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Research Article

Respectful Maternity Care and Midwives' Caring Behaviours During Childbirth in Two Hospitals In Calabar, Nigeria

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ABSTRACT

All women deserve humane, considerate, sensitive and respectful care in childbirth. Respectful maternity care (RMC) is human right and standard midwifery practice. However there have been general public complaints about lack of respectful behaviour by midwives. To determine clients' experience of respectful maternity care and midwives' caring behaviour, two hospitals in Calabar, Nigeria were selected for this study. This descriptive study collected data from 83 purposively selected postnatal women who had spontaneous vaginal delivery, and 51 midwives caring for them. Ethical clearance was obtained from the HREC of Cross River State Ministry of Health and informed consent from participants. Clients and midwives identified respectful maternity care received/practiced from the RMC checklist. Data were analyzed using SPSS version18.0. RMC was reported by 58 (69.9%) clients while 25 (30.1%) reported lack of it in different categories. Non-respectful care reported included lack of privacy, lack of information about progress of labour, denying preference and choice of childbirth position, lack of sensitivity towards clients' pain and culture, verbal abuse, detention in facility for non-payment of bill. Attending midwives confirmed not adequately screening or draping women (because of lack of screens and drapes); restricting women to deliver in the dorsal position and detaining women if they cannot pay the bill (because of hospital policy). Common acts of disrespectful care experienced by women in this study fit into some of the categories identified in literature. Appropriate maternity care must be respectful and rights-based in order to enhance utilization of maternity services and access to skilled care.

Keywords: *Respectful care, Maternity care, Caring behaviour, Childbirth*

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INTRODUCTION

Every woman has a right to humane, dignified, considerate, and respectful healthcare throughout pregnancy as well as skillful delivery care (WHO, 2014). However hospital records and studies have shown that the proportion of facility-based deliveries has been marginal in many areas of Nigeria, especially in rural communities (Dahiru and Oche, 2015; Yaya, Bishwajit, Uthman, and Amouzou, 2018). UNICEF (2018) puts the figure of babies born in health facilities in Nigeria at 38%, while National Population Commission/Nigeria Demographic and Health Survey, 2013; and WHO, 2013 put it at 36% (23% in public sector facilities and 13% in private sector facilities). These low percentages imply that skilled attendance at labour is low, especially in rural communities (WHO, 2013). Many women who are pregnant or in labour do not utilize health care facilities because of experiences by self or others in some healthcare facilities. Some studies (Idris, Sambo, and Ibrahim, 2013; Emelumadu, Onyeonoro, Ukegbu, Ezwama, Ifeadike, and Okezie 2014) have attributed this low utilization of maternity services in Nigeria to the attitude of the attending midwives, their non-welcoming stance, and non-availability of required materials in nearby healthcare facilities.

There has been a general public complaint about lack of respectful behaviour by attending midwives, with increasing evidence of disrespectful, neglectful and abusive treatment of women during facility-based childbirth in many countries. Bowser and Hill (2010) in their landscape analysis, initiated the exploration of the evidence of disrespect and abuse during facility-based childbirth and described seven categories of disrespectful care. Bohren, Vogel, Hunter, Lutsiv, Makh, Souza, *et al*, 2015) in their systematic review present a comprehensive, evidence-based typology of the mistreatment of women during childbirth in many countries. McMahon, George, Chebet, Mosha, Mpembeni, and Winch, 2014 reported women being ignored or neglected; discriminatory treatment; verbal abuse; and physical abuse in Tanzania; Sheferaw, Bazant, Gibson, Fenta, Ayalew, Tsigereda, *et al*,

(2017) reported 36% mistreatment in Ethiopia in the form of physical abuse, verbal abuse, violated privacy and abandonment. Such disrespect and abuse are reportedly more common in single mothers (Amroussia, Hernandez, Vives-Cases, and Goicolea, 2017). Singh, Chugani and James (2016) reported 98% mistreatment of patients during labour and delivery in India, particularly verbal abuse, being 'left without care', lack of information, and detention or confinement against will. Research in Nigeria (Okafor, Ugwu, and Obi, 2015) report disrespect and abuse during maternity care as high as 98%. Such poor practice of respectful maternity care may discourage many women from facility based births, make them report to the health facility only as a last resort, and therefore poses a burden to quality health care delivery in these countries. Although the proportion of women who experience disrespectful maternity care in Nigeria is not generally documented, such mistreatments along with poor quality of care have been cited as barriers to access to skilled care by pregnant women in the country (Dahiru and Oche, 2015; Yahaya, Bishwajit, Uthman, and Amouzou, 2018).

