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Intrapartum care experience and assessment of the factors associated with it as voiced by women

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Abstract
Childbirth experience plays a crucial role in how mothers foster positive feelings towards their newborn, good self-esteem, adaptation to the roles of motherhood, and future delivery. It is therefore important to identify factors that positively or negatively influence the birth experience. The study objective was to determine the social-demographic variables associated with intrapartum care experience at a tertiary Hospital in Kenya. This cross-sectional descriptive design employed systematic sampling to recruit 109 mothers. An established research instrument with local cultural adaptations was used. Independent variables were; parity, marital status, occupation, monthly income and education level. Dependent variables were effective communication; respect, care and dignity and emotional support. Almost half of the mothers were aged between 20-24 years, over two thirds (71.6%) were married, with almost half (48.6) attaining primary education and over a third (37.6%), secondary. Nearly half (45%) were self-employed, (52%) earned US$ 50-99.9 per month. Marital status (rs=-0.192, p=0.046) was significantly associated with midwives explanations, perceived to be in understandable terms. An inverse significant rs=-0.192, p=0.045 correlation, was found between being employed and explanation of procedures being performed. There was an inverse significant (rs=-0.216, p=0.024) correlation between being employed and genuine interest displayed by midwives. An inverse significant (rs=-0.202, p=0.036) correlation, was found between marital status and mothers being asked for consent before procedures. Majority reported being treated with respect, were accorded privacy, and had consent requested before procedures. Many reported they were left alone (88.1%), and almost all mothers were "scolded" by their midwives during child birth (97.2%).
The study revealed that various sociodemographic factors influence mothers' experience of care during the intrapartum period. Midwives need to be cognizant of this in order to improve quality of maternal care in Kenya.

Keywords: Kenya, experience, intrapartum care, quality, women, mothers

Abbreviations MMR: Maternal mortality ratio, WHO: World Health Organization, UNICEF: United Nations Children Fund, NICE: National Institute for Health and Care Excellence, SSA: Sub Saharan Africa

1. Introduction
Efforts by the global community to improve quality of care, and the experiences of women during childbirth has received growing attention in the past few years (World Health Organization (WHO) and United Nations Children Fund (UNICEF, 2015) [33]. Similarly, improving women's experiences of care is now seen as a critical element of approaches to improve quality of care (Tunçalp *et al*., 2015) [31]. These strategies include the provision of respectful care, effective communication between the care provider and the mothers, and emotional support for the woman in labour and childbirth (Størksen *et al*., 2013) [29].
Child birth is a significant life experience for many women that can have, long-lasting effects on the way they perceive themselves as females and as mothers. The experience of childbirth plays a key role in how mothers cultivate good self-esteem, positive feelings towards their newborn, and adapt to motherhood roles, and likewise future delivery experiences (Tunçalp *et al*., 2015) [31]. A woman's fear of childbirth has often been found to arise from a previous history of negative birth experiences (Hallam, Howard, Locke, and Thomas, 2016) [9]. Henriksen *et al*., (2017) [12], identified factors that positively or negatively influence the birth experience including expectations of the forthcoming birth, information given by the health care providers and interpersonal (midwife-client) communication.
Improving the quality of childbirth care is an integral part of improving the maternal health (Bryanton, Gagnon, Johnston, & Hatem, 2008; Baas *et al*., 2017) [7, 13]. Quality of care comprises of both the delivery of care (for example evidence-based clinical practices, information systems, and referral systems), in addition to the experience of care, for example

respect, communication and emotional support (Baas *et al*., 2017) [3]. To ensure a positive experience in labour and child birth, the service delivery system need to pay regard to mothers' expectations and rights to access, safety, comfort, dignity, privacy and confidentiality as well as the right to express their views about the services rendered (Bazant, 2008; Nystedt, *et al*., 2014) [15, 27]. However, as cited by Nystedt, *et al*., (2014) [27], efforts to advance quality of care have historically concentrated on improving the provision of care with little emphasis on the underlying social determinates of communication interactions. Another important factor in childbirth experiences is the quality of the patient's relationship with the care provider's (Hildingsson, Johansson, Karlström, & Fenwick, 2013) [14]. Enhanced communication between midwives and women should be reinforced by evidence-based practice tailored to the woman's requirements, (Hildingsson, Johansson, Karlström, & Fenwick, 2013) [14]. Furthermore, interventions and the health education information women are given must be culturally appropriate (NICE 2010) [30].

