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Original Article

Modified Conceptual Framework for Respectful Maternity Care for Promoting Quality in Health Facilities

Lucy Natecho Namusonge, KRCHN/BScN/MPH/M&E/PhD[1]

[1] Kibabii University, P. O. Box 2008-50200, Bungoma, Kenya.
*Author for Correspondence ORCID ID; https://orcid.org/0000-0001-8319-7467; Email: lucy.namusonge@gmail.com

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Respectful Maternity Care, Quality of Care, Conceptual Framework, Kirkpatrick Model, Three Delays, Health Facility.

ABSTRACT

Background: Respectful Maternity Care (RMC) is fundamental to improving maternal and neonatal health outcomes, yet mistreatment during childbirth remains widespread. Existing frameworks address either interpersonal mistreatment, structural delays, or quality standards, but often lack integration and clear evaluation pathways. **Objective:** This study presents a modified conceptual framework for RMC that unites training evaluation, systemic barriers, and patient experiences to guide quality improvement in Level 5 health facilities. **Methods:** The framework integrates three models: Kirkpatrick's training evaluation model (linking provider learning to outcomes), Bowser & Hill's landscape analysis (categorising disrespect and abuse), and the Three Delays model (addressing barriers to care). Principal Component Analysis (PCA) is proposed to enhance analytic rigour and weighting of variables. **Results:** The integrated framework demonstrates how provider training (reaction, learning, behaviour, results) influences women's experiences of autonomy, dignity, and supportive environments, ultimately reducing delays and improving maternal and neonatal outcomes. Resource requirements—including staff training, supervision, and infrastructure—and cultural adaptations, such as respecting local birthing norms and promoting birth companionship, are essential for effective application. **Recommendations:** The framework guides implementation through structured steps: baseline assessments, stakeholder engagement, resource allocation, context-sensitive training protocols, and continuous monitoring and evaluation using Kirkpatrick's four levels. **Conclusion:** By synthesising interpersonal, systemic, and evaluative dimensions, this model offers a robust and actionable tool for advancing RMC in resource-intensive settings. It provides policymakers, facility managers, and practitioners with a pathway to institutionalise respectful, equitable, and high-quality maternity care.

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INTRODUCTION

Mistreatment during childbirth—including disrespect, abuse, and neglect—remains a critical barrier to achieving safe and equitable maternal health. Such experiences not only contribute to maternal morbidity and mortality but also diminish women's trust in health facilities and discourage uptake of skilled birth services (WHO, 2018. While global initiatives have highlighted the need for Respectful Maternity Care (RMC), most existing frameworks either focus narrowly on typologies of mistreatment, structural delays, or quality standards without offering a comprehensive evaluative pathway. This study addresses these gaps by presenting a modified conceptual framework for RMC that integrates training evaluation, systemic barriers, and women's lived experiences. The purpose of this framework is to guide the design, implementation, and evaluation of RMC interventions in Level 5 health facilities, with the ultimate goal of strengthening maternal and newborn health outcomes in resource-intensive settings. To address these challenges, this paper presents a modified conceptual framework of Respectful Maternity Care (RMC) tailored to county-level referral hospitals (Level 5) (Maina *et al.,* 2021).

Specific Challenges and Gaps at Level 5 Facilities

County-level referral hospitals (Level 5) play a pivotal role in providing comprehensive emergency obstetric and newborn care (CEmONC), yet they face distinct challenges that compromise the delivery of Respectful Maternity Care (RMC). First, these facilities often experience high patient volumes and overcrowding, which strain physical infrastructure and limit the ability of health providers to deliver dignified and personalised care (Kruk et al., 2018). Second, shortages of skilled health personnel, coupled with uneven staff distribution and inadequate supportive supervision, result in provider fatigue and burnout, which are frequently linked to disrespectful or neglectful care practices (Afulani et al., 2017). Third, Level 5 facilities face gaps in essential supplies and functional referral systems, leading to delays in treatment, compromised quality, and negative patient experiences (Maina *et al.,* 2021).

In addition, women seeking care in referral hospitals often come from diverse cultural and socio-economic backgrounds, yet insufficient attention to cultural sensitivity and patient-centred communication creates barriers to trust and uptake of services (Bohren *et al.,* 2015). Furthermore, while policies and guidelines on quality maternal care exist, monitoring and evaluation mechanisms are weak, with limited tools for linking training interventions to behavioural change and patient outcomes. These systemic and interpersonal gaps underscore the need for a modified conceptual framework that integrates training evaluation, women's experiences, and systemic barriers. By doing so, the framework can provide a practical pathway for improving quality and equity of care in resource-intensive Level 5 settings.

The framework integrates operational definitions of key constructs such as autonomy, dignity, effective care, people-centeredness, and skilled attendance, grounded in established theoretical foundations: The Kirkpatrick Model, Bowser & Hill's landscape analysis, and the Three Delays model. This framework aims to guide the implementation and evaluation of quality

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improvement initiatives in resource-intensive environments.

