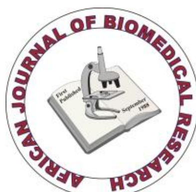

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Research Article

Midwives' Perception and Practice of Respectful Maternity Care During Pregnancy and Childbirth in Selected Health Facilities in Cross River State, Nigeria

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ABSTRACT

Respectful maternity care is a care organized for 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. This study examines midwives' perception and practice of respectful maternity care during labour and childbirth. The study adopted a correlational design. The study setting was Cross River State and the sites for the study were the University of Calabar Teaching Hospital and General Hospital Calabar. Two different populations were used. Midwives total was population (144 midwives). Data were collected using a structured self-explanatory questionnaire (with test-retest r of 0.86) and an observational checklist. Data were analysed using SPSS 25 and presented using descriptive and inferential statistics, hypotheses were tested using population t-test and Pearson product moment correlation coefficient. Findings from the study revealed midwives had a moderate (6.6/10) level of knowledge of respectful maternity care and a positive perception towards respectful maternity care. The practise of respectful maternity care was significantly high ($p<0.05$).However, some aspect of disrespect still exits (27% for self-reported, 42.8% for observed). Statistically significant relationship exists between the knowledge and practice of respectful maternity care and also between perception and practice of respectful maternity care ($p>0.05$).Midwives should seek to understand the views of women and their families on issues relating to their care, this will contribute immensely to the development and implementation of appropriate intervention.

Keywords: *Respectful maternity care, Midwives' knowledge and practice, labour and chilbirth*

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INTRODUCTION

Respectful and satisfactory maternity care is essential for promoting timely care-seeking behaviour, and ultimately ensuring the health and well-being of mothers and their babies. Women's experiences in relation to the quality of care can influence the utilisation of maternity services (Mrisho, 2009). According to the Donabedian model, the structure (physical facilities) and process (type of care) of healthcare delivery system, influences the outcome (satisfaction), this is illustrated by Bohren, et al (2014) that that recognised the experience of disrespectful and abusive as one of the barriers to seeking timely maternity health services. However, in Nigeria, respectful or disrespectful maternity care is generally not documented, so little is known about how frequently women actually experience these behaviours (John, Duke &Esienumoh, 2017)

Disrespect and abuse (DA) of women during childbirth in facilities has recently gained recognition not only as a marker for quality of maternal care but also as violation of basic human rights of birthing women (Freedman et al., 2014). DA can be defined generally as "interactions or facility conditions that local consensus seems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified" (Freedman et al., 2014, p917). Landscape analysis by Bowser and Hill (2010) described seven categories of disrespectful and abusive care during childbirth. These are; physical abuse, non-consensual care, non-confidential care, non- dignified care, discrimination, abandonment of care and detention in facilities.

Various manifestations of DA during childbirth have implications on maternal mortality, these manifestations may be direct or indirect. Direct manifestations of DA include the use of inappropriate and excessive invasive interventions (slap, harsh words, etc.) in vaginal birth, neglect, and delay of care, usually among females with discrimination on the basis of socioeconomic status (SES), HIV status, and marital status

(Sen, Reddy & Iyer, 2018). Indirectly, DA becomes a barrier to seeking childbirth care (Bohren, et al 2014), as women experiencing DA during childbirth may not choose the facility for subsequent deliveries (Balde et al., 2014) and may not recommend it to other women. DA during childbirth not only affects healthcare utilization and maternal mortality but also is a violation of basic human rights of females (Khosla et al., 2016). Recognizing this emerging public health problem, in 2014, World Health Organization gave a call for preventing and eliminating DA during facility-based childbirth (WHO, 2017).

WHO (2018), recommendation on respectful maternity care (RMC) charges midwives to provide care that is organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality. This care should also ensure freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth. Findings from the study by Burrowes et al., (2017) explore experiences of disrespect and abuse in maternal care from the perspectives of both providers and patients, were 45 in-depth interviews at four health facilities in Debre Markos, Ethiopia with midwives, midwifery students, and women who had given birth within the past year Students and providers also took a brief quantitative survey on patients' rights during labour and delivery and responded to clinical scenarios regarding the provision of stigmatized reproductive health services. The result showed that most abuse is unintended and results from weaknesses in the health system or from medical necessity.

