Health*, *12*(1), 7,8. https://doi.org/10.1186/s12978-015-0024-9

Asefa, A., Bekele, D., Morgan, A., & Kermode, M. (2018). Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. *Reproductive Health*, *15*(1), 4. https://doi.org/10.1186/s12978-017-0449-4

Bailey, P. E., Szászdi, J. A., & Glover, L. (2002). Obstetric complications: does training traditional birth attendants make a difference? *Revista Panamericana de Salud Publica*

= *Pan American Journal of Public Health*, *11*(1), 15–23. https://doi.org/10.1590/S1020-49892002000100003

Bazzano, A. N., Kirkwood, B., Tawiah-Agyemang, C., Owusu-Agyei, S., & Adongo, P. (2008). Social costs of skilled attendance at birth in rural Ghana. *International Journal of Gynecology and Obstetrics*. https://doi.org/10.1016/j.ijgo.2008.02.004

Bertucci, V., Boffo, M., Mannarini, S., Serena, A., Saccardi, C., Cosmi, E., Andrisani, A., & Ambrosini, G. (2012). Assessing the perception of the childbirth experience in Italian women: A contribution to the adaptation of the childbirth perception questionnaire. *Midwifery*, *28*(2), 265–274. https://doi.org/10.1016/j.midw.2011.02.009

Bohren, M. A., Hunter, E. C., Munthe-kaas, H. M., Souza, J. P., & Vogel, J. P. (2014). *Facilitators and barriers to facility-based delivery in low- and middle-income countries : a qualitative evidence synthesis*. 1,15. https://doi.org/10.1186/1742-4755-11-71

Bowser, D., & Hill, M. P. H. K. (2010). *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis*.

Brighton, A., D'Arcy, R., Kirtley, S., & Kennedy, S. (2013). Perceptions of prenatal and obstetric care in Sub-Saharan Africa. In *International Journal of Gynecology and Obstetrics* (Vol. 120, Issue 3, pp. 224–227). John Wiley and Sons Ltd. https://doi.org/10.1016/j.ijgo.2012.09.017

Bryanton, J., Fraser-Davey, H., & Sullivan, P. (1994). Women's Perceptions of Nursing Support during Labor. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *23*(8), 638–644. https://doi.org/10.1111/j.1552-6909.1994.tb01933.x

Burrowes, S., Holcombe, J. ., Niculescu, D., & Jara, D. (2016). *Delivering Respectful Maternity Care : Midwives ' and Patients ' Perspectives on Disrespect and Abuse*.

C.A., M., S., R., E.K., N., V.M., D., P., A.-B., J.R., L., Moyer, C. A., Rominski, S., Nakua,

E. K., Dzomeku, V. M., Agyei-Baffour, P., & Lori, J. R. (2016). Exposure to disrespectful patient care during training: Data from midwifery students at 15 midwifery schools in Ghana. *Midwifery*. https://doi.org/10.1016/j.midw.2016.07.009

Callaghan, P., & Morrissey, J. (1993). Social support and health: a review. *Journal of Advanced Nursing*, *18*(2), 203–210. https://doi.org/10.1046/j.1365-2648.1993.18020203.x

Christiaens, W., Verhaeghe, M., & Bracke, P. (2010). Pain acceptance and personal control in pain relief in two maternity care models: A cross-national comparison of Belgium and the Netherlands. *BMC Health Services Research*, *10*(1), 268. https://doi.org/10.1186/1472-6963-10-268

Crissman, H. P., Engmann, C. E., Adanu, R. M., Nimako, D., Crespo, K., & Moyer, C. A. (2013). Shifting norms: pregnant women's perspectives on skilled birth attendance and facility-based delivery in rural Ghana. *African Journal of Reproductive Health*, *17*(1), 15–26.

D'Ambruoso, L., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health*, *5*, 140. https://doi.org/10.1186/1471-2458-5-140

DHS, E. (2011). *Ethiopia Demographic and Health Survey 2011 Preliminary Report*.