The purpose of this study is to develop and present a modified conceptual framework for Respectful Maternity Care (RMC) that integrates established theoretical models to address gaps in quality care delivery in Level 5 health facilities.

The remainder of this paper is organised as follows: the literature review examines existing RMC frameworks, their limitations, and the rationale for integrating multiple models. The methodology describes how the Kirkpatrick Model, Bowser & Hill's typology, and the Three Delays framework were combined to construct the modified conceptual framework. The results present the framework and map Kirkpatrick's four levels to RMC outcomes, while the discussion explores implications for practice, including resource needs, cultural adaptation, and alignment with global RMC initiatives. The paper concludes by summarising the framework's unique contributions and offering practical recommendations for implementation, training, and monitoring in Level 5 health facilities.

OPERATIONAL DEFINITIONS OF KEY TERMS

Autonomy: - Implies that women are allowed to make informed decisions. Their views are respected in relation to what is appropriate, supported together with their families, and allowed to have birth companions.

Dignity: - Refers to the ability of women to receive care in a respectful and caring setting. It captures typologies of physical and verbal abuse from the literature of mistreatment of women during labour and delivery, as well as less subtle acts during patient-provider encounters that make women and their families disrespected.

Effective: - Providing services based on scientific knowledge and evidence-based guidelines. This is assessed through provider observation and health facility assessment.

Health facility environment: - This captures the quality of the facility and providing a fully enabled environment, including the commodities and equipment, referral system, communication and transportation, maternal and neonatal health team that can cover full continuum of care, environment where staff are respected and valued and that is clean, and the extent to which a health facility offers a welcoming and pleasant environment.

Health workforce training: - include in-service and on-the-job training, conferences, lectures, workshops, seminars, symposia, and courses. Clinical practice guideline implementation is also included.

Level-5 Health Facility: - Refers to a hospital with a capacity of more than 100 beds. It is run by a chief executive officer who must be a medical doctor. It has departments including medical, pediatric, surgical, maternity, gynaecology and outpatient. The maternity department provides Comprehensive Emergency Obstetric and Newborn Care services, more commonly known as CEmONC. The interventions, also known as signal functions, include parenteral administration of antibiotics, parenteral administration of uterotonics, parenteral administration of anticonvulsants, manual removal of the placenta, removal of retained products of conception, assisted vaginal delivery, neonatal resuscitation, caesarean section and blood transfusion.

Maternity Care: - All care about pregnancy, childbirth and the postpartum period, which entails the health and well-being of the mother and baby, health education, and assistance during labour and birth. Its components include Respectful Maternity Care, Emergency Obstetric Maternity Care, Essential Newborn Care, Focused Antenatal Care, and Malaria in Pregnancy.

Maternal mortality ratio: - The number of maternal deaths per 100,000 live births.

Maternal mortality: - Refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its

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management, but not from accidental or incidental causes.

Neonatal mortality ratio: - The number of deaths during the first 28 days of life, expressed per 1,000 live births.

People-centred: - Providing care which is respectful and responsive to patient preferences, needs, values and desires of individual service users and the culture of their community.

Perception: - A process involving beliefs, ideas, observation and feelings by which human beings interpret and organise sensation. It best describes one's ultimate experience of the world and dispositions to act in certain ways.

Quality of care: - The extent to which healthcare services provided to individuals and patient populations improve desired health outcomes that include positive user experience, reduced maternal and newborn morbidities and mortalities and increased uptake of skilled birth attendance. To achieve this, healthcare must be safe, effective, timely, efficient, equitable, and people-centred.

Respectful Maternity Care: - refers to care organised and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth.

Safe: - Delivering healthcare that minimises risks and harm to service users, including avoiding preventable injuries and reducing medical errors

Skilled birth attendant: - refers to a medically qualified health provider with midwifery skills (midwife, nurse or doctor) who has been trained and is competent in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications.

Treatment: - Refers to care during childbirth that is respectful and responsive to individual women and their families' preferences, needs, and values. It emphasises the quality of patient experience. This entails dignity and respect; autonomy; privacy and confidentiality; communication; social support; supportive care; predictability and transparency of payments; trust; stigma and discrimination; and health facility environment.

LITERATURE REVIEW

Respectful Maternity Care (RMC) has emerged as a global priority for improving maternal and neonatal health outcomes by ensuring that women are treated with dignity, autonomy, and compassion during childbirth (Namusonge *et al.,* 2022). Existing frameworks provide important foundations but reveal gaps that limit their effectiveness in guiding practice, training, and policy.

One of the earliest and most cited frameworks is **Bowser and Hill's (2010) landscape analysis**, which identified seven categories of disrespect and abuse—ranging from physical abuse and non-consented care to discrimination and detention in facilities. This framework brought global attention to mistreatment during childbirth but focused primarily on typologies of abuse, without offering pathways for systemic training evaluation or strategies for quality improvement.