A study by Rominski (2015) Ghanaian midwifery students' perceptions and experiences of disrespect and abuse during childbirth, where final year students were invited to participate in a focus group at their institution. Students were asked to describe disrespect and abuse of women that they had observed. Findings showed that while student midwives understand the reasons why respectful care is important, they believe that there are instances where abusive behaviour is necessary to ensure both the woman and her child survive childbirth. She concluded that midwives in training could benefit from increased training on ways to communicate with and motivate women during labour and delivery.

In a descriptive cross-sectional study by John et al., (2017) on respectful maternity care and midwives caring behaviours during childbirth in two hospitals in Calabar, results showed that attending midwives reported not adequately screening or draping women, restricting women to deliver in the lithotomy position, detaining women if they cannot pay for the bill, not being n constant attendance of women during the first stage of labour and not allowing family members into the labour room to stay with the client. They concluded that both respectful and disrespectful behaviours exist and common acts of disrespectful care are reported by both the client and the midwives. A study by Shimoda et al. (2018) to describe from actual observations the respectful and disrespectful care received by women from midwives during their labor period in two hospitals in urban Tanzania, using a naturalistic observation of two health facilities in urban Tanzania. Fourteen midwives were purposively recruited for the one-on-one shadowing of their care of 24 women in labour from admission to the fourth stage of labour. Findings from the study showed that all the 14 midwives showed both respectful and disrespectful care and some practices that have not been explicated in previous reports of women's experiences. For disrespectful care, five categories were recognized: 1) physical abuse, 2) psychological abuse, 3) non-confidential care, 4) non-consented care, and 5) abandonment of care. Two additional categories emerged from the un prioritized and disorganized nursing and midwifery management: 1) lack of accountability and 2) unethical clinical practices. Findings from the study by Burrowes et al., (2017) showed that both health care providers and patients report frequent physical and verbal abuse as well as non-consented care during labour and delivery.

A systematic review by Ishola et al. (2017) on disrespect and abuse of women during childbirth in Nigeria. Five electronic databases were searched for relevant published studies, and five data sources for additional grey literature. A qualitative synthesis was conducted using the Bowser and Hill landscape analytical framework on disrespect and abuse of women during childbirth. Findings revealed that the type of abuse most frequently reported was non-dignified care in form of negative, spoor and unfriendly provider attitude and the least frequent were physical abuse and detention in facilities.

Despite the multidimensional nature of DA, midwives understanding of women's right and respectful maternity care and their perception towards DA remains core to provision of respectful and satisfactory maternity care. Respectful maternity care encourages midwives to work in partnership with women and strengthen women's capabilities, making the recognition that quality midwifery care is not only about the provision of care but crucially also about how it is experienced (Tunçalp, 2015), this motivated the study to assess midwives' perception and practice of respectful maternity care during pregnancy and labour in selected health facilities in Cross River State, Nigeria.

MATERIALS AND METHODS

Research Design: The study utilized a correlational design. A correlational study is a type of research design where a researcher seeks to understand what kind of relationships naturally occurring variables have with one another (Polit & Beck 2010).

Research Setting: The site for the study was University of Calabar Teaching Hospital (UCTH), and General Hospital Calabar (GHC). UCTH is the only tertiary health institution in the state. It serves as a training hospital and a research centre and a reference hospital. General Hospital Calabar is a secondary health facility. The Hospital renders medical, surgical, maternity and gynaecological services; it is also a referral centre. Both health facilities are mostly patronized by women for maternity services as they provide quality care to pregnant women.

Research Population: A population is the total number of units (or individuals) from which data can potentially be collected (Parahoo 2015). In this study, two different populations were used.

Target Population: The target population for the quantitative phase consists of all midwives in Calabar while the accessible population comprised of midwives working in the maternity units of University of Calabar teaching Hospital or General Hospital Calabar. Data from the hospitals shows that there are currently 108 midwives in the maternity unit of University of Calabar teaching Hospital and 36 midwives in the maternity unit of General Hospital Calabar, making a total of 144 midwives.