According to Bartlett (2015) disrespect and abuse during childbirth reflect a lack of value for life, and is a systemic barrier to safe motherhood, as well as a violation of the human rights of the woman. Every woman strives for a positive childbirth experience. Memories of childbirth experiences tend to stay with the woman for a long time, and may influence future childbirth choices. The experiences with maternity caregivers have the power to ensure comfort, or to cause lasting damage and emotional trauma that would hinder future utilization of skilled care for childbirth. Disrespectful and abusive behaviour by health workers is an important, but little understood component of the poor quality of care experienced by women during childbirth in healthcare facilities. These tend to hinder access and deter utilization of maternity care services and skilled care for childbirth in many third world countries (Bowser & Hill, 2010; Rosen, Lynam, Carr, Reis, Bazant, and Bartlett, 2015). If a woman does not feel safe and respected during her visit to a maternity centre she is less likely to attend other antenatal care appointments or come to the health facility when in labour. Some may delay decision to seek care even when feeling ill. This would result to lack of skilled maternity care coupled with care that does not meet basic respect and dignity standards, and tend to increase the risk of pregnancy and childbirth-related morbidity and mortality.

Improving the quality of care around the time of birth has been identified as the most impactful strategy for reducing maternal and perinatal mortality and morbidity (Bhutta, Das, Lawn, Salam, and Paul, 2014). Respectful maternity care is gaining attention globally and is regarded as the standard midwifery practice (no matter the setting). It is believed that it could contribute towards the achievement of the health related Sustainable Development Goals (SDGs) by ensuring an increased proportion of births attended by skilled birth health care givers (Ogunlaja, Fehintola, Ogunlaja, Popoola, Idowu, Awotunde *et al*, 2017) The midwife is ethically bound to give patient-centred, culturally-sensitive and respectful care to every woman seen in the course of her practice, no matter the setting.

The objectives of this study were to describe clients' experience of respectful maternity care; and determine midwives' caring behaviour in two hospitals in Calabar, Nigeria. The seven categories of non-respectful maternity care by Bowser and Hill (2010) landscape analysis, and the White Ribbon Alliance (2011) guided the study. These are physical abuse, non-consented care, non-confidential care, non-dignified care and verbal abuse, discrimination, abandonment during care, and detention in facilities.

MATERIALS AND METHODS

Study design and location: Descriptive, cross sectional design was used to collect data from 83 purposively selected clients (postnatal women who had spontaneous vaginal delivery) from two health facilities (one tertiary and one secondary) in Calabar, Nigeria; and 51 midwives caring for them.

Data collection: The instruments used for data collection were two researcher-developed checklists – a Structured Clinical Observation Checklist with 18 items for direct observation of midwives' caring behaviour during pregnancy and childbirth, and a Reporting Checklist for clients and midwives to identify the respectful maternity care they received or practiced; and the non-respectful care they experienced or witnessed. The participants' response checklist were of two versions - one version for postnatal women with 42 Likert-type items, and one for midwives with 35 items. The instruments were pretested and had 0.82, 0.84 and 0.89 reliability coefficients respectively.

Midwives were observed during morning and evening shifts for three weeks with caring behaviour noted on the observation checklist. Clients and midwives identified from the checklists.

Ethical clearance: Ethical clearance was obtained from the HREC of Cross River State Ministry of Health with informed consent obtained from participants.

Data analysis: Descriptive and inferential analyses of data were done using SPSS version 18.0..

RESULTS

Socio-demographic data: Socio-demographic characteristics of clients and midwives (Table 1) showed that the mean age of client participants was 31±2.8, with mean number of children being 3, and 68.7% having secondary education, 51.8% were of Efik ethnicity. The mean age of midwives was 38±1.3, with 49.0% having 5 to 10 years of experience as midwives.

Respectful and/or disrespectful care: All the client participants were aware of the need for respectful maternity care. Fifty eight clients (69.9%) reported receiving respectful maternity care, while 25 clients (30.1%) reported experiencing or witnessing lack of respectful maternity care/non-respectful care in different categories.

