Delivering Dignity Under Constraints: Midwives' Perspectives on Respectful Maternity Care and Labour Pain Management: A Qualitative Study in Ghana.

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Abstract

Respectful Maternity Care (RMC) is vital for positive childbirth experiences and effective Labour Pain Management (LPM). This study examined midwives' knowledge, practices, and the barriers to implementing RMC during LPM at the Shai Osudoku District Hospital (SODH) in Ghana. Using an exploratory qualitative design, data were collected between July and November 2023 through purposive interviews with 20 midwives. Thematic analysis revealed two main themes and six subthemes. Midwives demonstrated sound knowledge of RMC principles, acknowledging its role in alleviating pain and improving birth outcomes. Core practices included effective communication, dignity, respect, privacy, and informed consent. However, implementation was constrained by the absence of protocols, limited resources, staff shortages, heavy workloads, language barriers, low motivation, and negative client attitudes. While midwives value and strive to practice RMC, their efforts are hindered by institutional, provider, and client-related challenges. Strengthening RMC requires continuous training, clear protocols, adequate resources, incentives, and strategies to foster client cooperation, thereby promoting respectful care and positive maternal experiences.

Keywords: Midwives, Respectful Maternity Care, Labour Pain Management, Ghana, Qualitative Research.

Introduction

The birth of a child brings joy to most women worldwide (Levey, 2023). Many women aspire to experience motherhood (Ganle et al., 2020). Childbirth is a remarkable event in a woman's life (Olza et al, 2018). However, it is inevitably accompanied by pain (Booth et al., 2019). The American College of Obstetricians and Gynaecologists (ACOG, 2019) describe labour pain as excruciating. It is often the most severe pain a woman may face in her reproductive life. Though temporary, this pain remains a major concern for many women. It is frequently associated with fear and anxiety (Amoateng, 2020; Booth et al., 2018; Czech et al., 2018).

Labour pain arises from complex physiological and psychological changes in the woman's body (Olza et al., 2018; Labor & Maguire, 2008). It has two main components: visceral and somatic. Visceral pain occurs during the first stage of labour. It is caused by uterine contractions and pressure of the foetal presenting part on the cervix, leading to cervical dilatation. Somatic pain emerges at the end of the first stage and during the second stage. It results from the pressure of the baby's head on the cervix, vagina, and perineum. Additional discomfort may also come from pressure on the bladder and bowels.

In the early stages, most women can tolerate labour pain and continue routine activities. As labour progresses, they rely more on support from others to cope. In the final stages, the intensity of pain often renders expectant mothers uncooperative (Olza et al., 2018). Sometimes, the severity of the pain leads them to abandon the process and choose operative interventions (Amoateng, 2020; Booth et al., 2018; Czech et al., 2018; Olza et al., 2018).

Perception of labour pain varies widely among women (Fuzy et al., 2020; WHO, 2018). While some experience it as moderate, others find it severe and overwhelming (Fuzy et al., 2020; Konlan et al., 2021). Factors shaping these perceptions include prior experiences, cultural background, emotional state, immune system, and coping mechanisms (Lennon, 2018; Rondung et al., 2019). Given this individuality in perception and expression, most women desire some form of Labour Pain Management (LPM) (Amoateng, 2020; Aziato et al., 2017; WHO, 2018), making individualized care essential.

Labour pain can be managed through pharmacological, non-pharmacological, or combined approaches (Beyable et al., 2022a; Lennon, 2018). Maternal request alone is a valid indication for pain relief (ACOG, 2019b; WHO, 2018). The chosen method should be reliable, accessible, and cost-effective (Beyable et al., 2022b). Effective LPM promotes positive childbirth experiences, enhances caregiver motivation, and reassures families, leading to reduced maternal and neonatal morbidity and mortality (Bradfield et al., 2018; Fuzy et al., 2020; Vargas et al., 2021; WHO, 2018).