Sample Size: The total accessible population was utilised for the study. Data from the hospitals shows that there are currently one hundred and eight (108) midwives in the maternity unit of University of Calabar Teaching Hospital and thirty six (36) midwives in the maternity unit of General Hospital Calabar.

Exclusion Criteria for Women

- Women who are not willing to participant in the study.
- Women that delivering in GHC or UCTH for the first time.
- Women that cannot communicate fluently

Sampling

A total population sampling technique was utilised for the quantitative phase of this study. That is all units in the accessible population are included in the research usually done when the population is small. A total population sampling is a study of every unit, everyone or everything, in a population. It is known as a complete enumeration, which means a complete count of all units in the accessible population are included in the research usually done when the population is small.

Inclusion and exclusion criteria: For this study, willingness to participant in the study as well as working in the maternity unit of UCTH or GHC for more than 6 months as at the start of the study were considered for inclusion.

Instrument for Data Collection: A four-section questionnaire and observational checklist to observe the practice of nursing during labour and childbirth was used for data collection

Reliability test:. A test-retest was conducted to determine the level of consistency of the research instrument. Ten (10) copies of the questionnaire were administered to 10 midwives working in the maternity unit of University of Uyo Teaching Hospital. Data collected from the two administrations were analysed using the Pearson Product Moment correlation statistical and a result of 0.86 was obtain

Procedure for data collection: The data collection for the quantitative aspect of this study was conducted with the aid of research assistants who were trained on the research objective and purpose.

Data Analysis: Data were entered in SPSS version 25 for windows and analyzed using descriptive statistics of simple percentages, graphs and tables. Hypotheses were tested using population t-test and Pearson's Product Moment Correlation Analysis

Ethical Consideration: The ethical clearance no CRSMOH/RP/REC/2021/132 and UCTH HREC/33/694 were granted by Cross River State ethical committee and UCTH ethical committee respectively. Decisions not to participate were strictly respected and pregnant women were assured that non-participation will not affect their health care. Strict confidentiality and privacy were ensured and maintained throughout the study

RESULTS

Socio-Demographic Data: Findings from the study shows that in all of the respondents were females and only in both UCTH and GHC were females. On the marital status, 79(83.2%) of the respondent in UCTH were married, 12 (12.6%) were single, 3 (3.2%) were widowed and 1(1.1%) was divorced, while for the respondents in GHC, 24(77.4%) were married, 6(19.4%) were single and 1(3.2%) of the respondents were widowed.

Table 1:
Socio-demographic data of the respondents

Variables	UCTH (%) n=95	GHC (%)n=31
Gender		
Male	0.0	0.0
Female	100	100
Marital Status		
Single	12.6	19.4
Married	83.2	77.4
Divorced	1.1	0.0
Widowed	3	3.2
Age (Years)		
21-30	16.8	19.4
31-40	37.9	51.6
41-50	29.5	19.4
51-60	15.8	9.7
Years of Experience		
1-7	22.1	19.4
8-14	31.6	29.0
15-21	24.2	35.5
22-28	14.7	9.7
29-35	7.4	6.5
Educational Attainment	28.4	38.7
SSCE	13.7	12.9
HND	50.5	48.4
B.Sc	4.2	Nil
PGD	3.2	Nil
M.Sc	Nil	Nil
PhD		
Professional Rank		
NO II	3.8	3.2
NO I	7.0	6.5
SNO	21.6	25.8
PNO	13.6	16.1
ACNO	21.1	29.0
CNO	23.9	16.1
ADNS	6.6	3.2
DDNS	2.3	Nil
Total	**100**	**100**

The findings further show that for the respondents in UCTH, 36(37.9%) were within the age range of 31-40years, 28(29.5%) were 41-50years, 15(15.8%) were 51-60 years and 16(16.8%) were within the age range of 21-30 years, while for the respondents in GHC 6(19.4%) were within the age range of 41-50 years, 16(51.6%) were 31-40 years, 6(19.4%) were 21-30 years and 3(9.7%) were within the age range of 51-60 years (see Table 1).