Duysburgh, E., Williams, A., Williams, J., Loukanova, S., & Temmerman, M. (2014). Quality of antenatal and childbirth care in northern Ghana. *BJOG : An International Journal of Obstetrics and Gynaecology*. https://doi.org/10.1111/1471-0528.12905

Duysburgh, E., Zhang, W. H., Ye, M., Williams, a., Massawe, S., Sié, a., Williams, J., Mpembeni, R., Loukanova, S., & Temmerman, M. (2013). Quality of antenatal and childbirth care in selected rural health facilities in Burkina Faso, Ghana and Tanzania: Similar finding. *Tropical Medicine and International Health*, *18*(5), 534–547.

https://doi.org/10.1111/tmi.12076

Fair, C. D., & Morrison, T. E. (2012). The relationship between prenatal control, expectations, experienced control, and birth satisfaction among primiparous women. *Midwifery*, *28*(1), 39–44. https://doi.org/10.1016/j.midw.2010.10.013

Floyd, B. L., Coulter, N., Asamoah, S., & Agyare-asante, R. (2015). *Women ' s views and experience of their maternity care at a referral hospital in Ghana*.

Ford, E., Ayers, S., & Wright, D. B. (2009). Measurement of maternal perceptions of Support and Control in Birth (SCIB). *Journal of Women's Health*, *18*(2), 245–252. https://doi.org/10.1089/jwh.2008.0882

Freedman, L. P., & Kruk, M. E. (2014). Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *The Lancet*, *384*(9948), e42–e44. https://doi.org/10.1016/S0140-6736(14)60859-X

Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., Kujawski, S., Moyo, W., Kruk, M. E., & Mbaruku, G. (2014a). Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. *Bulletin of the World Health Organization*, *92*(12), 916. https://doi.org/10.2471/BLT.14.137869

Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., Kujawski, S., Moyo, W., Kruk, M. E., & Mbaruku, G. (2014b). Defining disrespect and abuse of women in childbirth: A research, Policy and rights agenda. In *Bulletin of the World Health Organization* (Vol. 92, Issue 12, pp. 915–917). World Health Organization. https://doi.org/10.2471/BLT.14.137869

Gabrysch, S., & Campbell, O. M. R. (2009). Still too far to walk: literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth*, *9*, 34. https://doi.org/10.1186/1471-2393-9-34

GDHS. (2014). *Ghana Demographic and Health Survey 2014*.

Geltore, T. E., Taye, A., & Kelbore, A. G. (2018). Utilization of obstetric analgesia in labor pain management and associated factors among obstetric caregivers in public health facilities of Kembata Tembaro Zone, Southern Ethiopia. *Journal of Pain Research*, *11*, 3089–3097. https://doi.org/10.2147/JPR.S165417

Goodman, P., Mackey, M. C., & Tavakoli, A. S. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing*, *46*(2), 212–219. https://doi.org/10.1111/j.1365-2648.2003.02981.x

Hodnett, E. D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology*, *186*(5), S160–S172. https://doi.org/10.1016/S0002-9378(02)70189-0

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2012). Continuous support for women during childbirth. In *Cochrane Database of Systematic Reviews* (Vol. 10). John Wiley & Sons, Ltd. https://doi.org/10.1002/14651858.cd003766.pub4

Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., Lopez, A. D., Lozano, R., & Murray, C. J. (2010). Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet*. https://doi.org/10.1016/S0140-6736(10)60518-1

Jafari, E., Mohebbi, P., & Mazloomzadeh, S. (2017). Factors Related to Women's Childbirth Satisfaction in Physiologic and Routine Childbirth Groups. *Iranian Journal of Nursing and Midwifery Research*, *22*(3), 219–224. https://doi.org/10.4103/1735-9066.208161

Khan, Z., Siddiqui, A., Khalil, S., Mehnaz, S., Ansari, A., & Sachdeva, S. (2012). All slums are not equal: maternal health conditions among two urban slum dwellers. *Indian Journal of Community Medicine*, *37*(1), 50. https://doi.org/10.4103/0970-0218.94027

Knight, H. E., Self, A., & Kennedy, S. H. (2013). Why Are Women Dying When They Reach Hospital on Time? A Systematic Review of the 'Third Delay.' *PLoS ONE*, *8*(5), e63846.

https://doi.org/10.1371/journal.pone.0063846

Korsah, K. A. (2011). *Nurses ' stories about their interactions with patients at the Holy Family Hospital , Techiman , Ghana*. *2011*(June), 1–9. https://doi.org/10.4236/ojn.2011.11001

Kruk, M. E., Kujawski, S., Mbaruku, G., Ramsey, K., Moyo, W., & Freedman, L. P. (2018). Disrespectful and abusive treatment during facility delivery in Tanzania: A facility and community survey. *Health Policy and Planning*. https://doi.org/10.1093/heapol/czu079

Kruk, M. E., Paczkowski, M., Mbaruku, G., De Pinho, H., & Galea, S. (2009). Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *American Journal of Public Health*, *99*(9), 1666–1672. https://doi.org/10.2105/AJPH.2008.146209