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In contrast, poor Labour Pain Management (LPM) negatively affects both the labour process and the well-being of mother and baby. Consequences include foetal distress, increased fear and anxiety, prolonged labour, and psychological trauma. This trauma may result in post-traumatic stress disorder and pain catastrophe in future deliveries (Alatinga et al., 2021; Aziato et al., 2017; Fuzy et al., 2020; Labor & Maguire, 2008; Sim et al., 2021; Wigert et al., 2020). The focus of care must go beyond the method of pain relief. It should also consider how pain relief is delivered, ensuring that it is provided respectfully (Lennon, 2018; Vargas et al., 2021; WHO, 2020a, 2020b).

RMC is essential for positive childbirth experiences (Dzomeku et al., 2021; WRA, 2011, 2019). It is defined as care that preserves dignity, privacy, confidentiality, freedom from harm, informed choice, and support during labour (WHO, 2018; WRA, 2011, 2019). For over two decades, RMC has been a global priority, with midwives playing a key role (Homer et al., 2021). RMC domains include respect, dignity, autonomy, communication, and protection from mistreatment (WHO, 2018). Evidence shows RMC empowers mothers, relieves labour pain, and fosters positive childbirth memories, while also contributing to shorter labour, reduced medicalization, and improved outcomes (Adeyemo, 2022; Bohren et al., 2020; Bonapace et al., 2018; Downe et al., 2018; Dzomeku et al., 2021; Jolivet et al., 2021; Shakibazadeh et al., 2018; Unväs Moberg et al., 2019; WHO, 2018).

Nonetheless, evidence shows that not all women receive RMC, including during LPM (Bohren et al., 2020; Dzomeku et al., 2020a; WHO, 2018). Many experience Disrespectful and Abusive Care (D&AC), which includes neglect, non-consented procedures, physical and verbal abuse, non-dignified treatment, lack of privacy, and non-evidence-based practices during facility-based deliveries (WRA, 2019; Bohren et al., 2021). Such experiences leave negative imprints of childbirth. They create harmful consequences for mothers, babies, and families (Walter et al., 2021; WHO, 2021).

Despite the documented importance of LPM and RMC, evidence shows limited responsiveness to expectant mothers' labour pain needs. Many are denied their rights to informed decision-making, choice, and privacy. Their pain needs are left unmet. This exposes them to Disrespectful and Abusive Care (D&AC) (Dzomeku et al., 2019; Amoateng, 2020; Moyer et al., 2021).

Practical Significance: Respectful Maternity Care

Expectant mothers generally desire a labour experience that is less painful and of shorter duration (Favillia, 2018; Fuzy et al., 2020; Amoateng, 2020). While they trust the expertise of midwives in LPM, they also seek control over the birth process and expect a partnership with caregivers (Fuzy et al., 2020; Lennon, 2018; Amoateng, 2020). Thus, LPM is central to a positive childbirth experience and is embedded within RMC, which, when practiced, addresses individual needs and preferences (Aziato et al., 2017; Favillia, 2018; WHO, 2018; WRA, 2019).

RMC has been embraced and implemented in Ghana (MOH & NMC, 2021; WHO, 2020, 2021) and forms a core part of the professional practice of registered midwives both globally and nationally (NMC, 2022a; Homer et al., 2021). Midwives, as the primary caregivers for expectant mothers, are knowledgeable about the concept of RMC (Dzomeku et al., 2019; Moyer et al., 2020) and familiar with various approaches to LPM (Afulani et al., 2019; Aziato et al., 2017). Yet, LPM remains a persistent challenge in Ghana, with evidence pointing to limited integration of RMC in its practice (Amoateng, 2020; Konlan et al., 2021). This study explores the barriers hindering the practice of RMC in LPM in Ghana.

This qualitative study contributes to the literature by examining midwives' knowledge and practice of RMC during LPM, as well as the factors influencing its implementation in a resource-endowed health facility in Ghana. The findings highlight critical gaps that can inform policy development to enhance maternal care, better address the needs of expectant mothers, and advance progress toward the Sustainable Development Goals.