Data on years of experience shows that of the UCTH respondents, 23(24.2%) have had 15-21years of experience, 30(31.6%) have had 8-14 years of experience, 14(14.7%) have had 22-28 years of experience, 21(22.1%) have 1-7 years of experience and 7(7.4%) have had 29-35 years of experience, while for GHC respondents, 11(35.5%) have 15-21 years of experience, 3(9.7%) have 22-28 years of experience, 9(29.0%) have 8-14 years of experience, 2(6.5%) have 29-35 years of experience and 6(19.4%) have 1-7 years of experience (see Table 4).

Result also shows that of the respondents in UCTH, majority 48(50.5%) had a Bachelor degree, 27(28.4%) had a just the SSCE, 13(13.7%) had a Higher National Diploma, 4(4.2%) had a Post Graduate Diploma, 3(3.2%) had a Master degree and none of the respondents had a doctorate degree, for respondents in GHC, 12(38.7%) have just the SSCE, 15(48.4%) have a Bachelor degree, 4(12.9%) had a Higher National Diploma and none of the respondents had a post graduate diploma masters or doctorate degree.

Knowledge on respectful maternity care: The knowledge section was graded to ascertain the level of knowledge of the respondents. 1 mark was scored for each correct response and 0 for incorrect response and the total score was calculated. Scores of 0-3, 4-6, and 7-10 signifies low, moderate and high level of knowledge respectively.

Table 2 shows that in UCTH 7.4% of the respondents had low level of knowledge on Respectful maternity, 40.0% had moderate level of knowledge on respectful maternity and 52.6% had high level of knowledge on respectful maternity. In GHC 12.9% of the respondents had low level of knowledge on Respectful maternity, 38.7% had moderate level of knowledge on respectful maternity and 48.4% had high level of knowledge on respectful maternity. The general average score of the knowledge level of the respondents was 6.02 signifying a general moderate level of knowledge on respectful maternity

TABLE 2:
Respondents' level of knowledge on respectful maternity care

Level of knowledge	Score	UCTH (n=95)	GHC (31)
Low	0-3	7.4	12.9
Moderate	4-6	40.0	38.7
High	7-10	52.6	48.4
Total		**100**	**100**

Average Score: 6.02

Perception on Respectful Maternity Care: Table 3 shows midwives perception of different aspect of respectful and disrespectful care.

Table 4 shows that in UCTH, 17.9% of the respondents had negative perceptions towards respectful maternity while 82.1% had positive perception towards respectful maternity. In GHC, 28.7% of the respondents had negative perception towards respectful maternity while 71.3% had positive perception towards respectful maternity. The general average score of the knowledge level of the respondents was 27.68 signifying a general positive perception.

Table 5 shows the different aspect of disrespectful and respectful care practiced by midwives and how frequent they practice it. Figure 1shows 73% respondents practice respectful maternity care and 27% do not practice respectful maternity care.

As presented in table 6, the practice of respectful maternity care was not significantly high, the mean score should be significantly greater than the reference mean of 20 (the midpoint in the rating scales of practice). This hypothesis was analysed using population t-test analysis tested at 0 .05 level of significance. The result obtained showed the mean score for practice which was 24.48 with standard deviation of 2.98 was significantly higher than the reference mean of 20. The result indicates that the practice of respectful maternity care is not significantly high ($t= --16.89$, $df = 125$) $p < 0.05$), therefore the null hypothesis was rejected

Table 3:
Respondent's Response to Perception on Respectful Maternity Care

s/n	PERCEPTION ON RESPECTFUL AND DISRESPECTFUL CARE	SA (%)	A (%)	D (%)	SD (%)
1	Slapping the woman during childbirth is sometimes necessary to save her life and that of the baby.	16.7	19.0	34.9	29.4
2	Using harsh words help women and relative to cooperate	19.0	13.5	28.6	38.9
3	Shouting at a woman to push during child birth is a normal thing	17.7	17.7	41.1	23.4
4	The midwife knows what best for the woman and so should choose for her.	23.8	19.0	22.2	33.3
5	It is not necessary to give the woman detailed information of treatment and procedure as the woman may not understand	13.5	13.5	27.0	44.4
6	Retaining the woman after childbirth when she is unable to pay is permitted to make her pay	16.7	4.0	38.9	32.5
7	Woman who do not have money should not be attended to	13.5	11.1	30.2	43.7
8	It is not necessary to use curtains and screen in the labour ward	24.36	5.6	27.8	38.9
9	Once the child is born, the woman no longer need the midwife	12.7	11.1	23.0	46.8
10	Midwives are solely in-charge of childbirth and not the woman.	32.5	20.6	27.0	19.8

