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Experiences and perceptions of respectful maternity care among childbearing women in Busia district, Uganda: a phenomenological inquiry into maternal perspectives and healthcare dynamics

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Abstract

Introduction: Respectful Maternity Care (RMC) promotes dignified treatment of expectant mothers during healthcare encounters. Despite its critical role in improving access to quality maternal healthcare, mistreatment during childbirth remains common in rural public health facilities (PHFs). This study documented the experiences and perceptions of RMC among childbearing women in Busia District, Uganda, including how cultural, spiritual, and gender factors influence maternal care to inform policy development and program implementation in low-resource settings.

Methods: A qualitative phenomenological design was employed, purposively sampling childbearing women and healthcare workers from PHFs. In-depth interviews and focus group discussions were conducted, with data transcribed and analyzed using Atlas.ti V9 through thematic content analysis. Quality control included pre-testing tools, training bilingual research assistants, and daily supervision. Themes explored included healthcare provider attitudes, facility constraints, cultural norms, spiritual beliefs, and gender dynamics. Ethical considerations—REC approval, informed consent, confidentiality, and participant autonomy—were ensured. Limitations included non-generalizability and potential social desirability bias.

Findings: Some women reported positive experiences characterized by respectful treatment, but the majority encountered disrespect and abuse. Key contributors included limited awareness of maternal rights, gendered expectations affecting access and prioritization, spiritual beliefs guiding care choices, and systemic issues such as overcrowding, understaffing, insufficient supplies, and negative provider attitudes. Cultural and spiritual norms influenced care-seeking behaviors, including reliance on traditional birth attendants and ritual practices, sometimes conflicting with biomedical recommendations.

Conclusion: Disrespect and abuse persist in PHFs in Busia District, compounded by systemic, cultural, spiritual, and gender-related factors. The absence of structured complaint mechanisms limits accountability. The study recommends establishing a platform for reporting and resolving maternal complaints, integrating culturally sensitive,

gender-aware, and spiritually informed approaches to enhance maternal and child health outcomes and inform national, maternal healthcare policies.

Keywords: Respectful Maternity Care (RMC), Maternal and Child Health (MCH), public health facilities, cultural norms, spiritual beliefs, disrespect, abuse

Introduction

Maternal and Child Health (MCH) indicators remain a global concern, particularly in developing countries. In 2015, the United Nations established the Sustainable Development Goals (SDGs), targeting a reduction of the Maternal Mortality Ratio (MMR) to fewer than 70 per 100,000 births by 2030. Achieving this requires improved access to quality healthcare during childbirth. Central to this effort is Respectful Maternity Care (RMC), which prioritizes the rights and dignity of women, newborns, and families.[1] RMC ensures equitable access to evidence-based care while respecting the needs and preferences of pregnant women and newborns.

Despite global recognition, mistreatment during childbirth remains prevalent, especially in countries such as Nigeria, Zimbabwe, and Uganda, undermining maternal health outcomes.[2,3] RMC is considered a fundamental human right for all women accessing maternity services.[8] However, instances of abuse during labor are common worldwide, particularly in developing countries, and significantly affect maternal and newborn outcomes. This qualitative study explores global perspectives on RMC, its relation to maternal deaths, experiences of RMC, contributors, barriers, and efforts by Ministries of Health (MoH) to promote RMC.

The World Health Organization (WHO) acknowledges widespread disrespectful and undignified care during childbirth, particularly among underprivileged populations.[8] Sub-Saharan Africa bears a disproportionate burden of maternal deaths, with abuse during childbirth contributing to poor outcomes.[2] Studies in Nigeria and Ethiopia reveal high rates of disrespect and abuse, discouraging women from delivering in facilities, with some opting for Traditional Birth Attendants (TBAs) who often provide more respectful care.[2,3] Promoting RMC can improve birth outcomes and reduce maternal deaths.[6] Clinical trials demonstrate reductions in maternal mortality where RMC interventions are applied.[6] Studies in Jamaica, Kenya, and Tanzania document forms of abuse, including verbal insults, breaches of confidentiality, abandonment, and non-consented procedures.[9,10] Disrespectful maternity care is prevalent across Africa, though often under-reported.[9,10]