Methods

An exploratory descriptive qualitative design was employed to examine midwives' perspectives on the practice of RMC in LPM between July and November 2023 (Hunter et al., 2019). The study was conducted at Shai Osudoku District Hospital (SODH), a facility recognised for its resources to support RMC during LPM. In 2018, SODH gained international recognition for achieving zero maternal mortality over a five-year period and was identified by WHO as a potential benchmark for emulation (Adu et al., 2021; Watson, 2020). The study population comprised midwives working in the maternity unit, selected for their direct and relevant experience in managing labour, which integrates both RMC and LPM.

The study included midwives at SODH who provided labour and delivery services and gave informed consent to participate. Excluded were those unavailable during the study period due to study leave, maternity leave, or sick leave, as well as those unwilling to participate.

Purposive sampling was used to select midwives with characteristics relevant for exploring the phenomenon in depth. Data collection, comparison, and analysis were conducted concurrently until saturation was reached with 20 participants, at which point no new information, codes, or themes emerged (Braun & Clarke, 2021; Hunter et al., 2019).

A semi-structured interview guide was developed based on the study objectives, and ethical clearance was obtained prior to data collection. Participants were contacted through the ward in-charge, who explained the rationale of the study to midwives in the maternity unit. The backgrounds of potential participants were reviewed to ensure they met the inclusion criteria. Study objectives and information sheets were explained in simple, clear language, and face-to-face interviews were scheduled at convenient times and locations. Written informed consent was obtained before each interview, with participants indicating their willingness to be audio-recorded. They were assured of their right to withdraw from the study at any time without consequences. Interviews were audio-recorded, and extensive field notes were taken where participants declined recording or to capture non-verbal cues. All but two participants consented to audio-recording.

Ethical clearance and approval were obtained from the ethical committee of the Dodowa Health Research Centre Institutional Review Board (DHRCIRB/132/06/23). Permission was sought from the Greater Accra Regional Health Directorate to visit the study site. With permission from the authorities of SODH, where participants worked, and finally the ward in-charge of the maternity unit. Participants were assured of confidentiality and anonymity by removing possible identifiers such as names and ranks and assigning identification codes.

A total of twenty midwives with diverse years of professional experience participated in the study. Their ages ranged from 27 to 46 years. While most held diplomas in midwifery, four had obtained degrees. Five participants were single, none of whom had children, whereas the married participants each had between one and four children. Overall, participants had between two and eleven years of work experience. The socio-demographic characteristics are summarised in Table 1.

Table 1. Background characteristics of participants

Participants	Age	Education	Marital status	Number of children	Religion	Years of working experience
P1	43	Degree	Single	0	Christian	2
P2	34	Diploma	Married	2	Christian	10
P3	28	Degree	Single	0	Christian	2
P4	35	Diploma	Married	1	Christian	2
P5	46	Diploma	Married	4	Christian	8
P6	33	Diploma	Single	0	Christian	10
P7	35	Diploma	Married	2	Christian	5
P8	36	Diploma	Married	3	Islam	5
P9	34	Diploma	Married	2	Christian	7
P10	38	Diploma	Married	2	Christian	8
P11	36	Diploma	Married	2	Christian	11
P12	33	Diploma	Married	2	Christian	3
P13	32	Diploma	Single	0	Christian	7
P14	27	Diploma	Married	2	Christian	3
P15	36	Degree	Single	0	Christian	11
P16	33	Diploma	Married	2	Christian	5
P17	32	Diploma	Married	1	Christian	6
P18	38	Diploma	Married	3	Christian	3
P19	33	Degree	Married	3	Christian	8
P20	38	Diploma	Married	3	Christian	7

Table 1 presents the socio-demographic characteristics of the midwives who participated in the study. The distribution shows a relatively young workforce with varied years of experience, suggesting opportunities for knowledge transfer across generations. The majority were diploma holders, though a few had degrees, reflecting improvements in the educational profile of Ghanaian midwives. Most participants were married with children, and nearly all identified as Christians, consistent with national demographics. These characteristics provide context for understanding participants' perspectives on respectful maternity care and labour pain management.