Lakey, B., & Orehek, E. (2011). Relational Regulation Theory: A New Approach to Explain the Link Between Perceived Social Support and Mental Health. *Psychological Review*, *118*(3), 482–495. https://doi.org/10.1037/a0023477

Magoma, M., Requejo, J., Campbell, O. M. R., Cousens, S., & Filippi, V. (2010). High ANC coverage and low skilled attendance in a rural Tanzanian district: A case for implementing a birth plan intervention. *BMC Pregnancy and Childbirth*. https://doi.org/10.1186/1471-2393-10-13

Maya, E. T., Adu-Bonsaffoh, K., Dako-Gyeke, P., Badzi, C., Vogel, J. P., Bohren, M. A., & Adanu, R. (2018). Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study. *Reproductive Health Matters*, *26*(53). https://doi.org/10.1080/09688080.2018.1502020

Mensah, R. S., Mogale, R. S., & Richter, M. S. (2014). Birthing experiences of Ghanaian women in 37th Military Hospital, Accra, Ghana. *International Journal of Africa Nursing Sciences, 1*, 29–34. https://doi.org/10.1016/j.ijans.2014.06.001

Mohammad, K. I., Alafi, K. K., Mohammad, A. I., Gamble, J., & Creedy, D. (2014). Jordanian women's dissatisfaction with childbirth care. *International Nursing Review*, *61*(2), 278–284. https://doi.org/10.1111/inr.12102

Mohammad, K. I., Gamble, J., & Creedy, D. K. (2011). Prevalence and factors associated with the development of antenatal and postnatal depression among Jordanian women. *Midwifery*, *27*(6). https://doi.org/10.1016/j.midw.2010.10.008

Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., Engmann, C. M., & Devries, R. (2014). "it's up to the woman's people": How social factors influence facility-based delivery in Rural Northern Ghana. *Maternal and Child Health Journal*, *18*(1), 109–119. https://doi.org/10.1007/s10995-013-1240-y

Moyer, C. A., Managing, M. P. H., Adongo, P. B., Lecturer, S., Aborigo, R. A., Health, M. P. H., Hodgson, A., & Engmann, C. M. (2013). ' They treat you like you are not a human being ' : Maltreatment during labour and delivery in rural northern Ghana. *Midwifery*, 4,7. https://doi.org/10.1016/j.midw.2013.05.006

Mrisho, M., Obrist, B., Schellenberg, J. A., Haws, R. A., Mushi, A. K., Mshinda, H., Tanner, M., & Schellenberg, D. (2009). The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania. *BMC Pregnancy and Childbirth*, *9*, 10. https://doi.org/10.1186/1471-2393-9-10

Mselle, L. T., Moland, K. M., Mvungi, A., Evjen-Olsen, B., & Kohi, T. W. (2013). Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania. *BMC Health Services Research*, *13*, 174. https://doi.org/10.1186/1472-6963-13-174

Murray, L., Windsor, C., Parker, E., & Tewfik, O. (2010). The Experiences of African Women Giving Birth in Brisbane, Australia. *Health Care for Women International*, *31*(5), 458–472. https://doi.org/10.1080/07399330903548928

Nair, M., Yoshida, S., Lambrechts, T., Boschi-Pinto, C., Bose, K., Mason, E. M., & Mathai, M. (2014). Facilitators and barriers to quality of care in maternal, newborn and child health: a global situational analysis through metareview. *BMJ Open*, *4*(5), e004749. https://doi.org/10.1136/bmjopen-2013-004749

Nesbitt, R. C., Lohela, T. J., Manu, A., Vesel, L., Okyere, E., Edmond, K., Owusu-Agyei, S., Kirkwood, B. R., & Gabrysch, S. (2013). Quality along the continuum: A health facility assessment of intrapartum and postnatal care in Ghana. *PLoS ONE*. https://doi.org/10.1371/journal.pone.0081089

Okafor, I. I., Ugwu, E. O., & Obi, S. N. (2014). Disrespect and abuse during facility-based childbirth in a low-income country. *International Journal of Gynecology and Obstetrics*, *128*(2), 110–113. https://doi.org/10.1016/j.ijgo.2014.08.015

Oyerinde, K., Harding, Y., Amara, P., Garbrah-Aidoo, N., Kanu, R., Oulare, M., Shoo, R., & Daoh, K. (2013). A qualitative evaluation of the choice of traditional birth attendants for maternity care in 2008 Sierra Leone: Implications for Universal Skilled Attendance at Delivery. *Maternal and Child Health Journal*. https://doi.org/10.1007/s10995-012-1061-4