Contributors to RMC include addressing limited knowledge of rights among providers and clients, interventions to change attitudes and behaviors, and applying WHO criteria for defining RMC.[11,12] However, challenges such as inadequate workforce, weak infrastructure, and insufficient training in values transformation hinder RMC delivery.[11,12] Barriers exist at individual, facility, and systemic levels, including provider stress, poor mentorship, lack of training in respectful care, and weak monitoring of abuse.[13,14] Strategies such as staff training, improved privacy in wards, and educating women about their rights are essential for overcoming these challenges.[13,14] Uganda continues to face high maternal mortality, limiting progress toward SDG targets. In rural areas like Busia district, low uptake of facility-based delivery is linked to disrespect and abuse. Understanding women's experiences and perceptions of RMC is, therefore, crucial.[4] This study used a qualitative design to explore these perspectives.

Objective: To assess experiences and perceptions of RMC among childbearing women in Busia District, Uganda 2018 to 2019.

Specific objectives of study:

1. To explore experiences and perceptions of RMC among childbearing women in Busia district.
2. To understand community norms and values regarding RMC in Busia district.
3. To identify facility and health systems contributors to RMC in Busia district.

The study explored efforts to improve maternity care in Busia district, focusing on RMC since 2009, when White Ribbon Alliance initiatives and Millennium Development Goals (MDGs) targeted maternal health in Uganda. Despite interventions, Maternal Mortality Ratio (MMR) remained high at 250-350 deaths per 100,000 live births, above the WHO target of 70. Findings address forms of disrespect and abuse, including physical assault, non-consented care, breaches of confidentiality, indignity, discrimination, abandonment, and detention in facilities.[5] Insights from RMC experiences inform strategies to strengthen maternal and child health services, shape policies, and improve healthcare delivery in Busia and similar settings.[6] Alignment with the RMC Charter highlights seven rights of childbearing women: information, privacy, dignity, equality, timely healthcare, liberty, and autonomy as seen in Table 1.[7]

Table 1. Tackling disrespect and abuse: seven rights of childbearing women

Category of disrespect and abuse in RMC	Corresponding right
Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
Non-confidential care	Confidentiality, privacy
Non-dignified care (including verbal abuse)	Dignity, respect
Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
Abandonment or denial of care	Right to timely healthcare and to highest attainable level of health
Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

Notes. Adapted from White Ribbon Alliance Training Manual, 2011

Investigating RMC experiences in Busia district was essential for addressing challenges in maternal healthcare. By exploring perspectives of childbearing women, cultural norms, and health facility practices, this study aimed to identify barriers and opportunities for improving RMC. Findings contribute to national and global efforts to achieve SDGs through enhanced MCH services. The MoH has implemented targeted interventions to strengthen health systems, ensure accountability, promote equity in access and quality of care, and encourage collaboration with stakeholders. This study adds to the knowledge base guiding policy and practice improvements.

Materials and Methods

A phenomenological research design was employed to explore lived experiences of childbearing women regarding Respectful Maternity Care (RMC) in Public Health Facilities (PHFs) in Busia district.[11] Qualitative methods, including Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs), were used to capture nuanced insights.[2] Busia district, in eastern central Uganda, was selected due to known RMC challenges. It comprises 10 sub-counties and 27 PHFs, including one General District Referral Hospital.[11]

The study population included childbearing women who delivered in PHFs, healthcare providers (midwives), and stakeholders such as

District Health Team (DHT) members and PHF In-charges.[2] Four-to-five FGDs and 15-17 IDIs were conducted between April-May 2020 across selected PHFs and sub-counties until saturation was achieved.[11] Purposive sampling guided respondent selection, ensuring relevance to objectives and representation from diverse backgrounds.[11]

Inclusion criteria were women who delivered in Busia PHFs within the previous two years (2018-2019) to ensure recall accuracy. Exclusion criteria included deliveries beyond two years, refusal to participate, and mental instability (e.g., psychosis or severe depression) as recorded in facility health records.[2] Data collection was undertaken by the researcher and trained assistants, using pretested FGD and IDI guides.[11] Women hesitant to share sensitive issues in FGDs were shifted to IDIs, allowing confidential disclosure.