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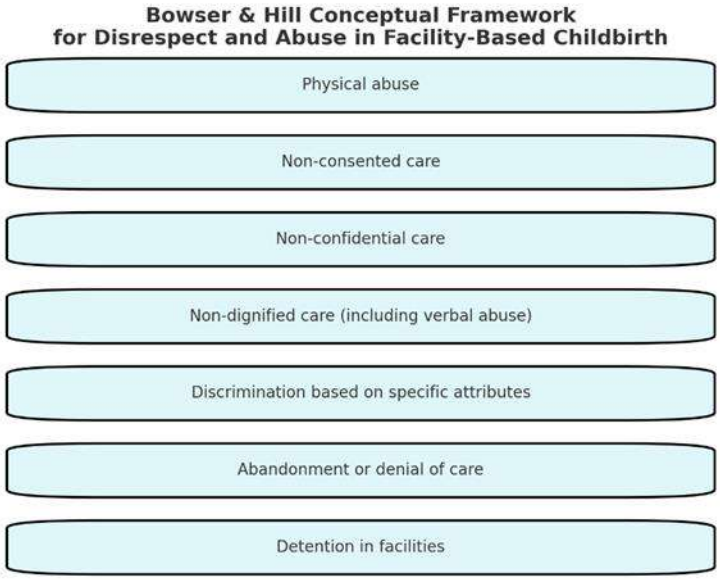
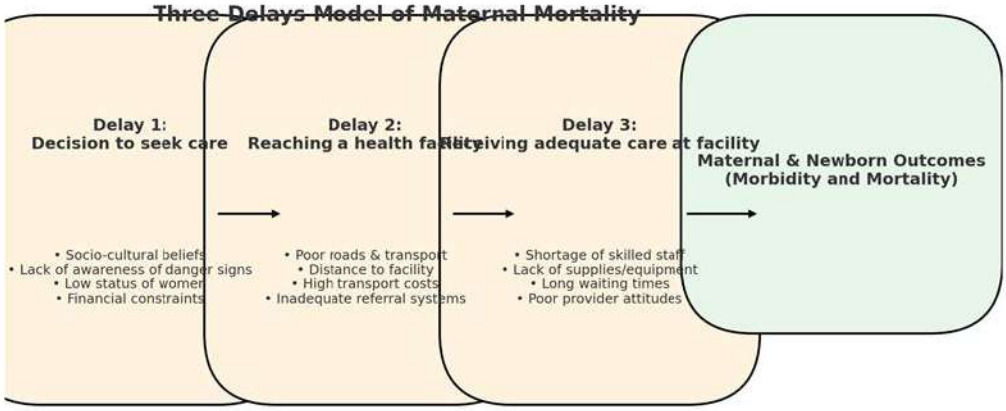
Figure 1: Bowser & Hill Conceptual Framework for Disrespect and Abuse in Facility-based Childbirth



The **Three Delays Model (Thaddeus & Maine, 1994)** provides another perspective, emphasising barriers to maternal care in three critical stages: (1) deciding to seek care, (2) reaching a facility, and (3) receiving adequate care at the facility. While highly influential in addressing structural delays, the model does not sufficiently capture interpersonal dynamics such as dignity, autonomy, and respect, which strongly influence women's decisions to seek and utilise facility-based care.

Figure 2: Three Delays Model of Maternal Mortality



The World Health Organization (WHO) Quality of Care Framework for Maternal and Newborn Health (2016) advanced the field by combining "provision of care" and "experience of care" into a holistic vision for quality. However, it largely functions as a set of quality standards rather than an evaluative framework. Similarly, initiatives such as the White Ribbon Alliance's RMC Charter (2011) established rights-based principles but provided limited methodological guidance for assessing implementation and outcomes in health facilities.

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Against this backdrop, the **Kirkpatrick Training Evaluation Model (1996)** offers a structured approach for evaluating how training interventions affect provider behaviour and patient outcomes across four levels: reaction, learning, behaviour, and results. While widely used in training contexts, it has rarely been integrated into maternal health frameworks to explicitly link provider capacity-building with women's experiences and health outcomes.

Taken together, these models illustrate critical but partial perspectives. Bowser & Hill focus on mistreatment categories, the Three Delays highlight structural barriers, WHO's framework sets quality standards, and Kirkpatrick emphasises training outcomes. However, no single framework comprehensively integrates these dimensions to address both provider performance and women's lived experiences of care in facility settings.

This study responds to these gaps by developing a **modified conceptual framework** that combines the strengths of existing models. Specifically, it integrates Bowser & Hill's typology of disrespect and abuse, the systemic barriers outlined in the Three Delays model, and Kirkpatrick's structured training evaluation approach. This hybrid framework situates women's experiences, provider performance, and systemic barriers along a causal pathway that leads to improved maternal and newborn outcomes. In doing so, it provides a more robust and actionable tool for evaluating and implementing RMC in Level 5 health facilities.