Perkins, J., Ehsanur Rahman, A., Mhajabin, S., Bakkar Siddique, A., Mazumder, T., Rifat Haider, M., & El Arifeen, S. (2019). *Sexual and Reproductive Health Matters*. *27*(1), 228–247. https://doi.org/10.1080/26410397.2019.1610277

Perkins, J., Rahman, A. E., Mhajabin, S., Siddique, A. B., Mazumder, T., Haider, M. R., & El Arifeen, S. (2019). Humanised childbirth: the status of emotional support of women in rural Bangladesh. *Sexual and Reproductive Health Matters*, *27*(1). https://doi.org/10.1080/26410397.2019.1610277

PMNCH. (2006). *Opportunities for Africa's Newborns. Practical data, policy and programmatic support for newborn care in Africa*. https://doi.org/10.1016/S0140-

6736(86)91254-7

Prata, N., Passano, P., Rowen, T., Bell, S., Walsh, J., & Potts, M. (2011). Where there are (few) skilled birth attendants. *Journal of Health, Population and Nutrition*, *29*(2), 81–91. https://doi.org/10.3329/jhpn.v29i2.7812

Rani, M., Bonu, S., & Harvey, S. (2008). Differentials in the quality of antenatal care in India. *International Journal for Quality in Health Care*, *20*(1), 62–71. https://doi.org/10.1093/intqhc/mzm052

Redshaw, M., & Heikkilä, K. (2010). *Delivered With Care. A National Survey of Women's Experience of Maternity Care 2010*.

Reis, V., Deller, B., Senior, M., Advisor, M., & Carr, C. (2012). *Respectful Maternity Care Country experiences Survey Report*.

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., Silva, D. R. A. D., Downe, S., Kennedy, H. P., Malata, A., McCormick, F., Wick, L., & Declercq, E. (2014). Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*. https://doi.org/10.1016/S0140-6736(14)60789-3

Rosen, H. E., Lynam, P. F., Carr, C., Reis, V., Ricca, J., Bazant, E. S., Bartlett, L. A., Abayisenga, G., Ametepi, P., Cantor, D., Chavane, L., Currie, S., de Graft-Johnson, J., Drake, M., Getachew, A., Gomez, P., Kagema, F., Makene, C. L., Malonza, I., … Zoungrana, J. (2015). Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy and Childbirth*, *15*(1), 10. https://doi.org/10.1186/s12884-015-0728-4

Rostampey, Z., Khakbazan, Z., & Golestan, B. (2010). Effect of Trained Female Relative on Active Phase Length during Labor among Low Risk Pregnancies. In *Journal of Guilan University of Medical Sciences* (Vol. 19, Issue 75). Journal of Guilan University of

Medical Sciences.

Sando, D., Ratcliffe, H., McDonald, K., Spiegelman, D., Lyatuu, G., Mwanyika-Sando, M., Emil, F., Wegner, M. N., Chalamilla, G., & Langer, A. (2016). The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. *BMC Pregnancy and Childbirth*, *16*(1). https://doi.org/10.1186/s12884-016-1019-4

Sauls, D. (2017). Effects of Labor Support on Mothers ,. *Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN*, *31*(November). https://doi.org/10.1177/0884217502239209

Schempf, A. H., & Strobino, D. M. (2009). Drug use and limited prenatal care: an examination of responsible barriers. *American Journal of Obstetrics and Gynecology*, *200*(4), 412.e1-412.e10. https://doi.org/10.1016/j.ajog.2008.10.055

Sharan, M., Ahmed, S., Ghebrehiwet, M., & Rogo, K. (2011). The quality of the maternal health system in Eritrea. *International Journal of Gynecology and Obstetrics*, *115*(3), 244–250. https://doi.org/10.1016/j.ijgo.2011.07.025

Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., & Tekie, M. (2013). Why do women prefer home births in Ethiopia? *BMC Pregnancy and Childbirth*. https://doi.org/10.1186/1471-2393-13-5

Simbar, M., Ghafari, F., Zahrani, S. T., & Majd, H. A. (2009). Assessment of quality of midwifery care in labour and delivery wards of selected Kordestan Medical Science University hospitals. *International Journal of Health Care Quality Assurance*, *22*(3), 266–277. https://doi.org/10.1108/09526860910953539

Simkin, P. (2002). Supportive Care During Labor: A Guide for Busy Nurses. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *31*(6), 721–732. https://doi.org/10.1177/0884217502239208