According to Halldorsdottir and Karlsdottir, (2011) [10], a positive birth experience derives from different contextual components, dependent on receiving accurate and adequate information. An adverse birth experience can disempower a woman, leading to negative effects on mental health and cause anxiety of a subsequent child birth (Størksen *et al*., 2013) [29].

International principles for maternal health care highlight the need for child birth services to be receptive to the women and community, and that women's experience and fulfilment with child birth care is paramount (Lerberg, Sundby, Jammeh & Frothier, 2014; Koblinsky, 2006) [21, 18]. Many factors have been associated with women's experiences of the social process of childbirth which includes: age, parity, prenatal education, expectations, social status, being informed and experience of feeling in control, also pain, method of delivery, medical mediations, experiences of support from caregivers and partners, length of labour, and the birth situation (Bryanton, Gagnon, and Johnston & Hatem 2008) [7]. It is important to identify women's experiences according to their socio economic and demographic characteristics, and the aspects that can be improved (Moyer *et al*., 2014) [24].

Sub Saharan Africa (SSA) has the lowest rate of births attended by skilled birth personnel in the world despite having the highest maternal mortality ratio (MMR), (WHO, UNICEF, UNFPA, The World Bank & the United Nations Population Division 2014). The sub-Saharan African countries, including Tanzania (Kujawski, *et al*., 2015) [20], Kenya (Abuya, *et al*., 2015) [1], Nigeria (Bohren, *et al*., 2017) [6] and Ghana (Moyer *et al*., 2014) [24], have reported mistreatment during childbirth by midwives with young women reporting a poorer quality of interpersonal care and stereotyping by health professionals. Studies done in this region by Abuya, *et al*., (2015) [1]; Moyer, Adongo, Aborigo, Hodgson, & Engmann (2014) [24], indicate that the level of "disrespectful" maternity care is high. Nilsson, Thorsell, Hertfelt Wahn, and Ekström, (2013) [26] contend that it is crucial to have the more effective midwifery engagement with women in the African context.

Women from low resource countries who give birth in health facilities, have reported that midwives sometimes impose unnecessary, uncomfortable and humiliating medical procedures, with a lack of respectful communication and on occasions are abusive, (Hildingsson, 2015) [13]. In Sub-Saharan Africa, numerous studies have showed that satisfaction derives from different contextual elements, for example receiving accurate and adequate information (Abuya, *et al*., 2015; Bohren, *et al*., 2017; Moyer *et al*., 2014) [1, 6, 24].

In Nigeria, Bohren *et al*., (2017) [6], showed that a trusting relationship between midwives and the women can be obtained by good communication and professional behaviour. In Kenya disrespect and abuse of pregnant mothers by midwives and other care providers in maternity settings has been identified as a significant deterrent to mothers' seeking facility-based deliveries (Lerberg *et al*., 2014) [21]. This has been further associated with lower satisfaction with quality of child birth services in health facilities. Abuya *et al*., (2015) [1] found that verbal abuse, stigma and discrimination, inability to meet professional standards of care, poor rapport and relationships between women and midwives, emerged as fundamental to women's distress stories. Women's unwillingness to use child birth care in low resource countries stems from the cultural incorrectness of care, disrespectful and inhumane services, absence of emotional support, along with high charges (Koblinsky, 2006; Thomson & Downe 2010) [18, 25]. Interventions aimed at improving interpersonal communication, connection and rapport between caregivers and labouring women are central to improving quality of care. (Chadwick, Cooper, & Harries 2014) [8].