Thematic analysis was employed as the analytic approach (Hunter et al., 2019), guided by Braun and Clarke's six-step model (Braun & Clarke, 2012). Data collection and analysis proceeded concurrently. Recorded interviews were transcribed verbatim, and audio files were replayed multiple times to verify accuracy and clarify ambiguities. Transcripts were read repeatedly for familiarity, after which codes were generated and organised into smaller, meaningful units. Related codes were grouped into subthemes, and subthemes were further merged into overarching themes. The authors reviewed and refined the themes by consensus. NVivo software (version 11) was used to support data management.

Results

The analysis yielded two main themes and corresponding subthemes. The first theme, *Midwives' level of awareness of Respectful Maternity Care (RMC) in Labour Pain Management (LPM)*, comprised three subthemes: Protocols and Procedures in Labour Management, Pain Management and Client Participation, and midwives' understanding of RMC. The second theme, *Barriers to the practice of RMC in LPM*, included health facility/system-related factors, client-related factors, and midwife-related factors. The results and discussions are presented in turn.

Midwives' Level of Awareness Respectful Maternity Care

This theme examined midwives' understanding of Respectful Maternity Care (RMC) in relation to Labour Pain Management (LPM). It highlighted the LPM options used at SODH, the processes involved in caring for expectant mothers, and the ways in which RMC is applied. Participants reported the absence of a formally documented LPM protocol. Nonetheless, they demonstrated sound knowledge of both RMC and LPM and were able to incorporate its key components into client care.

Protocols and Procedures in Labour Management

The data revealed variability in the existence and application of formal protocols within the labour ward. While some midwives described systematic procedures, such as taking history, checking vitals, and monitoring labour progress, others expressed a lack of standardized protocols or guidelines.

> *"We admit them and start our assessments… check vitals, do physical and vaginal examinations, measure symphysio-fundal height, check foetal heart rate, and plot on the partograph… if there is a deviation, we call the doctors; if labour is normal, we continue monitoring until delivery." (P9)*
>
> *"You welcome them, take their history, admit them, and check their vitals… you provide privacy and ensure confidentiality… we check their foetal heart… and ensure infection prevention procedures." (P1)*
>
> *"I cannot pinpoint one, two, or three protocols involved because I am not totally in the labour ward." (P4)*
>
> *"Protocol? No, we don't have it." (P5)*
>
> *"Over here, I have not seen any protocol like labouring." (P14)*

The above evidence showed that while some staff followed structured routines, there was inconsistencies, with several expressing uncertainty or absence of documented protocols. This indicates a need for clear, standardized guidelines to support quality and consistency in care.

Pain Management and Client Participation

Pain management is individualized, with emphasis on both pharmacological (see Fig. 1) and non-pharmacological strategies. Midwives highlighted the need to understand each client's coping mechanisms and involve women actively in their care. Clients are encouraged to communicate pain levels, ask questions, and participate in decisions about positioning and comfort measures.

> *"We should understand each client. Each client and their coping mechanism. Some will go through the pain without taking any medication; others too cannot stand the pain. The midwife has to understand them and give them the care differently." (P7)*
>
> *"We explain to them that it is normal physiology that they are going through. Sometimes, you provide diversional therapy, and we speak to them… give a sacral massage, sometimes, we hydrate them with fluids… sometimes we call the doctors in. Sometimes, they prescribe Pethidine and promethazine." (P9)*
>
> *"Because it is uncomfortable, you let them assume any position during contraction, and after contraction, they go back to their left lateral position." (P10)*
>
> *"The client also has a role to play in that she is the one bearing the pain. So, she needs to tell us… If we are to grade the pain from 1 to 10, she has to tell me, Oh, my pain is within 7 or 8. If that is it, then what do we do? It is based on what she tells me." (P6)*
>
> *"With the client when it comes to adopting a position, the clients play a major role. We tell them to adopt a comfortable position for themselves… So basically, they do that when it comes to adapting to a position where they play their major role." (P16)*

The approach to pain management was client-centered, focusing on the woman's preferences and input. There was also recognition that pain experience and tolerance vary, and that respectful care requires responsiveness to these differences.