Siraj, A., Teka, W., & Hebo, H. (2019). Prevalence of disrespect and abuse during facility

based child birth and associated factors, Jimma University Medical Center, Southwest Ethiopia. *BMC Pregnancy and Childbirth*, *19*(1), 185. https://doi.org/10.1186/s12884-019-2332-5

Souza, J., Tunçalp, Ö., Vogel, J., Bohren, M., Widmer, M., Oladapo, O., Say, L., Gülmezoglu, A., & Temmerman, M. (2014). Obstetric transition: the pathway towards ending preventable maternal deaths. *BJOG: An International Journal of Obstetrics & Gynaecology*, *121*, 1–4. https://doi.org/10.1111/1471-0528.12735

Tarekegn, S. M., Lieberman, L. S., & Giedraitis, V. (2014). Determinants of maternal health service utilization in Ethiopia: Analysis of the 2011 Ethiopian Demographic and Health Survey. *BMC Pregnancy and Childbirth*. https://doi.org/10.1186/1471-2393-14-161

ten Hoope-Bender, P., de Bernis, L., Campbell, J., Downe, S., Fauveau, V., Fogstad, H., Homer, C. S. E., Kennedy, H. P., Matthews, Z., McFadden, A., Renfrew, M. J., & Van Lerberghe, W. (2014). Improvement of maternal and newborn health through midwifery. *The Lancet*, *384*(9949), 1226–1235. https://doi.org/10.1016/S0140-6736(14)60930-2

UN. (2016). *Sustainable Develoment Goals*.

US Census Bureau. (2015). *Measuring Maternal Mortality PRB*. *December*, 1–6.

White Ribbon Alliance. (2011). *Respectful Maternity Care Charter*.

WHO. (2004). Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. *Geneva, Switzerland: WHO*.

WHO. (2007). *Harmonizing mind and body, people and systems People at the Centre of Health Care*.

WHO. (2008). *Factsheet Proportion of births attended by a skilled health worker 2008 updates Factsheet*.

WHO. (2015). Strategies toward ending preventable maternal mortality (EPMM). *Who*,

6736, 8. https://doi.org/ISBN 978 92 4 150848 3

WHO. (2020). *WHO | Skilled attendants at birth*. Global Health Observatory Data.

Windau-Melmer, T. (2013). *A Guide for Respectful Maternity Care.*

World Health Organization (WHO). (2018). *Intrapartum care for a positive childbirth experience WHO recommendations*.

Yakong, V. N., Rush, K. L., Bassett-Smith, J., Bottorff, J. L., & Robinson, C. (2010). Women's experiences of seeking reproductive health care in rural Ghana: Challenges for maternal health service utilization. *Journal of Advanced Nursing*, *66*(11), 2431–2441. https://doi.org/10.1111/j.1365-2648.2010.05404.x

Yakubu, J., Benyas, D., Emil, S. V., Amekah, E., Adanu, R., & Moyer, C. A. (2014). It's for the Greater Good: Perspectives on Maltreatment during Labor and Delivery in Rural Ghana. *Open Journal of Obstetrics and Gynecology*, *04*(07), 383–390. https://doi.org/10.4236/ojog.2014.47057

Yanagisawa, S., Oum, S., Wakai, S., Yakoob, M. Y., Ali, M. A. M. U., Ali, M. A. M. U., Imdad, A., Lawn, J. E., Van Den Broek, N., Bhutta, Z., Worku, A. G., Yalew, A. W., Afework, M. F., Wirth, M., Sacks, E., Delamonica, E., Storeygard, A., Minujin, A., Balk, D., … Iddrisu, M. (2013). Determinants of Antenatal Care , Institutional Delivery and Skilled Birth Attendant Utilization in Samre Saharti District , Tigray , Ethiopia. *BMC Pregnancy and Childbirth*, *7*(1), 1–9. https://doi.org/10.1007/s10995-013-1240-y

Appendices

Appendix A: Informed Consent Form

School of Public Health

College of Health Sciences

University of Ghana Legon

Title: Postnatal Women's Assessment of care received during childbirth at selected facilities at La-Nkwantanang Madina Municipality in Accra.

Background: My name is Agnes Asare a graduate student of University of Ghana School of Public Health researching **"Postnatal Women's Assessment of care received during childbirth at selected facilities at La-Nkwantanang Madina Municipality in Accra"**. Some Research Assistants will be assisting me in the study.