A need for individualised care and respect for the birthing woman's wishes requires highly developed interpersonal skills from midwives (Oikawa *et al*., 2014) [28]. Although many qualitative researches have been undertaken on women's experiences of midwifery care globally, very few have been conducted in Africa and with a focus on client provider communication. It is important to identify women's experiences of respectful midwifery psychosocial care and communication that accord with their socio economic and demographic characteristics, in the Kenyan context.

2. Material and Methods

A cross-sectional descriptive approach was used. Key independent variables were socio- economic and demographic of income, education, marital status, occupation age and parity, whereas the dependent variables were effective communication; respect, care and dignity and emotional support.

2.1 Site

The study was carried out at a referral public hospital in Nairobi with approximately 978 deliveries per month

2.2 Sampling

A Cochran (1963) population calculation was used to estimate the total population needed. The sampling frame of 327 was used from the delivery register. Systematic random sampling technique was employed to select mothers from a random starting point and a fixed periodic interval. The sampling interval, was calculated by dividing the population size per month by the desired sample size, to recruit a sample of 109 postnatal mothers within 48 hours of delivery. In Kenya the vast majority of mothers are discharged within 48 hours after birth. Data was collected over a period of two months.

2.3 Inclusion Criteria
All mothers who had been admitted to the labour ward in the first stage of labour at the study site, and who had delivered vaginally without any complications were included.

2.4 Exclusion Criteria
Mothers who were admitted during the second stage of labour or who gave birth before arrival in the hospital were not included. Mothers who underwent caesarean section, those who delivered through assisted vaginal delivery, and mothers who delivered still births were also excluded.

2.5 Instrument
The Experience of Psychosocial Care and Communication during Childbirth Questionnaire (EPCCQ) was adopted from Bazant, (2008) [15] with modifications made for Kenyan culturally specific items derived from the literature review. The three sub scales were respect, care and dignity, effective communication; and emotional support. The validity of the questionnaire was determined by two experts, reliability of scale measurement questions, and a Cronbach's alpha of 0.86 of the original questionnaire was reported (Bazant, 2008) [15]. The questionnaire consisted of questions scored on a 5 point Likert scale. The 5-points Likert scale was scored; strongly agree to strongly disagree. Scales for the experience in delivery care were created by, first, recoding the items from -2 to 2, with a higher score designating positive experience. Items worded negatively were coded in reverse. A reply of "unsure" was recoded as the centre value, "0". Secondly, principal components analysis (PCA) was performed to define the number of components. Third, exploratory factor analysis (EFA) was done to categorize latent factors underlying the survey items. Fourth, confirmatory factor analysis (CFA), based on structural equation modelling, was utilised to determine if the fit of the factor solution was empirically established. Finally, predicted factor scores for each mother were estimated based on the findings of factor analysis. Construct validity was increased by utilising these methods together. Questions were clustered under the subscales of the three clusters of the model, (effective communication; respect, care and dignity; and emotional support**).** The socio demographic data collected were; age, parity, marital status, occupation, monthly income and education level.

The questionnaire were administered to the respondents through personal face-to face interviews and completed by the primary researcher. English language was used in administering to majority of respondents though a few were translated to Kiswahili for the respondents who could not read and understand English. The primary researcher was proficient in Kiswahili

Pilot testing for content validity was undertaken on 10 mothers, minor modifications were made accordingly. The pilot engaged mothers who had provided consent, met the eligibility criteria and were in a different public hospital from that employed in the main study.

2.6 Analysis
The data was analysed used the Statistical Package for Social Sciences (SPSS) version 21 after data cleaning. The test of association of the socio-economic and demographic factors with respect to the mother's experience was based on the Spearman test. A P-value of 0.05 was used to determine the statistical significance of the results obtained.