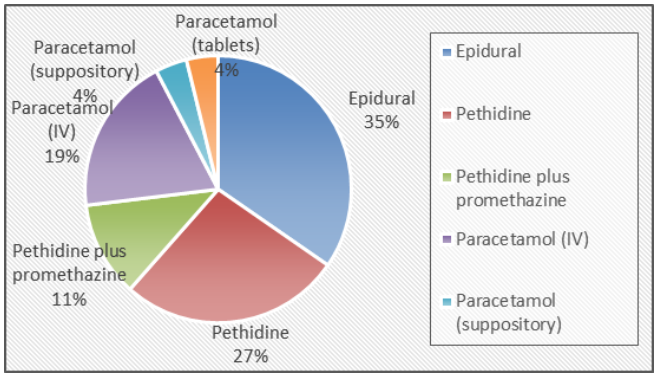

Fig. 1. Pharmacological labour pain management options at SODH

Figure 1 illustrates the pharmacological options for labour pain management reported at SODH. This distribution highlights both the limited range of pharmacological methods available and the reliance on a few key drugs, reflecting broader systemic and financial constraints on pain management in the facility.

Midwives' Understanding of Respectful Maternity Care

The midwives understood respectful maternity care as an approach characterized by upholding dignity, privacy, confidentiality, and treating each woman as a unique individual. This also involves comprehensive communication, explanation of procedures, and consideration of clients' choices.

> *"I think it's a dignified way of treating pregnant women throughout their pregnancy and labour, including after delivery; that's the postnatal." (P2)*
>
> *"Respectful maternity care is about seeing the client as a unique individual, treating them as they are supposed to be treated, maintaining confidentiality and privacy, and explaining procedures to them when they require such information." (P9)*
>
> *"When we say Respectful Maternity Care, it's to provide comprehensive care to the expectant mother and the relative, bearing in mind their dignity and the choice of service they want." (P18)*
>
> *"You provide privacy and ensure confidentiality… privacy is very important when taking care of them, and we have screens here that we use…" (P1)*

The data shows a strong commitment to respectful maternity care, with emphasis on privacy, dignity, and effective communication. These practices are viewed as essential for positive maternal experiences and outcomes.

The analysis highlights three central themes in labour ward care: variability in protocols, individualized pain management with active client involvement, and a strong emphasis on respectful and dignified maternity care. While strengths are evident in staff commitment to client-centered and respectful practices, the lack of standardized protocols may impact on the consistency of care. Addressing this gap could further enhance the quality and reliability of maternity services.

Barriers to Respectful Maternity Care practice in Labour Pain Management

This theme examined the challenges midwives faced in practicing RMC during LPM. They highlighted constraints such as inadequate staff strength, adverse health effects, client-related cultural factors, and work-related stress, all of which hindered the delivery of respectful care.

Resource Constraints and Systemic Challenges

A recurring theme was the acute shortage of essential resources, medications, equipment, and even staff, which severely hampers pain management and the provision of respectful maternity care. Financial barriers for clients and "cash and carry" systems also prevent timely access to pain relief. The lack of protocol, coupled with resource shortages, forces midwives to rely on discretion and improvisation.

> *"We do not have a protocol in managing pain in labour, so as a midwife, you use your discretion to do so. So as and when to provide the care becomes the challenge." (P7)*
>
> *"At times, you enter the medication into the system that the doctor has ordered, but there is no money to purchase the drugs. That person can lie here for two days without the drug I need to manage the pain." (P14)*
>
> *"With the pharmacological, we do not have it; it is just the monitoring aspect. You have to monitor the client very well… Here we can't do that because of the staff strength. So, with non-pharmacological methods, we can do our best." (P10)*
>
> *"We are not getting the things to work with… Sometimes, even with ordinary infusions, we are not even getting gloves to work with; you can't get them… you have to be going around looking for it. It gets too frustrating." (P9)*
>
> *"Our leaders should provide what we need, such as beds and screens… If an emergency comes, this midwife is using the screen; what of the other if I want to attend to the other one? I would do it without a screen to save lives because we don't have it." (P4)*

Resource limitations directly affect care quality, restrict pain management options, and compromise patient privacy and comfort. These systemic barriers increase the burden on midwives and reduce patient satisfaction.