Purpose of Study: The study seeks to find out the level of satisfaction with the care received during childbirth and the choice of facility-based delivery on subsequent births

Study procedures: You are required to share your satisfaction or displeasure with the care received during childbirth in this facility by responding to questions about care during labour and delivery.

The time required: the questionnaire will be administered one on one within 40 minutes.

Risk: be assured that the research comes at minimum risk because the researcher/assistant does not work in the facility and the existing interview is conducted on study participants at their sixth-week postnatal clinic review.

Benefit: your participation in this study shall come with no benefit directly to you, however, we hope that information obtained from this study may contribute towards policy decisions making in order to improve facility-based delivery.

Compensation: you shall be given a hand sanitizer as a token of appreciation after completing the questionnaire.

Anonymity and Confidentiality: you can choose a place of convenience to answer the questions. Personal information that will make you identifiable will not be included in the questionnaire rather code names or numbers will be assigned if necessary. Your responses will be anonymous (will not bear names of participants) so you will not be identified. The information gathered shall be kept strictly confidential between you and the researcher and the data stored with a password only known to the researcher.

Participation and Withdrawal: you are free to be part of the study and decide to leave at any point you want. No one will be upset, if you decide not to take part in the study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawal will not affect the relationship you have, if any with the researcher but data initially collected will not be used in the study.

Dissemination of information: the results of the research will be submitted to the School of Public Health in partial fulfilment of the requirement of the award of a Master of Public Health Degree.

Contact information: if you have questions at any time about this study, or you experience adverse effects as a result of participating in the study, you may contact me on 0243168774. If you have any questions regarding your rights as a research participant, or if problems arise which you do not feel to discuss with the principal investigator, please contact the Ethics Administrator, Ms Hannah Frimpong GHS/ERC on 024-333-5225/050-704-1223.

Volunteer agreement

The above document describing the benefits, risks, confidentiality and other procedures for the research title "**Postnatal Women's Assessment of care received during childbirth at selected facilities in La-Nkwantanang Madina Municipality**" has been explained to me. I have read or had a witness interpret/explain all of the above, asked questions, received answers regarding participation in this study and am willing to give consent to participate in this study as a volunteer.

…… ……

Name and Signature/thumb print of volunteer Date

If the volunteer is below the legal age of 18years, a witness must sign here:

I was present when the nature and purpose of this study were read to the volunteer. All questions asked were answered satisfactorily regarding participation in this study, and a volunteer gave consent to participate in this study.

…… ……

Name and Signature or thumbprint of witness Date

I certify that the nature and purpose in this research have been duly explained to the above individual.

…….. ……

Name and Signature of Researcher/Assistant Date

Appendix- B: Questionnaire

School of Public Health

College of Health Sciences

University of Ghana, Legon

This is a research on **POSTNATAL WOMEN'S ASSESSMENT OF CARE RECEIVED DURING CHILD BIRTH AT SELECTED FACILITIES IN LA-NKWANTANANG MADINA MUNICIPALITY**. The study tries to assess the level of care received during child-birth at the postnatal clinic. This information you gathered shall be kept strictly confidential between you and the researcher. Be assured that the research comes at minimal risk. The information obtained may contribute towards improving facility-based delivery.

Kindly tick [√] where appropriate

A Socio-Demographic Factors

1 Age (State your current age) …….

2 Marital Status: Single [ ] Cohabitation [ ] Married [ ] Divorce [ ] Widow [ ]

3 Educational level: No Formal Education [ ] Primary [ ] Secondary [ ] Tertiary[ ]

4 Occupation: Trader [ ] Unemployed [ ] Civil service [ ] Others (state)……..

5 What is the current household income: Under GH500[ ] GH500-1000 [ ]

GH1001-1500 [ ] GH1501-2000 [ ] Above GH 2000 [ ]

6 Religion: Christian [ ] Muslim [ ] Others [ ]

B Reproductive factors

1 Parity (how many children in all? Alive and dead): 1-2 [ ] 3-4 [ ] 4+[ ]

2 Mode of delivery: Vaginal birth [ ] Caesarean section [ ]

C Do you have any clinical condition for which you felt prejudiced or **discriminated** in your case? Yes [ ] No [ ]

If Yes, State your clinical condition……..