3. Results and Discussion
3.1 Demographic Characteristics
Approximately a half (45.9%) of mothers surveyed were aged between 20 and 24 years. The average age of the study mothers was 26±4.5 years. Parity ranged from 2 to 5. Over two thirds (71.6%) of the mothers were married. Nearly half of the mothers (48.6) had attained primary education and over a third (37.6%) attained secondary education. Nearly a half (45%) of mothers were self-employed and slightly over a half (52%) earned between US$ 50-99 per month (Table 1.1).

Table 1: Demographic characteristics of mothers

Characteristic	Frequency (n)	Percent (%)
Age in years		
20-24	50	45.9
25-29	35	32.1
30-34	19	17.4
35-40	5	4.6
Marital status		
Married	78	71.6
Single	15	13.8
Cohabiting	10	9.2
Divorced/Widowed	6	5,5
Educational level		
Primary	53	48.6
Secondary	41	37.6
College/University	15	13.8
Parity		
Para 2	37	33.9
Para 3	41	37.6
Para 4	17	15.6
Para 5 and above	14	12.8
Occupation		
Permanent	13	11.9
Casual worker	18	16.5
Self-employed	49	45.0
Housewife	29	26.6
Income per Month		
US$ 20-49.9	19	22.6
US$ 50-99.9	44	52.4
US$100-149.9	16	19.1
US$ 150 and above	5	6.0

*US$- US Dollar

3.2 Experience Regarding Interpersonal Communication, Respect Care and Dignity, and Emotional Support among the Mothers
The Sub Scale Interpersonal Communication During Childbirth included; explaining procedures before performing them, listening to the mother's questions with concern, and explaining the mothers condition in the terms they could understand; Respect, Care and dignity included; treated with respect, scolded/shouted at, offered privacy, and requested to consent before procedures. Emotional support included questions on whether they were left alone, showed compassion, and showed genuine concern.

3.2.1 Effective Interpersonal communication
The majority of the clients had a positive experience in relation to communication between midwives and the mothers as demonstrated in table 2.1

Table 2: Effective Interpersonal Communication

Experience		
Characteristic	**Positive**	**Negative**
	n (%)	n (%)
Explained to procedures	100 (91.7)	9 (8.3)
Listened to	102 (93.6)	7 (6.4)
Explained health status	97 (89.0)	12 (11.0)

*Results in percentages (%)

3.2.2 Respect, care and dignity

Most of the respondents had a positive experience regarding respect, care and dignity from the midwives as they stated that they were accorded privacy (77.1%), and consent was requested before performing procedures (91.7%). However, a significant number (97.2%) reported that they had a bad experience from being scolded by their midwives during child birth. (See Table 2.2).

Table 3: Respect, care and dignity

Experience		
Characteristic	**Positive**	**Negative**
	n (%)	n (%)
Treated with respect	104 (95.4)	5 (4.6)
Scolded	3 (2.8)	106 (97.2)
Accorded privacy	84 (77.1)	25 (22.9)
Asked for consent	100 (91.7)	9 (8.3)

*Results in percentages (%)

3.2.3 Emotional support

The majority of the women stated that they were "shown compassion" during labour and childbirth (89.0%) and that the midwives showed "genuine interest" (89.0%) during the care of these mothers. Of concern however is that, 88.1% gave a negative response citing that they were left alone for prolonged periods during labour (Table 2.3).

Table 4: Emotional Support

Experience		
Characteristic	**Positive**	**Negative**
	n (%)	n (%)
Left alone	13 (11.9)	96 (88.1)
Shown compassion	97 (89.0)	12 (11.0)
Shown genuine interest	97 (89.0)	12 (11.0)

*Results in percentages (%)

3.3. Factors Associated With Delivery Experience

The test of association of the socio-economic and demographic factors with respect to the mothers' experience (regarding the three aspects) was based on the Pearson test. A p-value of 0.05 was used to determine the statistical significance of the results with a confidence interval of 95%.