Barriers to Respectful Maternity Care

Challenges to respectful maternity care arise from insufficient training, inadequate infrastructure for privacy, lack of staff, and communication barriers (including language). Midwives also experience occupational stress, which impacts their ability to provide dignified care consistently. Client and family cooperation can be difficult, especially when privacy is compromised or when beliefs about pain inhibit certain interventions.

> *"Yes, if I am not trained or have not been trained in respectful maternity care, I will definitely provide just any care to the patient. Now, I don't even know that that is not even respectful." (P18)*
>
> *"With privacy in our hospital settings, the screens are not enough to provide adequate privacy. So, it makes the clients feel shy of themselves, which inhibits us from getting the quality services to render for them." (P19)*
>
> *"Sometimes, there are also language barriers. When the clients come in, they are unable to understand you, so you cannot explain the procedure to the person very well." (P3)*
>
> *"Sometimes, relatives do not cooperate. You tell them to excuse you, and they do not see why they should excuse you. Sometimes, the client also wants her relatives to be around, which does not help privacy." (P13)*
>
> *"We, the midwives have waist pains. Sometimes, we fall sick and even the facility to take care of you, you need to pay. If I help you and at the end of the day, I find myself wanting, or maybe I will suffer the consequences, I will not do it. I will not kill myself. You have rights; I also have rights." (P4)*

Respectful maternity care is undermined by lack of training, privacy, and communication. Midwives' well-being and working conditions directly influence their ability to deliver dignified, patient-centered care.

Client-Centered Care and Sociocultural Factors

Client participation is crucial, but various sociocultural beliefs, client behaviors, and communication difficulties affect care delivery. Some clients avoid pharmacological pain relief due to cultural beliefs or fear of complications. Others are reluctant to share sensitive information or to cooperate, especially when privacy is lacking or language barriers exist.

> *"Because they have experience, whatever you tell them, they choose to do it. The main difficulty is the clients with experience." (P3)*
>
> *"We have labour anaesthesia; we give them, that is, if they opt for it. Most of them do not want to go through that; it is just a few who opt for it. Most of them feel that pain is pain. It is like they have been brainwashed in their houses that they had to go through pain to get the baby." (P10)*
>
> *"Some still feel that their information may not be all secured confidentially. So, it takes time for them to tell you everything that is going on." (P1)*
>
> *"But if you get a client that does not let you work… she does not allow you; some clients come like that. So, if she does not allow you to attend to her properly, it will make things difficult for you to practice the routines and practices of respectful maternity care for her." (P16)*
>
> *"We have instances of language barrier, such as when you cannot express yourself or you can't explain how things are going to the client. The client also finds it difficult to talk to you because of the language barrier." (P12)*

Clients' beliefs, experiences, and communication abilities play a significant role in their care. Cultural expectations around pain and privacy, as well as language barriers, challenge midwives' efforts to deliver personalized, respectful, and effective maternity care.

This analysis reveals that resource constraints, systemic and communication barriers, and sociocultural factors all intersect to challenge the consistent delivery of respectful, client-centered maternity care. Addressing these issues requires investment in training, resources, and infrastructural improvements, as well as culturally sensitive communication strategies and organizational support for midwives

Discussion

The midwifery profession in Ghana has long faced challenges with an ageing workforce, threatening the quality of care, including respectful maternity care (RMC) (Asamani et al., 2019; MOH, 2016). Findings from this study, however, suggest a narrowing age gap, with most midwives relatively young and fairly distributed across age groups. With experience ranging from 2 to 11 years, and the majority between 6 and 10 years, there is potential for knowledge transfer across generations to sustain quality care.

The study also showed that the minimum qualification of participants was a diploma in midwifery, with some holding degrees. This reflects improvements in the educational profile of Ghanaian midwives and suggests a basic understanding of RMC (WHO, 2020, 2021). It also signals optimism for the advancement of the profession and better collaboration with obstetricians (Kemp et al., 2021). Notably, most participants (15) had experienced childbirth, which placed them in a unique position to relate to the issues under study.