Table I
Socio-demographic Characteristics of Respondents

Clients participants (n = 83)		Midwives (n = 51)	
Variable	**No. (%)**	**Variable**	**No. (%)**
Age (in years):		**Age (in years):**	
20 – 30	22 (26.5)	20 – 30	09 (17.6)
31 – 40	51 (61.4)	31 – 40	27 (52.9)
Over 40	10 (12.0)	Over 40	15 (29.4)
Mean age: 31 ± 2.8		Mean age: 38 ± 1.3	
Number of Children:		**Years of Practice as Midwife**	
1 – 2	18 (21.7)	Less than 5	09 (17.6)
3 – 4	49 (59.0)	5 – 10	25 (49.0)
More than 4	16 (19.3)	More than 10	17 (33.3)
Mean number of children 3.0		Mean number of years 7.0	
Ethnicity:		**Professional Cadre**	
Efik/Efut/Qua	43 (51.8)	Nursing Officer I	09 (17.6)
Ibibio/Annang	20 (24.1)	Senior Nursing Officer	23 (45.1)
Ibo	09 (10.8)	Principal Nursing Officer	15 (29.4)
Others	11 (13.3)	ACNO/CNO	04 (7.8)
Highest Education attained:			
Primary	12 (14.4)		
Secondary	57 (68.7)		
Tertiary	14 (16.9)		
Occupation			
Professional	34 (41.0)		
Skilled labour	38 (45.8)		
Unskilled labour	11 (13.3)		

Table 2:
Client participants' response to categories of non-respectful care (n = 83)

Non-respectful care*	Agree No (%)	Undecided No (%)	Disagree No (%)
Physical abuse	05 (6.0)	21 (25.3)	57 (68.7)
Non-consented care	18 (21.7)	07 (8.4)	58 (69.9)
Non-confidential care	25 (30.1)	17 (20.5)	41 (49.4)
Non-dignified care and verbal abuse	25 (30.1)	30 (36.1)	28 (33.7)
Discrimination	10 (12.0)	27 (32.5)	46 (55.4)
Abandonment or denial of care	25 (30.1)	13 (15.7)	45 (54.2)
Detention in facility	63 (76.0)	02 (2.4)	18 (21.7)
Lack of information	25 (30.1)	04 (4.8)	54 (65.1)
Lack of sensitivity towards pain and cultural preference	25 (30.1)	07 (8.4)	51 (61.4)
Not allowing preferred childbirth position	22 (26.5)	32 (38.6)	29 (34.9)

** Not mutually exclusive*

These fitted into Bowser and Hill's categories. Clients identified from the checklist common respectful care received as, freedom from discrimination (55.4%), explanation of procedures/answer to questions (65.1%), and consent seeking (69.9%).

The 25 clients who reported non-respectful care identified multiple types of non-respectful care occurring together, including lack of information about the progress of labour, (100%); lack of privacy, (100%); verbal abuse – being scolded or shouted at (100%); lack of sensitivity towards clients' pain and culture, (92.0%); being denied preferred childbirth position, (88.0%); lack of companionship during labour, (80.0%); and detention in facility for failure to pay the bill (76.0%). Only 5(20) reported physical abuse by way of being rough handled and restrained forcibly. Table 2 shows the common types of non-respectful care identified by clients.

Attending midwives confirmed the presence of non-respectful care in health facilities. Common ones include restricting women to deliver in the dorsal position (100%); detention of women if they cannot pay the bill (100%); not being in constant attendance of women during the first stage of labour (94.1%); and not adequately screening or draping women (82.4%). Midwives' report of non-respectful care aligned with that of client participants in four areas. Lack of materials like drapes and portable screens; staff shortage; inadequate knowledge and skills in other birthing positions; and hospital policy were reported by midwives as issues responsible for the above examples of non-respectful care.

Using Bowser and Hill's landscape analysis, non-respectful behaviour observed in caring midwives by the researchers include non-attendance of midwife during most of the first stage of labour, restricting women to deliver in the dorsal position, and lack of sensitivity towards clients' pain.

Clients in this study stated that midwives should be caring (to include kindness, emotional support, compassion, respect, and giving comfort). They reported midwives' caring behaviour to include, motivating positive behaviour during labour and childbirth (65.1%); informing clients about progress of labour (55.4%), and being generally supportive (50.6%). Some clients (21.7%) however reported that they did not receive the type of care/caring they had expected from

midwives, and identified some physical and emotional non-caring behaviours experienced to include being shouted at, not caring about their pain, and not being present when needed.

DISCUSSION

Clients' report of types of non-respectful care aligned with that of the caring midwives in four areas. Common acts of disrespectful care were identified by both the clients and the attending midwives in this study, similar to findings by Abuya *et al* (2015) in Kenya, McMahon *et al*. (2014) in Tanzania, Bohren *et al*. (2017) in Northern Nigeria and Amroussia *et al*. (2017) in Tunisia. Some of these fit into some categories identified by Bowser and Hill (2010), and The White Ribbon Alliance (2011).