METHODS

The study employed a structured approach in developing its methodological underpinnings. First, detailed operational definitions were established for all key constructs, including autonomy, dignity, effective care, facility environment, workforce training, skilled birth attendance, maternal and neonatal mortality, people-centeredness, perception, quality of care, Respectful Maternity Care (RMC), safe treatment, and other relevant terms. These definitions ensured conceptual clarity and consistency in interpretation across the study.

The theoretical framework was grounded in the Kirkpatrick Model (1996), which outlines four sequential levels—Reaction, Learning, Behaviour, and Results—that describe how training influences both provider performance and patient outcomes (Figure 1). This model provided a systematic lens for evaluating the impact of training interventions on respectful maternity care practices.

In developing the conceptual framework, the study integrated elements from Bowser and Hill's categories of disrespect and abuse in maternity care with the Three Delays model. This hybrid framework illustrates the causal pathway from women's experience of care (independent variable) through facilitators of dignity and respect (mediating variables) to the ultimate goal of quality maternal and newborn health outcomes (dependent variable) (Figure 2). This integration allowed the framework to address both the structural and interpersonal dimensions of maternity care.

For data analysis, Principal Component Analysis (PCA) was proposed as the primary analytical strategy. PCA would serve to reduce data dimensionality, summarise complex variables into key components, and assign statistical weights to both independent and mediating variables for empirical testing. This approach enhances the robustness and interpretability of findings, ensuring that the framework can be practically applied and empirically validated.

Study Design and Scope

This is a theoretical/conceptual study that develops an integrative framework for Respectful Maternity Care (RMC) tailored to Level 5 health facilities. No primary data were collected; instead, we specify constructs, hypothesised pathways, and an analytic strategy to enable future empirical validation.

Model-Integration Procedure (Step-by-Step)

Step 1 — Define the Problem Apace and Core Constructs.

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The study first delineated the RMC problem space into three domains: (a) **experience of care** (e.g., dignity, autonomy, communication, privacy), (b) **provision/enabling environment** (e.g., supplies, staffing, referral readiness), and (c) **maternal–newborn outcomes** (e.g., satisfaction, service uptake, morbidity/mortality).

Step 2 — Select Complementary Theoretical Lenses.

Three established models were purposively selected for their non-overlapping strengths:

- **Bowser & Hill**: typologies of **disrespect and abuse** to operationalise the **experience-of-care** domain.
- **Three Delays**: a system lens to position barriers at the **decision to seek**, **reaching**, and **receiving adequate care**.
- **Kirkpatrick**: a training-evaluation mechanism linking **provider learning and behaviour change** to **patient and system results**.

Step 3 — Map Bowser & Hill to Measurable Experience-of-Care Indicators.

Each category (e.g., non-consented care, discrimination, detention, verbal/physical abuse, abandonment) was translated into measurable indicators suitable for patient surveys, observations, and record reviews. These constitute the **independent variables** (experience of care).

Step 4 — Situate Experience-of-Care within the Three Delays Pathway.

The study positioned disrespect/abuse as proximal drivers of **Delay 1 (decision to seek)** and **Delay 3 (receiving adequate care)**, and linked facility environment/readiness to mitigation of **Delay 3**. This created the **structural pathway** connecting interpersonal treatment to system performance.

Step 5 — Embed the Kirkpatrick Model as the Change Mechanism.

The study specified how **training inputs** propagate through **Kirkpatrick Levels 1–4** to shift provider behaviour and, in turn, women's experiences and outcomes. The mapping is summarised in **Table 1** (Reaction → Learning → Behaviour → Results) and used to define **mediators** (e.g., provider knowledge/skills, observed respectful practices) and **results** (e.g., quality, satisfaction, uptake, morbidity/mortality).

Step 6 — Synthesise the Causal Pathway.

The integrated framework thus links: Training (Kirkpatrick L1–L3) → **Provider behaviour** (reduction in disrespect/abuse; improved communication/support) → **Experience of care** (autonomy, dignity, privacy) → **Delays** (↓ Delay 1 and 3 via trust and facility readiness) → **Results** (quality, satisfaction, service uptake, maternal–newborn outcomes at L4).

Constructs and Measurement

- **Independent variables (Experience of care):** autonomy/consented care, privacy/confidentiality, dignified treatment, non-discrimination, absence of verbal/physical abuse and no abandonment or detention.
    - *Data sources:* exit interviews, validated patient-reported measures, structured observations.
- **Mediators:** provider reaction to training (L1), knowledge/skills/attitudes (L2), observed respectful behaviours and adherence to RMC protocols (L3); facility readiness (commodities, staffing, referral/transport, cleanliness, respectful workplace climate).
    - *Data sources:* pre/post knowledge tests, skills checklists, observations, facility assessments.
- **Outcomes (Results/L4):** patient satisfaction and trust, uptake of skilled birth attendance, timely care processes, and maternal/newborn morbidity and mortality.
    - *Data sources:* patient surveys, HMIS registers, routine quality indicators.