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Table 4:
Respondents Level of Perception towards Respectful Maternity care

Perception on Respectful Maternity	Score	UCTH (n=95)	GHC (31)
Negative	10 – 25	17.9	28.7
Positive	26 – 40	82.1	71.3
Total		**126**	**100**

Average Score: 27.68

A Pearson Product Moment Correlation Coefficient test was conducted to test the relationship between knowledge of respectful maternity care and practice of respectful maternity care in pregnancy and labour. The result as shown in table 7 above, indicates a statistically significant relationship between knowledge of respectful maternity and practice of respectful maternity care r(N=126) .697p> .05. The null hypothesis was therefore rejected

Table 5:
Aspect of respectful and disrespectful reported by respondents

	WHO	How often do You	Always	Often	Rarely	Never
1	Physical Abuse	Pinch, slap or beat women to enable them push*	21(16.5)	29 (22.8)	52(40.9)	24 (18.9)
2	Detention	Detain women when they have not paid their bill*	12(9.4)	16 (12.6)	38(29.9)	60 (47.2)
3	Dignify care	Change bedding in the labour ward	50(39.4)	54 (42.5)	19(15.0)	3(2.4)
4	Abandonment/ neglect	Deny women maternity services because they do not have money to pay*	7(5.6)	24 (19.0)	57(45.2)	38 (30.2)
5	Verbal Abuse	Shout on women to enable them push*	18(14.3)	30 (23.8)	36(28.6)	42 (33.3)
6	Confidential/ privacy	Examine women ensuring privacy	70(55.6)	37 (29.4)	12(9.5)	7(5.6)
7	Quality healthcare	Go out of your way to ensure women are well cared for	66(52.4)	46 (36.5)	8(6.3)	6(4.8)
8	Discrimination	Discriminate against women with HIV and Hepatitis B virus*	15(11.9)	14 (11.1)	41(32.5)	56 (44.4)

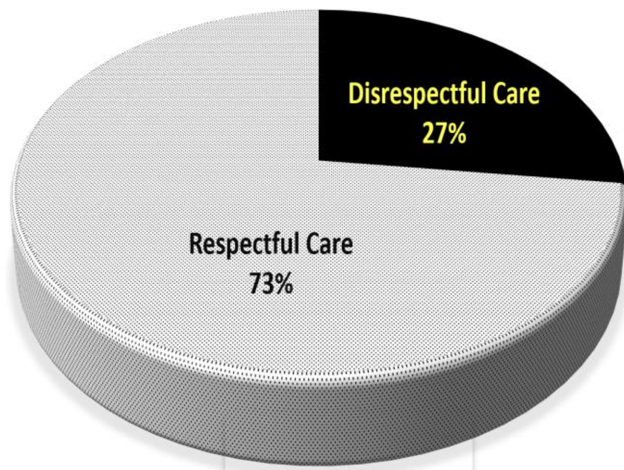

Figure 1
Practice of Respectful Maternity Care

Table 6:
Population t-test analysis for practice of respectful maternity care

Variable	$\bar{x}$	SD	Mean difference	t-value	p-level
Practice of respectful maternity care	24.48	2.98	4.484	16.89	.000

μ = 20

Table 7:
Pearson Product Moment Correlation analysis of the relationship between knowledge of respectful maternity care and practice of respectful maternity care

Correlations		
		Practice of respectful maternity care
Knowledge of respectful maternity care	Pearson Correlation	.697
	Sig. (2-tailed)	.035
	N	126

DISCUSSION

The study discovered a general moderate level of knowledge on respectful maternity this may be as a result of the series of in training service provided for midwives in their respective facilities (although the level is a little bit higher in UCTH compared to GHC, but the difference is not significant). This is congruent with the study by Burrowes et al., (2017) and D-zomeku, et al., (2020), showing that nurses generally understand the rights of pregnant women and what is expected of them when caring for pregnant women. This level of knowledge implies that various campaign and seminar organised in the past to enlighten midwives was successful, however, more work needs to be done as a score of 6.61/10, through significantly high, can still be improved upon.