3.3.1 Factors associated with effective communication

A Spearman correlation test was conducted to find the relationship between socio demographic characteristics and the aspects of effective communication. Marital status was significantly inversely related to midwives explaining the health status to the mother (rs=-0.192, p=0.046). Occupation was significantly, inversely related to midwives explaining the procedures before performing (rs=-0.192, p=0.045) (Table 3.1).

Table 5: Factors associated with effective communication by midwives

Characteristic	**Explained procedures** Statistical test	**Listened to** Statistical test	**Explained health status** Statistical test
Age	r_s=0.070, p=0.467	r_s=0.056, p=0.562	r_s=0.040, p=0.567
Marital status	r_s=-0.044, p=0.649	r_s=0.004, p=0.963	***r_s=-0.192, p=0.046**
Parity	r_s=0.007, p=0.940	r_s=0.016, p=0.872	r_s=0.151, p=0.118
Education	r_s=0.072, p=0.455	r_s=0.132, p=0.171	r_s=0.150, p=0.120
Occupation	**r_s=**-0.192, p=0.045	r_s=-0.164, p=0.089	r_s=0.144, p=0.135
Income	r_s=0.136, p=0.216	r_s=0.154, p=0.162	r_s=0.113, p=0.307

*Significant at 0.05

3.3.2 Factors associated with respect, care and dignity

A correlation was conducted to find the relationship between socio demographic characteristics and the aspects of respect, care and dignity. An inverse significant correlation, was found between marital status and consent from the mothers before doing procedures (r_s=-0.202, p=0.036), (Table 5).

Table 6: Factors associated with respect, care and dignity

Characteristic	**Respectful Statistical test**	**Shouted at Statistical test**	**Privacy Statistical test**	**Consent Statistical test**
Age	r_s=0.099, p=0.308	r_s=0.041, p=0.671	r_s=0.092, p=0.342	r_s=0.039, p=0.686
Marital status	r_s=-0.049, p=0.612	rs=-0.104,p=0.280	rs=-0.037 p=0.701	***r_s=-0.202,p=0.036**
Parity	r_s=-0.007, p=0.940	r_s=0.027, p=0.779	r_s=0.041, p=0.676	r_s=0.138, p=0.153
Education	r_s=-0.004, p=0.968	r_s=-0.072, p=0.45	r_s=0.078, p=0.421	r_s=0.183, p=0.057
Occupation	r_s=-0.073, p=0.448	r_s=0.154, p=0.11	r_s=-0.164, p=0.089	r_s=-0.154, p=0.109
Income	r_s=-0.096, p=0.387	r_s=0.005, p=0.964	r_s=-0.110, p=0.318	r_s=0.072, p=0.515

*Significant at 0.05

3.3.3 Factors associated with emotional support

A correlation was sought between socio demographic characteristics and the components of emotional support. There was an inverse significant correlation, between occupation and genuine interest displayed by the midwives (r_s=-0.216, p=0.024). (Table 6).

Table 7: Factors associated with emotional support

Characteristic	**Left alone** Statistical test	**Compassion** Statistical test	**Genuine** Statistical test
Age	r_s=-0.135, p=0.162	r_s=0.110, p=0.255	r_s=0.110, p=0.255
Marital status	r_s=0.154, p=0.11	r_s=-0.123, p=0.204	r_s=-0.123, p=0.204
Parity	r_s=-0.063, p=0.512	r_s=0.112, p=0.245	r_s=0.112, p=0.245
Education	r_s=-0.172, p=0.073	r_s=0.150, p=0.120	r_s=0.150, p=0.120
Occupation	r_s=0.071, p=0.464	r_s=-0.129, p=0.182	*r_s=-0.216, p=0.024
Income	r_s=-0.050, p=0.654	r_s=0.123, p=0.264	r_s=0.136, p=0.216

*Significant at 0.05

4. Discussion

These findings provide for the first time, Kenyan based maternal data on socio-economic and demographic associations with midwifery psychosocial care communication during childbirth.