Almost all participants (19) identified as Christians, reflecting national religious demographics (Ghana Statistical Service, 2017). However, demographic characteristics such as age, marital status, and religion did not appear to influence perspectives, since all participants were trained under the same curriculum.

Knowledge of Midwives about RMC during LMC

Evidence suggests midwives in Ghana are knowledgeable about RMC, though such knowledge must be verified. This study found that all participants could describe RMC, often referring to it as dignified, comprehensive, individualised, or quality care. These findings align with Alatinga et al. (2021) and Dzomeku et al. (2020), who also reported that Ghanaian midwives were well informed about the RMC model. Knowledge of the model is critical as it underpins effective maternity care nationwide.

Consistent with Dzomeku et al. (2020, 2022), participants demonstrated awareness of RMC components such as privacy, confidentiality, dignity, respect, effective communication, continuous support, and companionship. They also described ways these could be applied in labour management. This knowledge may be linked to the Nursing and Midwifery Council's integration of RMC into curricula, manuals, and job descriptions (NMC, 2021, 2022).

Participants showed good knowledge of the general routines of caring for labouring women, including rapport building, privacy, confidentiality, history taking, physical examination, labour monitoring, delivery, and postnatal care. While some midwives described ward-specific routines, most outlined procedures for the entire maternity unit, reflecting both training and practice.

Opinions varied on pain management. Most midwives mentioned both pharmacological and non-pharmacological approaches, while a few cited only the latter. This reflects the absence of a structured labour pain management protocol and reliance on unit practices. Non-pharmacological methods dominated, consistent with the midwifery philosophy of promoting physiological birth (Kemp et al., 2021; WHO, 2018).

As Amoateng (2021) observed, epidural analgesia, Pethidine, Pethidine with Promethazine, and Paracetamol were the pharmacological options most frequently cited. Their use depended on affordability, cultural beliefs, client health status, availability of prescribers, staff capacity, and caregiver expertise. Non-pharmacological measures included reassurance, postural changes, ambulation, sacral massage, companionship, and communication, as identified by Boateng et al. (2019). Utilisation, however, was often limited by staff shortages, infrastructural deficits, workloads, and client preferences.

Barriers to Labour Pain Management within the Respectful Maternity Care model

Although midwives were knowledgeable about RMC, they lacked a protocol to guide its application in labour pain management. In its absence, they relied on discretion, which created inconsistencies and gaps in care. Smith et al. (2020) similarly noted that the absence of clear guidelines and visual cues limited consistent practice.

Limited client cooperation was another barrier. All participants linked this to the intensity of labour pain, especially in later stages when women were less responsive to instructions, a finding echoed by Olza et al. (2018). Midwives also cited multiparity, past experiences, and client attitudes as contributing factors. Mothers with prior experiences sometimes rejected non-pharmacological interventions, preferring their own approaches. This frustrated midwives and, in some cases, discouraged them from practicing RMC.

Cultural factors also shaped client behaviour. Many women viewed labour pain as something to be endured, often rejecting pharmacological interventions such as epidural analgesia. As Boateng et al. (2019) also found, high costs discouraged women from using pharmacological options, leaving them to cope without medical support. This undermines RMC's commitment to informed choice and positive childbirth experiences.

System-level constraints reinforced these challenges. Shortages of logistics, medications, and staff prevented midwives from delivering individualised care and limited access to pharmacological options, which required authorised personnel. These systemic gaps align with findings by Wassihun et al. (2022), who identified inadequate infrastructure and human resources as key barriers to RMC.

Workload pressures and stress further hampered care. Midwives reported being outnumbered by clients, leaving little time to explain procedures or provide continuous support. Physical strain, including waist pain and fatigue, added to the burden. Similar to Klomp et al. (2017), this study found that such pressures sometimes led midwives to prioritise their own well-being over client needs, reducing the quality of care.