Knowledge on respectful maternity was discovered to be significantly related to practice of respect, this relationship is a strong positive relationship, meaning that the higher the level of knowledge comes the more likelihood to practice respectful maternity, this buttresses the need to improve midwives' level of knowledge on respectful maternity.

The study also discovered that general, midwives had a positive perception towards respectful maternity care, although there is a general positive perception some midwives still scores classifying them to have negative perception and among those who had scores for a positive perception, some still had negative perception on some aspect of respectful maternity module. However, while negative perception exists among some midwives and in some modules of respectful maternity, those with positive perception were largely higher than those with negative perception; this means midwives are gradually appreciating respectful maternity as the gold standard for midwifery practice. This is in line with studies by Burrowes et al., (2017) and Bradley, McCourt, Rayment & Parmar (2019) who identified that midwives favour some aspect of respectful maternity; they also favour some aspect of disrespect and abuse.

While the perception score was high in both setting, the score was slightly higher in UCTH than in GHC, this may be as a result of the fact that UCTH is a tertiary hospital and by standard and more, is normally expected to be higher than GHC even in the aspect of the perception of its staff. Perception was also found to be related to the practice of respectful maternity, although a weak relationship, it could be reason for the presence of both respectful and disrespectful care as experienced by the women and as observed.

The observed labour and child and midwives self-report identified high levels of the practice of respectful care (however there are still some level of the practice of disrespect and abuse, this may as a result of the fact that while some midwives have knowledge on women's right and see respectful maternity care as gold standard, some midwives haven't been able to completely get rid of the old way of doing things, this means that the aim of respectful maternity which is the eradication of any form of disrespect and abuse have not been well achieved, this may be due to knowledge and/or perception as these have been found to have a positive relationship to the practice of respectful maternity. This is similar to the studies by Burrowes et al., (2017), Ishola, et al., 2017) and Shimoda et al. (2018), that identified both respectful and disrespectful care but contradicts the study by Ukke, et al., (2019) that recorded a 98.9% prevalence of disrespect and abuse. Also, the level of education was the only predictor of the practice of respectful maternity care; those with a bachelor's degree and a post graduate degree were more likely to practice respectful maternity compare to those without. This implicates the need for midwives to further their education as it enables them to acquire more knowledge on not just respectful maternity but on every aspect of midwifery.

Although the record levels of respectful care were high in both the observation of labour and childbirth and the self-report of midwives, the level of respectful care was higher in self-report of midwives as compared to the level in observed of labour and childbirth, this could be because midwives maybe not be aware of their course of action while conducting care, but are theoretically knowledgeable of what constitutes respectful maternity care. That is, while midwives may feel they practice respectful maternity, they sometimes fall short unknowingly.

In conclusion, aspects of respectful care as well as disrespect an abuse was experienced by some women during labour and childbirth (bringing about the concept of patchy birth territory), however, aspects of respectful care that exist was higher than that of disrespect and abuse, also some experience a totality of respectful care indicating a shift towards respectful maternity. This discrepancy in type of care receive was attribute to either the presence of partiality in care or/and as a result of individual differences of the midwives providing care, where some practice respectful maternity and some have few shortcomings.

The study showed that the level of practice of respectful maternity care among midwives was directly related to their level of knowledge and their perception on respectful maternity, implicating that to ensure that midwives need to improve on their knowledge on respectful maternity care and upgrade their educational qualification which will in turn help midwifery. Not only midwives are charge with responsibility of ensuring the provision of respectful maternity, midwives should seek to understand the views of women and their families on issues relating to their care, this will contribute immensely to the development and implementation of appropriate intervention

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