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Analytic Strategy (for future empirical application)

- **Index construction & dimensionality reduction:** Apply **Principal Component Analysis (PCA)** to (i) summarise experience-of-care indicators and (ii) derive weights for mediators (training/behaviour) and enabling-environment indices.
- **Pathway testing:** Use **structural equation modeling (SEM)** or **mediation analysis** to estimate direct and indirect effects from training → behaviour → experience of care → delays → outcomes, with facility readiness as a moderator of Delay 3.
- **Model fit & sensitivity:** Evaluate fit indices (e.g., CFI/TLI/RMSEA); run sensitivity analyses varying PCA weights and excluding collinear indicators.
- **Equity lenses:** Stratify by age, parity, socioeconomic status, and other axes of potential discrimination to assess **equity of respectful care**.

Assumptions and Boundaries

The framework assumes (i) training quality is measurable and influences behaviour, (ii) behaviour materially shapes women's experiences, and (iii) experiences influence delays and outcomes alongside structural readiness. External shocks (e.g., stock-outs, strikes) may attenuate training effects and should be accounted for in the analysis.

RESULTS

Theoretical Framework

The study was based on Kirkpatrick's model (Kirkpatrick, 1996). It is probably the best-known model for analysing and evaluating the results of training and educational programs. It takes into account any style of training, both informal and formal, to determine aptitude based on four-level criteria. Level 1 Evaluation- Reaction, Level 2 Evaluation- Learning, Level 3 Evaluation-Behaviour, Level 4 Evaluation-Results (Figure 3).

Level 1- Reaction

The objective for this level is to evaluate how individuals react to the training model by asking questions that establish the trainees' thoughts. Questions figure out if the participant enjoyed their experience and if they found the material in the program useful for their work. This particular form of evaluation is typically referred to as a "smile sheet." Examples of resources and techniques for level one: Online assessment that can be graded by delegates/evaluators; Face-to-face interviews can be done immediately after the training ends to find out if the participants were happy with the instructors.

Level 2- Learning

Evaluating at this level is meant to gauge the level participants have developed in expertise, knowledge, or mindset. Exploration at this level is far more challenging and time-consuming compared to level one. Techniques vary from informal to formal tests and self-assessment to team assessment. If at all possible, individuals take the test or evaluation before the training (*pre-test*) and following the training (*post-test*) to figure out how much the participant comprehended.

Level 3- Behaviour

This level analyses the differences in the participants' behaviour at work after completing the program. Assessing the change makes it possible to figure out if the knowledge, mindset, or skills the program taught are being used in the workplace. For the majority of individuals, this level offers the truest evaluation of a program's usefulness. This level starts 3–6 months after training. Examples of assessment resources and techniques for level three: This can be carried out through observations and interviews. 360-degree feedback is a tool that many organisations use, but it is not necessary before starting the training program. It is much better utilised after training since participants will be able to figure out on their own what they need to do differently. After changes have been observed over time, the

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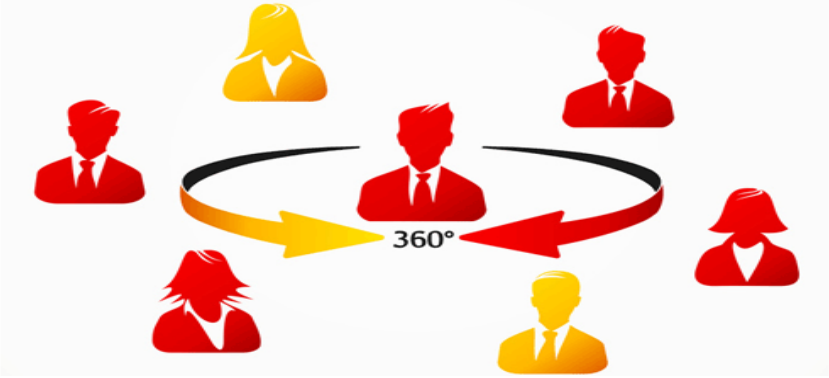
individual's performance can be reviewed by others for proper assessment.

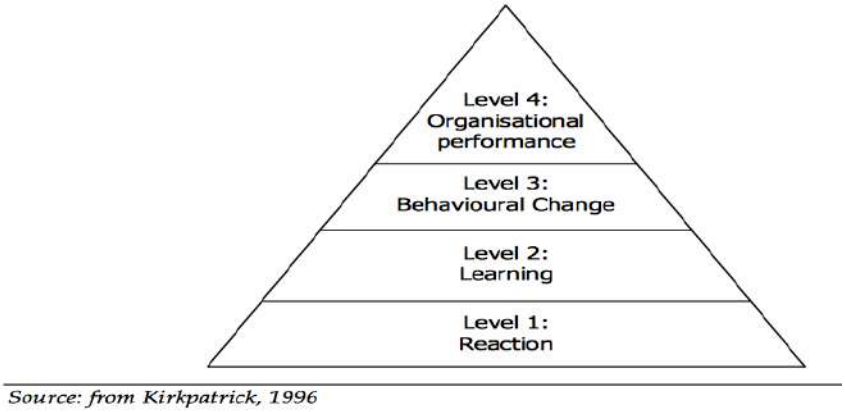
Figure 3: Note: 360 Refers to the Change in Behaviour by All People Based on the Intervention