Language barriers compounded these difficulties. Communication broke down when midwives and clients did not share a common language, limiting explanation, consent, and trust. Privacy concerns added to the problem, as inadequate infrastructure discouraged women from disclosing sensitive information, particularly about past abortions or complications. This insecurity further undermined cooperation and care quality.

In sum, while midwives possess strong knowledge of RMC, their ability to apply it in labour pain management is constrained by systemic inadequacies, cultural norms, client behaviour, and occupational pressures. Addressing these challenges requires clear protocols, improved staffing and resources, continuous training, and culturally sensitive approaches that empower midwives and mothers to ensure respectful, effective maternity care.

Limitations

This study had some limitations that must be acknowledged. First, the findings were based on a relatively small sample of midwives drawn from a single health facility, which may limit the generalisability of the results to other contexts. Second, the reliance on self-reported data may have introduced social desirability bias, as participants could have provided responses that reflected expected professional standards rather than their actual practices. Third, the absence of observational data meant that the study could not independently verify whether reported practices of respectful maternity care were consistently applied in real clinical settings. Despite these limitations, the study provides valuable insights into midwives' knowledge and experiences of respectful maternity care during labour pain management in Ghana.

Conclusion

This study examined midwives' knowledge and practice of Respectful Maternity Care (RMC) during Labour Pain Management (LPM) and the barriers encountered in its implementation. Findings showed that midwives demonstrated a strong understanding of RMC, describing it in terms of dignity, privacy, confidentiality, effective communication, and individualised care. They were also knowledgeable about pharmacological and non-pharmacological options, though practice leaned heavily toward the latter because of financial, cultural, and systemic constraints.

Despite this knowledge, consistent practice of RMC during LPM was hindered by several challenges. These included the absence of formal protocols, staff shortages, limited material resources, high costs of pharmacological methods, and inadequate training. Client-related barriers, such as cultural beliefs, prior experiences, lack of cooperation, and language difficulties, further complicated care. Midwives themselves faced occupational strain and health risks that undermined their capacity to provide respectful and compassionate support.

Overall, the study demonstrates that while midwives are well positioned to provide RMC, their effectiveness is constrained by systemic gaps, client behaviours, and workplace challenges. Addressing these barriers is essential to enhance positive childbirth experiences and advance maternal health outcomes, consistent with global commitments such as Sustainable Development Goal 3.

Recommendations

To strengthen the practice of RMC in labour pain management, this study proposes several measures.

First, the Ministry of Health and the Nursing and Midwifery Council should develop clear, context-specific protocols to guide RMC in LPM. Standardised guidelines will reduce reliance on individual discretion and promote consistency across facilities.

Second, continuous professional training should be prioritised to reinforce midwives' competencies in both pharmacological and non-pharmacological methods. Training must also emphasise communication skills, cultural sensitivity, and patient engagement to enhance respectful care.

Third, staffing levels and resource allocation need improvement. More midwives are required to reduce workload pressures, while facilities must ensure reliable supplies of essential drugs, analgesics, and equipment to meet client needs.

Fourth, pharmacological options for pain management should be made affordable and accessible. Incorporating these into the national health insurance scheme or subsidising their cost will reduce financial barriers and allow clients to make choices based on need rather than affordability.

Fifth, culturally sensitive approaches should be promoted. Midwives should engage women and their families in education on labour pain management to address misconceptions, challenge norms of pain endurance, and encourage trust in respectful care.

Sixth, language and privacy barriers must be addressed. Recruiting interpreters or training staff in commonly spoken local languages will improve communication, while infrastructural investments such as screens and private labour rooms will safeguard confidentiality and client security.

Finally, the well-being of midwives must be prioritised. Workload management, rest periods, and access to medical and psychosocial support will help protect midwives' health and sustain their ability to provide compassionate and respectful care.

Ethical approval

Ethical clearance and approval were obtained from the ethical committee of the Dodowa Health Research Centre Institutional Review Board (DHRCIRB/132/06/23).

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Declaration of Competing Interest

The authors declare that there are no competing interests.

Data availability

The authors confirm that the data supporting the findings of this study are available within the article [and/or] its supplementary materials

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