D Respect and Dignity

1 Were you greeted respectfully or received warmly when you arrived at the labour ward? Yes [ ] No [ ]

2 Did any health care provider talk or use hash tone at you

Yes [ ] No [ ] Don't Know [ ]

E Informed Consent and Dissemination of Information

1 Did your provider explain what will be happening during labour to you?

Yes [ ] No [ ] Don't Know [ ]

2 Did the health provider explain procedures before proceeding?

Yes [ ] No [ ] Don't Know [ ]

3 Were you informed of the findings when examined by the provider?

Yes [ ] No [ ] Don't Know [ ]

4 Did the provider ask if you had any questions?

Yes [ ] No [ ] Don't Know [ ]

5 Was your consent sort for every procedure performed on you?

Yes [ ] No [ ] Don't Know [ ]

F Privacy and Confidentiality

1 Were you screened, draped or nursed in a labour ward with curtains?

Yes [ ] No [ ] Don't Know [ ]

2 Were you treated in any way that violated your confidentiality?

Yes [ ] No [ ] Don't Know [ ]

G Physical Abuse

1 Were you hit, slapped or pinched by any of the Health workers during labour?

Yes [ ] No [ ] Don't Know [ ]

2 Were you hit, slapped or pinched by the Health worker during childbirth?

Yes [ ] No [ ] Don't Know [ ]

H Neglect and Abandonment

1 Were you left unattended to by a health worker when you needed care?

Yes [ ] No [ ] Don't Know [ ]

I Detention in the Facility

1 Where you prevented from leaving the facility because you could not pay for a service?

Yes [ ] No [ ] Don't Know [ ]

J Forms of Support during labour and childbirth

1 Were you encouraged by the provider to have a support person or companion during labour or delivery?

Yes [ ] No [ ] Don't Know [ ]

2 Did you like the idea that a support person should be present in labour?

Yes [ ] No [ ] Don't Know [ ]

3 Who was your companion in labour?

Mother [ ] Friend [ ] Husband [ ] Others [ ]

4 Did the health worker encourage or assist you to ambulate during labour?

Yes [ ] No [ ] Don't Know [ ]

5 Were you encouraged to consume food during labour by the health provider?

Yes [ ] No [ ] Don't Know [ ]

6 Were you encouraged to consume fluids during labour by the health Provider?

Yes [ ] No [ ] Don't Know [ ]

7 Were you given pain relieve during labour?

Yes [ ] No [ ] Don't Know [ ]

8 Did you have episiotomy/ tear of the lower genital tract

Yes [ ] No [ ] Don't Know [ ]

9 Did you receive pain relieve for repair of episiotomy /tear after delivery?

Yes [ ] No [ ] Don't Know [ ]

10 Were you kept together with your baby immediately after delivery?

Yes [ ] No [ ] Don't Know [ ]

K Staff Strength

1 How many health providers attended to you during labour?.....

2 How many health providers attended to you during delivery?.....

3 Were the providers overwhelmed by the number of clients present at the labour ward?

Yes [ ] No [ ] Don't Know [ ]

L Satisfaction with Care

1 How would you rate the care received during childbirth?

Satisfied [ ] Dissatisfied [ ] Neutral [ ]