Primary data came from FGDs and IDIs, while secondary data were drawn from PHF records and reports.[11] To ensure data quality and rigor confidentiality, anonymity, and informed consent were upheld throughout.[2] Neutral, bilingual interviewers were trained to minimize bias, and multiple coders supported thematic analysis. Emerging findings were validated through member-checking with selected respondents.

Interviews were audio recorded, transcribed, and cleaned before analysis. Research assistants fluent in English and Lusamya performed transcription and cleaning, which involved correcting errors, retrieving missing information from field notes, eliminating duplicates, and removing identifiers. Data were systematically coded in Atlas.ti Version 9 and analyzed thematically to deepen understanding of participants' experiences.[11]

Ethical approval was granted by Uganda Christian University Research Ethics Committee (UG-REC_26 UCU REC), approval number 301-660-247.

Results

Study respondents. Out of 57 respondents, 47 participated in IDIs and FGDs. They included key stakeholders in RMC such as childbearing women, health workers/midwives, in-charges, and DHTs (*Table 2*).

Table 2. Breakdown of study respondents

Category of respondent	Number
Child bearing women (4 FGDs) each with 8 Respondents	32
Health workers/midwives (IDI)	5
PHFs In-Charges (IDI)	4
Childbearing mother (IDI)	5
DHTs	1
Total	**47**

Experience and perception

Data revealed a mixed picture regarding RMC. While efforts to sensitize patients about their rights and display patient charters were noted, disrespect and abuse in PHFs persist. The prevalent forms of disrespect and abuse reported included: extortion, non-dignified care, neglect, discrimination, lack of privacy and confidentiality, non-consented care, and detention in care as indicated in *Table 3* below.

Table 3. Experiences and perception of RMC among childbearing women in Busia

Theme	Sub themes	Voices
Lived experiences	Extortion	• Asking for money • Health workers responding late. • Health workers Absenteeism
	Non-dignified care	• Abusive and embarrassing words • Harshness (slapping and rudeness) • Physical and psychological abuse
	Neglect and abandonment	• Pushing without midwife's attention • Time of reaching at facility
	Discrimination	• Appearance • Birth items/preparedness • Tribal differences • HIV Status • Birth Complications
	Privacy and confidentiality	• Structural challenges
	Non-consented care	• Clients do not know their rights
	Detention in care	• Mother detained for failure of payment in PHFs

Extortion. Respondents shared instances where they were asked for money for services, leading to delays and complications during delivery. For instance, one participant stated,

> *When I was pregnant with this child, I fell sick and came to this health facility... we had come for maternity services but were told to go to the laboratory for blood tests and I did not know that they needed money for tests when the laboratory attendant asked me for money* (FGD1 R4, 2020).

Non-dignified care. Respondents described experiences of harsh treatment and physical and verbal abuse. One respondent narrated,

> *Sometimes you come to hospital when you are in labor and don't find a midwife to attend to you...And when they come, they are excessively bitter and rude, they slap you and abuse you, asking who sent you to get pregnant* (FGD1 R3, 2020).

Neglect and abandonment. Mothers reported instances of being left unattended during labor or even asked to deliver themselves. A participant shared,

> *I called watchman and asked him to go and call midwife for me, but she refused to come...there is another child I produced from that tree because nurse failed to pay attention to me* (FGD2 R1, 2020).

Discrimination. Discrimination based on socio-economic status, HIV status, and complications during pregnancy was reported. One respondent mentioned,

> *Discrimination in maternity...In most cases, if a mother may be has been brought by a husband with a car a midwife will expect in return a bigger token so attention will be given faster and better treatment will be given to that person* (IDI Midwife 2, 2020).

Privacy and confidentiality. Structural challenges led to lack of privacy and confidentiality in maternity wards. A midwife expressed,

> *we combine all mothers for postnatal and those who haven't delivered, so you find that there is no privacy...So, we need privacy where those who are laboring are in one place* (IDI Midwife 5, 2020).

Non-consented care. Instances of procedures being conducted without mothers' consent were reported. A respondent mentioned, "*consenting, we haven't been doing it...It has to be done but I didn't know that*" (IDI Midwife 1, 2020).