Regarding communication between the midwives and the mothers, the majority of the mothers had a positive experience, stating that the midwives had explained the procedures being performed, they listened to them and their health status had been explained to them, (91.7%, 93.6% and 89.0% respectively). These findings differ from studies done in East Africa by Kujawski *et al*., (2015) [20] and McMahon (2014) [23], which document that improper provider client communication such as "scolding" led to negative childbirth experiences. A similar outcome was reported in a Tanzanian study where negative client – provider interactions, unmindful staff and embarrassment were identified as impacting negatively on mothers child birth experiences (Kujawski *et al*., 2015) [20]. These forms of verbal abuse often include use of rude and or harsh language, (Atuyambe, Mirembe, Johansson, Kirumira, & Faxelid, 2005) [2]. Two recent studies conducted in sub-Saharan Africa have revealed poor communication between mothers and midwives, (Kujawski *et al*., (2015) [20] and McMahon (2014) [23]. Similar results were found in Tanzania, Ghana and South Africa (McMahon, 2014; & Moyer *et al*., 2014) [23, 24] where negative experiences were reported during mother-midwife interactions, due to inattentive staff and humiliation.

Regarding respect, care and dignity, the majority of mothers in the current study felt they had been treated with respect, were accorded privacy, and were requested consent before performing procedures. This was in contrast with recent studies conducted in sub-Saharan Africa, Bohren, *et al*., (2017) [6] and East Africa, Abuya, *et al*., (2015) [1]; Moyer *et al*., (2014) [24] where mothers reported bad experiences reporting that they were left alone for prolonged periods of time during labour. A study in north-eastern Tanzania by McMahon, (2014) [23] established that disrespectful and abusive treatment during childbirth was related with considerably lower satisfaction with the childbirth experience, perceived quality of care during delivery, when adjusting for demographic and delivery experience influences. Similarly Kujawski *et al*., (2015) [20] found out that mothers who delivered in the public health facilities experienced a lack of respect and dignity from the midwives. These three outcomes may be seen as diminishing patient trust in the health system (McMahon, 2014 & Moyer *et al*., 2014) [23, 24].

Regarding emotional support, most of the women in this study indicated that they were "shown compassion" during labour and childbirth and that the midwives showed "genuine interest" (89%), during the care by the midwives. The finding were different from the results of the study conducted by Moyer *et al*., (2014) [24] whose findings showed lack of emotional support from the midwives during child birth.

A finding of critical importance is that a large percentage of mothers reported that they had been "scolded" (97.2%) and (88.1%) cited that they had been left alone by their midwives during child birth. The finding of being "scolded" by the midwives compares with a South African based study where women felt ashamed when midwives made inappropriate remarks to them regarding their sexual activity particularly unmarried women. Studies undertaken in East Africa by Kujawski *et al*., (2015) [20] and McMahon (2014) [23], document that the lack of proper provider client communication such as scolding can led to negative childbirth experience. Our negative experience findings can be compared with those findings from Tanzanian study where negative client – provider communications, inattentive staff and embarrassment were found (Kujawski *et al*., 2015) [20]. Similarly, a study undertaken in Kenya by Kabo, Karani, Oyieke, Wakoli & Cheruiyot, (2016) revealed that mothers were commonly left alone and told off during childbirth at a government hospital. Furthermore, mistreatment including physical and verbal abuse, was experienced by mothers during child birth in Kenya (Warren, Njue, Ndwiga, & Abuya, 2017) [32].

The significance of "marital status'' in our study compares with a Ghana study where unmarried women felt they were not always sufficiently informed of the risks and benefits and felt that the midwives and obstetricians only went over the motions of gaining consent (Moyer, Adongo, Aborigo, Hodgson, & Engmann, 2014) [24]. Some single women in South Africa have been reported to evade or fear health facility-based delivery owing to being ridiculed by the midwives, (Odhiambo, 2011) [10]. Results of our study showed that women who were not married and/or employed experienced disrespectful midwifery care. In Uganda, adolescent mothers were criticized and ridiculed by midwives for engaging in sexual activity before marriage and some felt that their confidentiality was breached due to their age, (Atuyambe *et al*., 2005) [2].