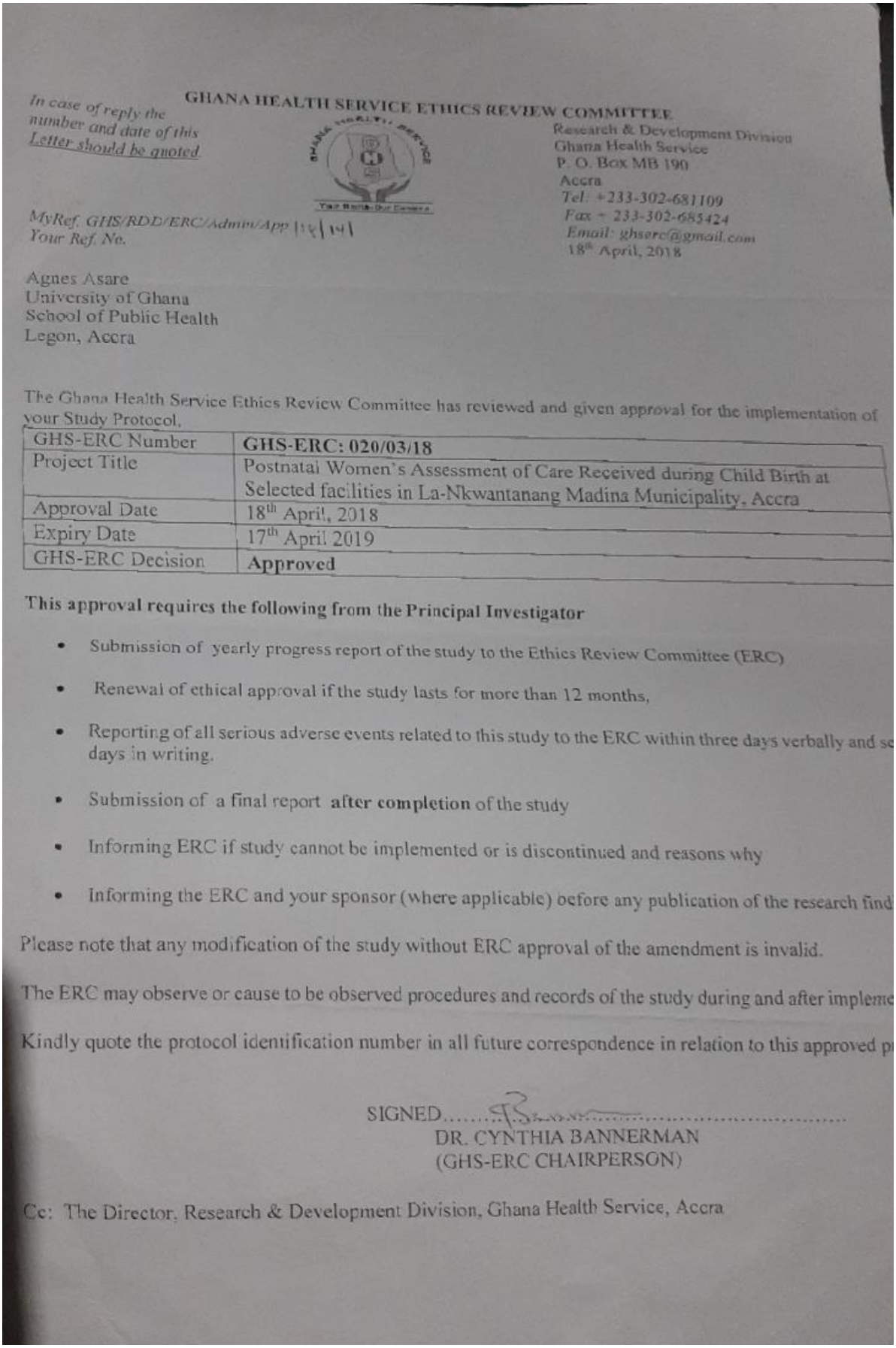
M Preference for Facility-Based Delivery

1 Would you like to deliver here at your next delivery?

Yes [ ] No [ ] Don't Know [ ]

2 Name of Facility…….

Appendix C: Ethical Approval Letter



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
18th April, 2018

MyRef. GHS/RDD/ERC/Admin/App 114/14
Your Ref. No.

Agnes Asare
University of Ghana
School of Public Health
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC: 020/03/18**
Project Title	Postnatal Women's Assessment of Care Received during Child Birth at Selected facilities in La-Nkwantanang Madina Municipality, Accra
Approval Date	18th April, 2018
Expiry Date	17th April 2019
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and se days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research find

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after impleme

Kindly quote the protocol identification number in all future correspondence in relation to this approved p

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted

My Ref ghsec@gmail.com/19/141
Your Ref No

Research & Development Division
Ghana Health Service
P. O. Box MB 190
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GPS Address: GA-050-3305
Tel: +233-0302-966628
Fax: +233-0302-665414
Email ghsec@gmail.com
Email: info.research@ghsmail.org

2nd May, 2019

Agnes Asare
School of Public Health
University of Ghana
Legon, Accra

RE: APPLICATION FOR RENEWAL OF ETHICAL APPROVAL

Reference is made to your letter dated 29th April, 2019 on the above subject matter.

Please be informed that the Ghana Health Services Ethics Review Committee has reviewed the request and has given approval for renewal of the approval letter dated 18th April, 2018.

GHS-ERC Number	**GHS-ERC: 020/03/18**
Project Title	Postnatal Women's Assessment of Care Received during Child Birth at Selected F in La-Nkwantanang Madina Municipality, Accra
Effective Date of Renewal	18th April, 2019
Expiry Date	17th April, 2020
GHS-ERC Decision	**Renewal Approved**

The following applies:

- Submission of yearly report of the study to the Ethics Review Committee (ERC).
- Renewal of ethical approval if the study lasts for more than 12 months.
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study.
- Informing the ERC if study is discontinued and reasons why.
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approval protocol.

SIGNED.....

DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIPERSON)

Cc: The Director, Research and Development Division, Ghana Health Service, Accra