Detention in care. Mothers reported being detained in PHFs due to their inability to pay for services. An in-charge mentioned an incident, saying,

> *...woman produced, after delivery this midwife kind of requested for money in return but woman did not afford so midwife instructed this woman to be there not until money is gotten"*(IDI In-Charge 1, 2020).

Community Beliefs and Norms

Beliefs and norms significantly influence attitudes toward maternity care. Traditional Birth Attendants (TBAs) are perceived as better maternal health practitioners by some community members. Additionally, there are cultural beliefs such as expectation that women should handle childbirth alone and belief that women never fall ill, which contribute to attitudes towards maternal care (Table 4).

Table 4. Community attitude and values regarding RMC in Busia district

Theme	Sub-theme	Voices
Perception	Attitude	• Traditional Birth Attendants • Community maternal status • Personal hygiene
Community	Cultural beliefs and practices	• Women never fall ill. • Childbirth not men's business • Community liaison • Spiritual consideration • Placenta handling • Use of traditional herbs

Traditional Birth Attendants (TBAs). Respondents mentioned community's continued belief in effectiveness of TBAs in maternal health care. A midwife stated, *"Much as we give information, some people still believe a lot in TBAs because with Samyas they have this belief"* (IDI Midwife 1, 2020).

Community maternal status. Some community members believe they know their maternal health status better than health workers, leading to resistance to medical advice. A respondent shared, *"Some mothers are talked to but remain stubborn and insist saying, 'I had first child normally and did not have any problem'"* (FGD 2 R2, 2020).

Personal hygiene. Cultural norms surrounding personal hygiene shape interactions with health workers and can reinforce implicit victim-blaming. One respondent noted, *"Pregnant women don't take care of themselves like cleaning themselves, shaving and this makes health workers abuse them"* (FGD3 R3, 2020).

Community liaisons. Local council officials play a role in addressing grievances and facilitating communication between community and health facilities. A respondent stated, *"Patients report to chairman whom they tell that or doctors are not treating them well when they go to seek health care services"* (IDI Childbearing Mother 1, 2020).

Cultural and Spiritual Beliefs

Culture surrounding maternal healthcare in Uganda highlight the intersection of tradition, religion, and modern medical practices, significantly influencing women's experiences during pregnancy and childbirth.

Spiritual consideration. Many women believe that God communicates through dreams, guiding decisions like who should assist with childbirth. One midwife shared,

> *...She told me, "Musawo," whether you talk like what! I have been dreaming about you throughout my pregnancy… That she has been dreaming about me during her pregnancy that when you go to deliver and get that brown midwife that is the woman to deliver you and that is the woman to save your life. So, I tried all possible ways to refer her, but the woman refused, I had to monitor…* (IDI Midwife 1, 2020).

This belief can override medical recommendations and influence medical care.

Value attached to placenta. Placenta is seen as sacred, with specific rituals required for its disposal. A belief that failure to perform these rituals can lead to fears of infertility. A midwife noted,

> *We get some clients we deliver and after delivery, she says, "give me my placenta," and remember as a health worker you will have trashed it in the placenta pit, then you will see chaos* (IDI midwife 4, 2020).

Use of traditional herbs. Traditional herbs are often used by women to speed up labor or reduce pain. These herbs are taken orally or inserted into the vagina, depending on desired effect. However, these practices conflict with modern medical care, and women who use these herbs may face discrimination or mistreatment from healthcare workers who view these methods as incompatible with medical protocols. As one in-charge noted:

> *mothers who can get abused and discriminated, I think these mothers who use herbs, may be you come, then they have put down their herbs which means that they will give birth without pain. So such mothers get much abused in maternity more especially in my place they get more abused than others because you come when you have put there such things that don't tally naturally and clock does not tally naturally* (IDI In-charge 3, 2020).

The interplay of these cultural and spiritual factors highlights a need for healthcare providers to be culturally competent and sensitive. Providers must acknowledge and respect these beliefs while offering safe and effective care, creating an environment where both traditional

and modern practices can coexist. In some cases, integrating spiritual sensitivity into medical care could help bridge gaps between modern medicine and cultural practices, fostering trust and improving maternal health outcomes.