Level 4- Results

Commonly regarded as the primary goal of the program, level four determines the overall success of the training model by measuring factors such as reduced maternal and newborn mortality and morbidity, quality of life, patient self-esteem, improved service coverage, recipient satisfaction with care, increased uptake of care, lowered costs, lowered spending, provider adoption of evidence-based interventions and compliance with desired practice.

Figure 4: Kirkpatrick's Training Evaluation Model (Adopted from Kirkpatrick, 1996.



Source: from Kirkpatrick, 1996

Conceptual Framework of the Study

The conceptual framework on treatment of mothers during childbirth in promoting respectful maternity care was derived and modified based on a comprehensive landscape analysis on disrespect and abuse framework conducted by Bowser and Hill in 2010, as well as the three delays model by Thaddeus and Maine (1994). Seven categories of disrespect and abuse in childbirth have been identified, and exist in medical facilities around the world. Manifestations of disrespect and abuse often fall into more than one category, so the categories are not intended to be mutually exclusive. Rather, they should be seen to overlap one another along a continuum (Bowser & Hill, 2010). Treatment of mothers during childbirth has been defined as the care that is respectful and responsive to individual women and their families' preferences, needs, and values. It emphasises the quality of patient experience. This entails dignity and respect; autonomy; privacy and confidentiality; communication; social support; supportive care; predictability and transparency of payments; trust; stigma and discrimination; and health facility environment (Afulani *et al.,* 2017).

The Three Delays model is one of the most widely applied models used in maternal health programming today. It promotes the presence of a

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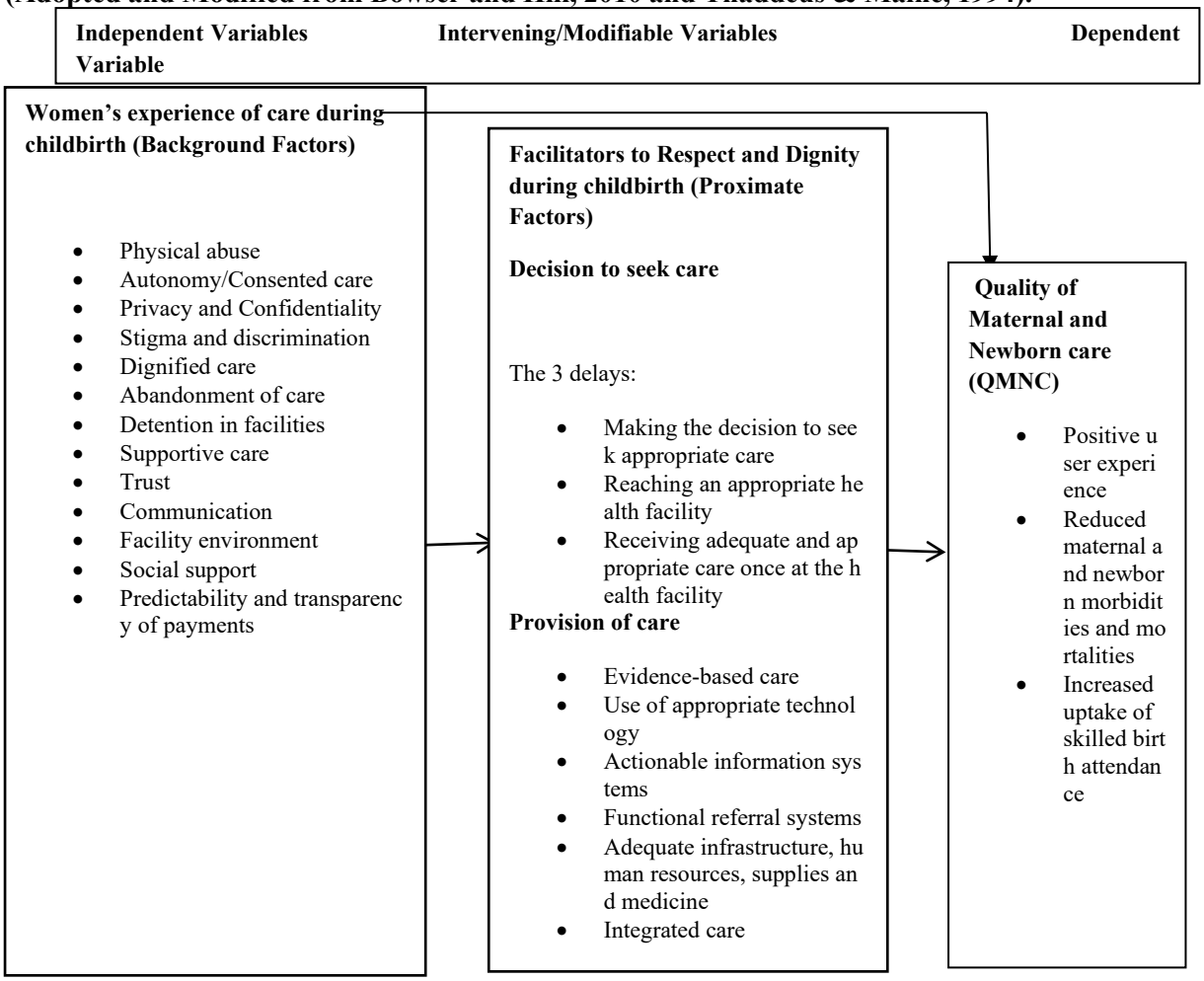
skilled birth attendant who is linked to a functioning health system. Improving accessibility and adequate treatment and care by skilled birth attendants seems to be crucial in preventing maternal mortality (Namusonge *et al*., 2016). The "three delays", that impact maternal mortality encompass delay in decision to seek care; delay in reaching care; and delay in receiving adequate health care once at the health facility (Thaddeus & Maine, 1994). Disrespect and abuse contribute to delays #1 and #3.