Furthermore, in our reported study the experience of being left alone and scolded by their midwives, may have contributed to a negative birth experience. Our findings are similar to the findings of Bohren *et al*., (2017) [6], which showed that good interpersonal care and effective communication empowers the mothers during their first birth and increases their likelihoods of a positive experience during child birth.

Our finding of unemployment and an association of poverty compares with Moyer *et al*., (2014) [24], who suggested that women with no sources of income alleged that they received inferior treatment during childbirth since they were not capable of paying for services or to pay enticements. Fear of such discrimination from unemployment was considered a powerful limiting factor for women to deliver in health facilities in Ghana, Sierra Leone, and Tanzania. (Kruger, &

Schoombee, 2010; Atuyambe *et al*., 2005) [19, 2]. Furthermore, unemployed women in Kenya have cited language barriers and interpretation challenges communicating with midwives in government health facilities during labour and childbirth, (Izugbara, & Ngilangwa, 2010) [15]. In Izugbara, & Ngilangwa 's study unemployed Kenyan mothers were discontent with the explanations from midwives regarding their care stating that the midwives actively dismissed their concerns regarding possible complications of their impending deliveries.

Standards for maternal health services in Kenya contend that a women has a right to dignity, privacy, and information, and all woman should have access to skilled attendance at child birth (WHO, UNICEF, UNFPA, The World Bank & the United Nations Population Division 2014). Our study of women's experiences in midwifery care during childbirth reveals both strengths and weakness in the quality of midwifery care in Kenya. Our results are consistent with other findings in low-income countries that have indicated the crucial part of a women's social status in women's satisfaction with their birth experiences, (Hildingsson, *et al*., 2013; Moyer, *et al* 2014) [14, 24]. In Sub Saharan Africa, Balde *et al*., (2017) [4] found that physical, verbal abuse, stigma and discrimination, being left alone, failure to be asked for consent before procedures and poor communication between women and midwives were the main factors leading to a negative birth experience. Similarly, in South Africa (McMahon *et al*., (2014) [23] and in Ghana (Moyer *et al*, (2014) [24] reported that midwives used disrespectful language during their patient communication, (verbal abuse), physical abuse, abandonment and lacked explanation of what to do during child birth, found to be related to a negative childbirth experience.

5. Conclusion and Recommendations

In Kenyan maternal care the social demographic variables of marital status and occupation are linked to receiving poor psycho social care and communication form midwives during childbirth. These findings may pose an important deterrent in women choice of health facility delivery and may negatively affect a Kenyan women's confidence in her birth related health care. While the Kenya maternal health care services are free those most at need, unemployed and unmarried mother are the most vulnerable. Kenyan maternal healthcare providers and midwifery delivery services must prioritise a patient cantered and health care equity approach within a respectful communication framework regardless of marital status and occupation to enable optimal birth outcomes.

Kenyan midwives need to individualise care to mothers in childbirth irrespective of their marital and socio-economic status. Effective, respectful and dignified delivery of midwifery care during child birth places the birthing woman in a point of control and are key to positive birth experience, and the criteria towards realizing these rights include midwives. Particular attention needs to be paid to young and unmarried mothers.

Non-stigmatization, seeking women's opinions, encouraging women to ask questions, explaining procedures and diagnoses, and offering information in an open-and responsive manner must be prioritized to Kenyan midwifery care during childbirth. This can be achieved through revised midwifery educational curricula with a focus on human and patient rights, communication strategies and feedback through role play and reflective assessment approaches. Implementation of patient rights charters and hospital protocols for respect and dignity would further reinforce these new interventions.

There is need for new policy framework for more focused interventions to uphold respectful maternity care, preceded by midwifery education that emphasises non stigmatisation and on respectful health care communications during childbirth.

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7. Conflict of Interest

The authors have no conflict of interest to declare.

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