Facility System Contributors to RMC

Facility contributors to RMC, including physical distance, space adequacy, complaint mechanisms, power reliability, professionalism, choice of respectful health workers, and spousal accompaniment prioritize positive birth experiences (Table 5).

Table 5. Facility system contributors to RMC in Busia district

Theme	Sub-theme	Voices
Structural	Transport Challenges	• Long distances to PHFs for some women • Bad road terrain • Cost of transport
	Working Space	• Inadequate space at some health facilities • Privacy and confidentiality
	Power reliability	• No hydro power in most facilities • Spoilt batteries for solar
Staff competency	Professionalism	• Use of abusive and harsh language. • Complaint's mechanism
	Customer care	• Preference of health worker, • Discrimination • Workload • Male involvement
Leadership	Role of local leaders	• Meetings with staff • Health Unit Management Committee

Transport challenges. Discussions with mothers revealed that sometimes labor starts when they are still at home and cannot rush to PHFs immediately for some are far away from them. Thus, they resort to TBAs since they stay in their villages. The bad road terrain that increases cost of transport was also mentioned as a challenge. *"Sometimes what these mothers consider first is distance" (*IDI Midwife 2, 2020).

Working space. Inadequate space at some PHFs compromises privacy and confidentiality in that postpartum mothers and those in labor use same room. There was a facility where even labor suite was in same ward they just improvised with a side bed curtain.

> *Of course in labor suite when one is pushing you can see each other; there are no screens to prevent others from seeing each other fellow pushing, friends and also caretakers want to bump in, and maybe we encourage some husbands to come in and by the time a husband of another mother is pushing, this one is also able to see so we don't maintain privacy of other mothers due to small and inadquate rooms* (IDI Midwife 4, 2020).

Power reliability. Most PHFs use solar power in that once battery is down, they will remain in darkness, especially during rainy seasons. This was illustrated by a respondent who stated: *"Sometime back we had a challenge of power…"* (IDI Midwife 2, 2020).

Professionalism. Some health workers are too harsh and abusive yet there is no designated system of complaints and addressing such challenges at facility level. Mothers resort to complaining among peers, thus, deliberately or inadvertently discouraging others from seeking maternity services. One mother wondered whether abusive treatment could even be reported. When asked whether she has ever reported such incidences, she responded that, *"Where could I go to report…Yes, I just keep quiet, life is precious" (*FGD1 R1, 2020).

Health Systems Contributors to RMC

Health systems contributors included individual attitudes, resource inadequacies, and communication barriers. Strengthening infrastructure, enhancing training, and fostering stakeholder collaboration are essential for sustainable improvements. (Table 6)

Table 6. Health systems contributors to RMC

Theme	Sub themes	Voices
Drivers of disrespect and abuse	Individual factors	• Lack of awareness about RMC • Cooperation between mothers and midwives • Workload and burnouts
	Medical supplies and sundries	• Inadequate medical supplies • Inadequate Public Health Care funds
	Infrastructural	• Inadequate working space
	Attitude	• Community expectations • Emotional breakdown • Upbringing • Character
	Training	• Methods of training for health workers • Refresher courses • Upgrading
	Leadership	• Support supervision • Penalties for abuse and disrespect of mothers
	Communication	• Language barriers • Communication skills
	Male involvement	• Failure to accompany wives. • Not knowing facts of pregnancies
Future recommend-ations	Role of stakeholders	• Infrastructure • Stress management • Time management • Medical supplies • Clients' charter

Individual factors. Midwives complained of being understaffed, yet they have lots of work from family planning, antenatal care services, immunization, postnatal care, and delivery services all on only two midwives at a given facility. Some of these contributors were described by a respondent thus:

> *human resources are few, like now this is health center III, and we have only two midwives—they have to work, day and night. I wish we could have three or four, where one could work from morning up to 2pm, and another one takes over then there is a time when one is supposed to be off…*(IDI Midwife 3, 2020).

Medical supplies and sundries. Inadequate supplies lead to frequent stock out of drug supplies and sundries usually bring a misunderstanding between midwives and mothers. Mothers think that midwives just sell what government allocated for use at the health facility, especially when they are told to buy gloves among others.