The relationship between the treatment of mothers during childbirth (experience of care), which is the independent variable and quality of maternal and newborn care, the dependent variable, was mediated by facilitators to dignity and respect during childbirth (Figure 1). To cover the theoretical framework, the Principal Component Analysis method was used to summarise the information content in large data tables by means of a smaller set of "summary indices" that can be more easily visualised and analysed (Deutsch, 2004). Weights were assigned to each of the independent and intervening variables. The conceptual framework follows the causal pathway of treatment of mothers during childbirth (experience of care), which are independent variables potentially associated with outcomes of respectful maternity care. Intervening/modifiable variables were described by facilitators to respect and dignity during childbirth, which sit in the middle of the diagram because the experience of care relies on them in promoting respectful maternity care.

The theoretical framework (Kirkpatrick's model) helped to guide the path of intervention (Reaction-learning-behaviour-results) with respect to the variables in the conceptual framework

Figure 5: Landscape Analysis of Disrespect and Abuse Framework by Lucy Namusonge, 2022 (Adopted and Modified from Bowser and Hill, 2010 and Thaddeus & Maine, 1994).



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Narrative: Autonomy and dignity bolster women's willingness to seek care (delays #1), whereas facility environment and provider training reduce delays incurred inside the facility (delay #3). Effective care and a people-centred approach amplify quality outcomes, including reduced mortality, higher satisfaction, and improved uptake.

DISCUSSION

The presented framework articulates a logical and evidence-driven pathway from provider training (Kirkpatrick's Levels 1–3) through to improved maternal and neonatal health outcomes (Level 4). Embedding operational definitions ensures clarity and replicability in measurement. By including Principal Component Analysis (PCA), this framework supports robust empirical analysis. The model highlights key leverage points for interventions in Level 5 facilities: enhancing autonomy and dignity, ensuring functional environments and training, and preventing delays. This aligns with global quality-of-care priorities and offers practical guidance for policymakers and facility managers.

Table 1: Mapping Kirkpatrick's Four Levels to RMC Outcomes

Kirkpatrick Level	Focus of Evaluation	Application in RMC	Expected Outcomes
Level 1: Reaction	Measures participants' satisfaction and engagement with training.	Assess providers' perceptions of RMC training relevance, usefulness, and acceptability.	High levels of provider satisfaction with RMC training; motivation to apply respectful practices.
Level 2: Learning	Assesses knowledge, skills, and attitude gained.	Evaluate provider acquisition of RMC principles (dignity, autonomy, people-centredness, communication).	Increased knowledge of RMC standards; improved confidence and competence in applying respectful care.
Level 3: Behaviour	Examines changes in workplace practices post-training.	Determine whether providers adopt RMC behaviours in facility settings.	Observable reductions in disrespect/abuse; increased patient-centred communication and supportive care.
Level 4: Results	Evaluates organisational and patient-level outcomes.	Link provider training and behaviour to maternal and neonatal health outcomes.	Improved quality of care, higher patient satisfaction, reduced maternal and newborn morbidity/mortality, increased uptake of facility-based care.

To strengthen the explanatory power of the framework, Kirkpatrick's four levels of training evaluation were directly mapped to outcomes in Respectful Maternity Care (RMC). This mapping provides a structured pathway for assessing how provider training translates into improved maternal and newborn health outcomes. By aligning each evaluation level with specific RMC dimensions, the model demonstrates how changes at the individual and provider level can scale up to measurable system-level results.