The World Health Organisation (WHO) recommends that care given to all women should be in a manner that maintains their dignity, privacy and confidentiality. Such care should ensure freedom from harm and mistreatment, enable informed choice as well as continuous support during labour and childbirth (WHO, 2018). The main thrust of respectful maternity care is to use human rights approach to reduce maternal morbidity and mortality.

As revealed by this study, all the respondents were aware of the need for respectful maternity care. Conversely, only some (69.9%) received respectful care. The implication of this is that those who did not receive respectful care may not likely return to the health facility for care subsequently. As a result, such women may end up patronising traditional birth attendants and other unskilled birth attendants. This category of birth attendants have been found not to have the capacity to successfully manage obstetric emergencies; thus have resulted in maternal morbidities and mortality (Etuk, Itam & Asuquo, 2000; Esienumoh, Allotey & Waterman, 2018).

Studies have shown that women choose place of delivery based mostly on their perceptions of the way they will be treated in such facilities (Freedman & Kruk, 2014). Similarly, Ogunlaja, Fehintola, Ogunlaja *et al*., 2017; Kyomuhendo, 2003) found that abuse and disrespect during pregnancy and childbirth makes most women only report to the hospital for care as a last resort. Some other authors have found that such women only report to the hospital for care by skilled attendants when they experience life-threatening complications at which point little or nothing could be done to save their lives (Esienumoh, Allotey & Waterman, 2018; Mboho, Furber & Waterman, 2013).

The respectful care received by women in this setting included freedom from discrimination, explanation of procedures and providing answers to the questions of the women by midwives as well as seeking consent before performing procedures. These aspects are congruent with the International code of ethics of midwifery care stipulated by the International Confederation of Midwives (ICM). Midwives have the responsibility to develop partnership with women in their care so that they can share relevant information that can lead to informed decision-making. Additionally, midwives support the right of women and their families to enable them participate actively in decisions about their care (ICM, 2014). In support of the code of ethics of midwifery, Lothian (2019) posited that primary responsibility of childbirth educators is to respect and promote the rights and wellbeing of the childbearing woman. These persons should also provide accurate and up-to-date information to empower the woman to make informed decision.

Contrarily, in this study, several non-respectful aspects of care provided by the midwives were revealed. These included verbal / physical abuse, lack of privacy, denying preference for choice of childbirth position, lack of companionship during labour, lack of information on the progress of labour and detention in the health facility for failure to pay for services. These findings corroborate some of those of Ogunlaja *et al*. (2017) who also found several disrespectful aspects of maternity care such as physical abuse, abandonment or denial of care and detention in facility. Furthermore, they found non-consented care and non-confidential care as the most common forms of disrespect in Western Nigeria.

Denying the women of their preferred positions for childbirth such as squatting, kneeling and lying on the side contradicts the findings of the Royal College of Midwives (2011) which also reported kneeling and squatting as some of the positions generally preferred by women. Conventionally some midwives are used to having the women lie on their back during childbirth, thus the clients' demands in this study call for transformation of care by the midwives. Transforming care at the bedside involves transformation based on knowledge, attitude and skills of the midwife. Respectful maternity care is one of the concepts involved in transforming care for the woman during labour and childbirth. Although caring forms the core of midwifery and nursing, there have been public complaints about uncaring behaviour among midwives attending women during labour and childbirth.

Additionally, the findings of this study show that disrespect is not only restricted to the individual care-provider but also by the health system or facility. For example, detention for non-payment of hospital bills is commonly a policy in some health facilities in this setting and midwives are under pressure to implement such policies. As described by Freeman and Kruk (2014), disrespect involving providers and the facility is a signal of a health system in crisis which may indicate that such health system tolerates disrespect and devalues women. This has been implicated as an underlying cause of slow progress on the reduction of maternal mortality.

As revealed in this study, a mix of respectful and disrespectful care are rendered by midwives to the women. This implies a deficit in maternity care because it is not fully rights-based; thus the women are not obtaining optimal care. In response the women may resort to unskilled birth attendants who may be 'friendlier' but with consequence of morbidities and mortality. Therefore, there is need to scale up maternity care in the contemporary health facilities to reflect fundamental human rights.

In conclusion, both respectful and disrespectful behaviours exist during maternity care, as reported by both the clients and the midwives. Appropriate maternity care must be respectful and rights-based in order to enhance access to skilled care at birth. Midwives need to transform care given to women while providing maternity services through respectful care. This would make a difference by promoting women's rights and ensuring their dignity.

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