> *now if you don't have what you are going to use, obviously you cannot work well, you will expect them to buy for themselves but for them, they may see it as abusing them and be like as if you are forcing them to buy when those items are there in stores"* (IDI Midwife 4, 2020).

Attitude. Attitude towards work versus community expectations brings about emotional breakdown when combined with character and upbringing, which leads to abusive language towards mothers by some midwives.

> *to me i have a mentality, if somebody is interested and motivated to work even if alone, she can handle without even complaining. What makes my midwife or us midwives to complain is because i am running. When running for activities, it is never late but when they stay at the health centre, they say we are over working. Isn't that mindset?* (IDI Midwife 3, 2020).

Training. The kind of training midwives go through affects their future RMC as they were trained to be tough which others think could be improved by refresher courses and upgrading.

> *there are some midwives who cannot change, they love to do things way they used to do them maybe in 1990s they didn't want to change to new modern knowledge so somebody is glued on their knowledge the way they used to do things then* (IDI DHT, 2020).

Leadership. Support supervision by district leadership has not been frequent since it is done quarterly. Respondents feel support supervision should be more frequent like monthly so that they address health facility issues in time, *"supervision system is a bit okay because we have district people who supervise, sub-county, they come every quarter*" (IDI Midwife 3, 2020).

Communication. Communication was also mentioned as a driver of abuse. When health worker is not able to speak the same language as mothers, they end up disagreeing on small issues or developing assumptions that lead to misunderstandings. Health system should require that they allocate health workers in facilities where they can speak the same language. *"Yes, so they consider those that speak that same language as their's first*" (IDI Childbearing mother 2, 2020).

Male involvement. Where a mother comes with her husband, she is given priority, but those who come without are worked on later. It becomes worse where a mother doesn't know a person responsible for her pregnancy.

> *Male involvement. It's found only in these or big hospitals like Nakasero, IHK for Ian Clarke those international hospitals where you find husbands coming bragging with mothers, pushing, they are given due care when they go; but here cultural way is those are feminine issues, you don't go to labor ward. You just come see which baby has come out if it is a girl, good news, and if it is a boy he says, "I am tired of boys."* (IDI DHT, 2020).

Recommendations by Respondents

Several recommendations emerged from the discussions, reflecting key areas where improvements are needed. These included provision of dignified care; reduction of waiting time; support for alternative birth positions and companionship during labor; a change in health workers' attitudes; improvements in service quality and health facility infrastructure; increased sensitization on clients' rights; regular refresher courses for healthcare workers; stress management support; and strengthening of associations to present issues to the Ministry of Health, among others.

One respondent elaborated on the issue of waiting time, stating,

> *they tell us to come at 8 am and health workers begin working on us at 11 am and we reach time of going home when we are so hungry, so we request they work on us early enough, they should work on us early such that people go back home….if tea is there that will be okay, but still we need to be worked on early because we leave other children at home and other household work to do* (FGD3 R1, 2020).

Discussion

Experiences and perceptions of childbearing women: women's experiences of maternity care in Busia District reflected both positive and negative interactions with healthcare providers. Some women appreciated attentive care during labor, but many reported disrespect and verbal abuse consistent with other Ugandan studies.[8,2] Participants noted that perceived neglect often resulted from facility constraints and overburdened staff rather than personal malice.[9,15] aligning with prior studies showing structural and human resource limitations affect care quality.[8,16] This study adds nuance by showing how women interpret certain behaviors as judgmental or punitive, especially when unable to maintain hygiene or meet staff expectations due to limited resources.[9] This contrasts with studies attributing disrespect solely to provider attitudes, emphasizing the interaction between patient capacity, facility limitations, and provider responses.