At **Level 1 (Reaction)**, the focus is on providers' satisfaction with RMC training—whether they find it relevant, engaging, and useful. A positive reaction is critical for motivating providers to embrace respectful care principles. **Level 2 (Learning)** captures the extent to which providers acquire knowledge, skills, and attitudes related to RMC, such as understanding dignity, autonomy, and patient-centred communication. Moving beyond knowledge, **Level 3 (Behaviour)** examines whether providers apply these

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principles in clinical practice, thereby reducing disrespect and abuse and improving women's experiences of care. Finally, **Level 4 (Results)** connects these behavioural changes to broader maternal and neonatal outcomes, including improved quality of care, higher patient satisfaction, reduced morbidity and mortality, and greater uptake of facility-based services.

This alignment underscores the utility of the Kirkpatrick model within the proposed conceptual framework. It shows that respectful maternity care cannot be achieved solely by structural improvements or policy reforms; rather, it requires systematic investment in provider training, behaviour change, and evaluation of results. By embedding Kirkpatrick's four levels into the framework, the model offers a practical tool for monitoring and evaluating interventions, ensuring that respectful care principles translate into tangible improvements in maternal and newborn health.

Successful implementation of this framework requires careful consideration of both resource needs and cultural adaptation. On the resource side, facilities must invest in adequate staffing, continuous professional development, essential supplies, and supportive supervision to sustain respectful care practices. Training programs should be allocated sufficient funding for refresher courses, mentorship, and monitoring systems. Equally important are culturally responsive adaptations that align respectful care principles with local norms, beliefs, and expectations of women and their families. For example, allowing birth companions, respecting traditional birthing practices where safe, and using local languages during care provision are crucial to building trust and ensuring that interventions are both acceptable and effective. By addressing resource requirements alongside cultural adaptation, the framework increases its feasibility and relevance in diverse health facility contexts.

Limitations

Implementation may require context-specific adaptation; measurement of constructs like dignity or perception can be challenging.

CONCLUSION

This study has presented a modified conceptual framework for Respectful Maternity Care (RMC) that integrates three influential models—Kirkpatrick's training evaluation, Bowser & Hill's typology of disrespect and abuse, and the Three Delays model—into a unified structure for guiding quality improvement in Level 5 health facilities. By linking provider training and behaviour to women's experiences of dignity, autonomy, and care, and situating these within broader systemic barriers, the framework provides a comprehensive pathway for enhancing maternal and neonatal outcomes.

Unlike existing RMC frameworks that address either interpersonal or structural dimensions in isolation, this model uniquely connects training outcomes, facility environments, and patient experiences into one coherent evaluative tool. It highlights key leverage points for intervention, including provider capacity-building, facility readiness, cultural adaptation, and continuous monitoring.

The framework's implications extend beyond theory to practice. It offers policymakers, health managers, and practitioners a structured basis for designing interventions, allocating resources, developing training protocols, and establishing monitoring and evaluation systems. By aligning with global priorities while addressing contextual realities in resource-intensive settings, it contributes both to the advancement of maternal health research and to the delivery of respectful, equitable, and high-quality care for women and newborns.

RECOMMENDATIONS

Based on the proposed framework and its implications, several recommendations are offered to guide implementation in Level 5 health facilities and similar contexts:

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Implementation Steps

- Conduct a baseline assessment of facility readiness, provider capacity, and women's experiences of care.
- Engage stakeholders—including health managers, frontline providers, community representatives, and policymakers—in co-designing implementation strategies.
- Pilot the framework in selected facilities to refine processes, identify barriers, and adapt interventions before scaling.
- Institutionalise RMC principles within facility policies, standard operating procedures, and accountability mechanisms.

Resource Allocation

- Allocate dedicated budgets for RMC interventions, including staff training, essential supplies, and infrastructure improvements.
- Prioritise investment in supportive supervision, mentorship, and feedback systems to reinforce positive provider behaviours.
- Integrate RMC indicators into routine monitoring systems to ensure sustainability.

Training Protocols

- Develop structured training modules that integrate RMC principles with clinical competencies.
- Incorporate continuous professional development, refresher training, and mentorship to sustain knowledge and behaviour change.
- Use participatory and context-sensitive approaches, such as role-play and case-based learning, to strengthen provider empathy and communication skills.

Monitoring and Evaluation

- Apply Kirkpatrick's four-level model to evaluate training outcomes, linking provider satisfaction, knowledge, and behavioural change to patient-level health outcomes.
- Use quantitative tools (e.g., patient satisfaction surveys, PCA-based indices) alongside qualitative methods (e.g., focus group discussions, observations) for a comprehensive assessment.
- Establish feedback loops where evaluation results are communicated back to providers and managers to inform continuous quality improvement.

By following these recommendations, facilities can move beyond ad hoc interventions toward a systematic, evidence-informed approach that embeds Respectful Maternity Care into routine service delivery.

Future Research

Pilot application of this model in selected county referral hospitals with empirical Principal Component Analysis (PCA) and training evaluations is recommended.

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