Cultural norms, gender, and spiritual beliefs: Cultural norms and gender roles strongly shape care-seeking behaviors and RMC provision.[1,2,3] Traditional practices, such as placenta handling and herbal use, can conflict with biomedical protocols, increasing the risk of mistreatment.[8] Reliance on TBAs reflects trust in local knowledge, while maternal status and

prior childbirth experience may lead women to resist medical advice.[4,5] Cultural expectations about hygiene—for example, *"Pregnant women don't take care of themselves…and this makes health workers abuse them"* (FGD3 R3, 2020)—reinforce victim-blaming.[6,7,11] Gender norms limit male involvement; mothers accompanied by husbands are prioritized, whereas those alone wait longer: *"Male involvement…only in big hospitals…husbands come…they are given due care; but here…those are feminine issues…"* (IDI DHT, 2020). Spiritual beliefs also influence maternal care: *"…She told me… 'I have been dreaming about you…get that brown midwife…that is the woman to save your life'…I tried to refer her, but she refused"* (IDI Midwife 1, 2020).[8,9] These findings highlight the need for culturally sensitive, gender-aware, and spiritually informed maternity care.[1,2,3,13]

Facility systems contributors: inadequate staffing, limited supplies, and constrained infrastructure were cited as barriers to RMC, leading to overworked staff, delayed interventions, and perceived neglect.[12,15] Staff shortages, limited space, and insufficient equipment influence provider behavior and patient experiences.[8] Poor road access affects care-seeking: *"Sometimes what these mothers consider first is distance"* (IDI Midwife 2, 2020). Limited labor and postpartum space compromises privacy: *"Of course in labor suite when one is pushing you can see each other…we don't maintain privacy due to small and inadequate rooms"* (IDI Midwife 4, 2020). Power outages further challenge care delivery: *"Sometime back we had a challenge of power…"* (IDI Midwife 2, 2020). Without formal complaint mechanisms, mothers remain silent: *"Where could I go to report… Yes, I just keep quiet, life is precious"* (FGD1 R1, 2020). Addressing staffing, infrastructure, power reliability, and complaint mechanisms is essential to protect privacy, build trust, and increase service utilization.

Health system contributors: inadequate training, unclear protocols, limited supervision, and resource constraints contributed to suboptimal RMC.[12,18] Staff shortages increase workload*: "Only two midwives…they have to work day and night"* (IDI Midwife 3, 2020), consistent with previous findings.[12,15] Limited supplies create misunderstandings: *"If you don't have what you are going to use…they may see it as abusing them"* (IDI Midwife 4, 2020).[20] Resistance to updated practices affects care: *"Some midwives cannot change…they are glued on their knowledge"* (IDI DHT, 2020).[18] Infrequent supervision and language barriers further hinder service delivery.[2,1] Male involvement affects prioritization, as mothers accompanied by husbands receive faster care.[17] Strengthening staffing, training, supervision, supply management, communication, and consent processes is essential to enhance maternal experiences, dignity, privacy, trust, and service utilization.[12,19]

Recommendations

Improving RMC in Busia District requires multi-level interventions. **First**, provider training should incorporate clinical skills, ethical care, communication, and culturally sensitive practices, using women's experiences to guide respectful handling of hygiene lapses and traditional practices. **Second,** facility improvements—including adequate staffing, mama kits, and infrastructure—are crucial to reduce burnout and enable respectful care. **Third,** community engagement should involve male and female leaders to address gendered barriers to disclosure and reporting of disrespectful care. **Fourth,** integration of spiritual and cultural practices into maternity care should be supported, ensuring safe accommodation of rituals like placenta handling and herbal use while maintaining biomedical standards.[8,9] **Finally,** consenting processes must be strengthened through verbal, written, and visual communication to ensure mothers understand procedures, risks, and rights, fostering autonomy and trust.[1,9] These recommendations address structural and interpersonal determinants of RMC, drawing directly from study findings.

Conclusion and Suggestions

RMC in Busia District is shaped by an interplay of provider behavior, facility constraints, health system factors, cultural norms, and spiritual beliefs. Challenges such as overworked staff, limited resources, and inconsistent consenting contribute to negative experiences, but women's perspectives highlight the importance of culturally sensitive, spiritually aware, and patient-centered interventions. Integrating these findings into policy and practice can improve maternal satisfaction, safety, and trust. Future research should explore safe integration of cultural practices into biomedical care, barriers to consent comprehension in rural settings, and how male-dominated community leadership affects reporting of disrespectful care. Evaluations of system-level interventions—including staffing, resource allocation, and supervision—are warranted to assess effectiveness in improving RMC and maternal outcomes in Uganda and similar contexts.

References

1. Victora CG, Requejo JH, Barros AJ, Berman P, Bhutta Z, Boerma T, et al. Countdown to 2030: tracking progress towards universal coverage for reproductive, maternal, newborn, and child health. Lancet. 2018;391(10129):1538-48. https://doi.org/10.1016/S0140-6736(18)30104-1
2. Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, et al. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PLoS One. 2015;10(4):e0123606. https://doi.org/10.1371/journal.pone.0123606
3. Afulani PA, Kirumbi L, Lyndon A. What makes or mars facility-based childbirth experience: a thematic analysis of women's childbirth experiences in Western Kenya. Reprod Health. 2017;14(1):180. https://doi.org/10.1186/s12978-017-0446-7
4. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth: *Report of a landscape analysis*. USAID-TRAction Project, Harvard T.H. Chan School of Public Health; 2010. Available from: https://content.sph.harvard.edu/wwwhsph/sites/2413/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf
5. Vogel JP, Bohren MA, Tunçalp Ö, Oladapo OT, Gülmezoglu AM, Temmerman M. How women are treated during facility-based childbirth: development and validation of measurement tools in four countries—Phase 1 formative research study protocol. Repro Health 2015;12(1):60. https://doi.org/10.1186/s12978-015-0047-2
6. Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OM, Feigl AB, et al. Quality maternity care for every woman, everywhere: a call to action. Lancet. 2016;388(10057):2307-20. https://doi.org/10.1016/S0140-6736(16)31333-2
7. White Ribbon Alliance. Respectful maternity care: universal rights of childbearing women [Internet]. 2011. Available from: https://content.sph.harvard.edu/wwwhsph/sites/2413/2014/05/Final_RMC_Charter.pdf
8. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. [Internet]. Geneva: World Health Organization; 2018. Available from: https://www.who.int/publications/i/item/9789241550215
9. Orpin J, Puthussery S, Davidson R, Burden B. Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. BMC Preg Childbirth. 2018;18(1):213. https://doi.org/10.1186/s12884-018-1847-5
10. Warren CE, Njuki R, Abuya T, Ndwiga C, Maingi G, Serwanga J, et al. Study protocol for promoting respectful maternity care initiative to assess, measure, and design interventions to reduce disrespect and abuse during childbirth in Kenya. BMC Preg Childbirth. 2013;13(1):21. https://doi.org/10.1186/1471-2393-13-21
11. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. Mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS Med. 2015;12(6):e1001847. https://doi.org/10.1371/journal.pmed.1001847

12. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, Bartlett LA. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. BMC Preg Childbirth. 2015;15(1):306. https://doi.org/10.1186/s12884-015-0728-4
13. Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, Comandé D, et al. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. Lancet. 2016;388(10056):2176-92. https://doi.org/10.1016/S0140-6736(16)31472-6
14. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reprod Health. 2015;12(1):33. https://doi.org/10.1186/s12978-015-0024-9
15. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP, et al. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. Health Policy Plan. 2016;33(1):e26-e33. https://doi.org/10.1093/heapol/czu079
16. Okafor II, Ugwu EO, Obi SN, Mbamara SU. Disrespect and abuse during facility-based childbirth in a low-income country. Int J Gynecol Obstet. *128*(2), 110–113. https://doi.org/10.1016/j.ijgo.2014.08.015
17. Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, et al. Prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. BMC Preg Childbirth. 2016;16(1):236. https://doi.org/10.1186/s12884-016-1019-4
18. Tunçalp Ö, Were WM, MacLennan C, Oladapo OT, Gülmezoglu AM, Bahl R, et al. Quality of care for pregnant women and newborns—WHO vision. BJOG. 2015;122(8):1045-9. https://doi.org/10.1111/1471-0528.13451
19. Holy Bible: New International Version. Ephesians 4:32. Bible Gateway [Internet]. 1984 [cited 2025 Apr 7]. Available from: https://www.biblegateway.com/passage/?search=Ephesians%204:32&version=NIV
20. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979). The Belmont Report: ethical principles and guidelines for the protection of human subjects of research. U.S. Government Printing Office. Available from: https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

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