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ORIGINAL ARTICLE

Women's Experiences of Respectful Maternity Care during Facility-based Childbirth in Benin City, Southern Nigeria

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Keywords

Respectful Maternity Care;

Women;

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ABSTRACT

Background: Respectful maternity care (RMC) is an effective strategy for improving the quality of care experienced by women during facility-based childbirth. A lack of RMC is a key factor driving both the low proportions of facility-based deliveries and high maternal and neonatal mortality. This study was conducted to assess the experiences and predictors of RMC among women of reproductive age in Benin City, Edo State.

Methods: A descriptive cross-sectional study was carried out among mothers in Benin City, who had facility-based childbirth within three months of the study. Respondents were selected using a two-stage sampling technique. Data was collected using a structured interviewer-administered questionnaire. RMC was assessed using 15-item RMC scale in four domains and analysed using IBM SPSS version 22.0. Binary logistic regression was conducted to determine significant predictors of RMC. A p-value <0.05 was considered statistically significant.

Results: A total of 393 women with a mean age (SD) of 33.42 (7.4) years participated in the study. Overall, 141 (35.9%) of respondents experienced RMC. Friendly care, abuse free care, timely care and discrimination free care were experienced by 147 (37.4%), 211 (53.7%), 252 (64.1%), and 124 (31.6%) respectively. Formal education [AOR = 0.318 (0.106-0.956)], primiparity/multiparity [AOR = 0.527 (0.294-0.945)] and use of public facility for childbirth [AOR = 1.623 (1.047-2.516)] were significant predictors of RMC.

Conclusion: The proportion of respondents who experienced RMC was low in the studied population. Effective communication and engagement of health care providers is essential for the provision of RMC in all contexts and settings.

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INTRODUCTION

Despite remarkable progress in reducing maternal and neonatal mortality, low and medium income countries (LMICs) still account for approximately 99% of global maternal deaths, with sub-Saharan Africa accounting for 66% of these deaths.[1,2] Although the promotion and implementation of healthcare facility-based deliveries with skilled birth attendants through policies, has had a positive impact in lowering these rates, further increases in use of maternal health services over the past decade has not been matched with reductions in maternal and neonatal mortality.[3-5] Evidence suggests that even when services are available, care may be compromised by social, ethnic and cultural barriers, an unwelcoming reception at the

health care facility, lack of privacy and information for the client, and disrespect and abuse (D&A) in the hands of maternity care providers[6-8] There is compelling evidence from many countries on the negative impact of mistreatment during the uptake of facility-based childbirth.[9] A synthesis of studies from 16 LMICs and China revealed that mistreatment during childbirth is a powerful deterrent to future facility-based childbirth.[10] It is also an important determinant of a woman's future decisions related to seeking health care from health facilities.[11, 12]

Respectful Maternity Care (RMC) is an effective strategy for improving quality of care experienced by women during facility-based childbirth in low- and middle-income countries (LMICs)[13,14] In the move towards mitigating disrespect and abuse during childbirth, a focus on RMC is growing globally, and the 'Universal Rights of Childbearing Women' has been endorsed in many countries.[15]The World Health Organisation (WHO) defines RMC as 'the 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'.[16] The term RMC has been used synonymously with women-friendly care, women-centered care and person-centered maternity care.[12] RMC is recognized as one of the basic rights of every childbearing woman, and a valued dimension of quality of maternal and new born care.[17,18] The RMC approach is centered on the individual and is based on principles of ethics and respect for human rights. The RMC Charter, developed by the White Ribbon Alliance and RMC partners, is based on a framework of human rights and is a response to the growing body of evidence documenting a lack of RMC of childbearing women.[15] A systematic review of five studies in Ethiopia, Kenya, Nigeria and Tanzania found that the prevalence of D&A ranged from 15 to 98%.[19] Another WHO-led study in Ghana, Guinea, Nigeria and Myanmar found that 35.4% of women experienced physical or verbal abuse, or stigma or discrimination during childbirth.[20]

Information on RMC during facility-based childbirth is limited in the study area. Hence, this study aimed to assess the experiences of women who gave birth in health facilities in Benin City, and determine the predictors of RMC. This study will identify gaps which will aid in designing interventions to promote positive childbirth experiences.

METHODOLOGY

This community-based descriptive cross-sectional study was conducted June to November, 2019, in the metropolitan city of Benin, the capital of Edo State, Nigeria. Benin City comprises three Local Government Areas (LGAs) namely, Egor, Oredo and Ikpoba-Okha. The projected population of Benin City for 2019 at a growth rate of 3.99% per annum was 1,495,800,[21] with a male/female ratio of nearly 1:1. There are three (3) tertiary facilities, 158 secondary health facilities and 268 primary health care facilities in Benin City, providing maternal services such as antenatal care (ANC), delivery and child birth, family planning, HIV/AIDS counselling and testing, and obstetric and gynaecological emergencies care services to its citizens.[22]

The study population comprised women in the reproductive age group (15 to 49 years), who utilised labour and delivery services in a health facility in Benin City within three months of the study. A minimum sample size of 352 was calculated using the appropriate formulae for single proportion.[23] The assumptions made in computing the sample size were standard normal deviate of 1.96 at 5% level of significance, measure of variability by the prevalence of RMC of 64.6% (how women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys four countries, including Nigeria),[20] and an margin of error of 5%. Two-stage sampling method was utilised in selecting women that participated in the study. All LGAs in Benin City were used for the study. The first stage comprised selection of wards. Oredo, Ikpoba-okha and Egor LGA have 12, 10 and 10 wards, respectively. Two wards (one rural and one urban), from each of the 3 Local Government Areas that make up Benin City were selected from a list of wards in each local Government Area using simple random sampling by balloting. Thus, a total of 6 wards (3 urban and 3 rural) were selected for the study. In stage two, one community within each ward was selected using simple random technique by balloting, giving a total of six communities. Each community served as a cluster and all women living in households within the selected communities who met the inclusion criteria were invited to participate in the study using house-to-house recruitment of respondents.

The tool for data collection was the 15-item RMC scale[12] adapted to suit the study objectives.[12] 15-item RMC scale is classified into four subscales on the basis of a 5-point Likert scale (5–strongly agree, 4–agree, 3–undecided, 2–disagree, and 1–strongly disagree). The questionnaire assessed four (4) dimensions of RMC viz; friendly care (7 questions), non-discriminatory care (3 questions), abuse free care (3 questions) and timely care (2 questions). The RMC tool has correlated strongly with the global satisfaction measures, indicating criterion-related validity of the scale. Content-related validity was assured by the process of item generation. Construct validity of the 15-item RMC scale was confirmed by high average factor loading of the four components ranging from 0.76 to 0.82 and low correlation between the components.[12] The 15-item scale also showed an adequate reliability with $\alpha = 0.834$ in this study. Six research assistants who were 600 Level medical students were trained for two days on data collection to enhance validity and repeatability of the research tool prior to study. The RMC questionnaire was interviewer-administered in a private area around the respondent's home.

Data was serialized and analyzed using IBM SPSS version 22.0. Data on women's experiences of RMC was assessed using a 5-point Likert scale which was considered as an interval scale. A composite score was computed for all respondents using their responses to the 15 items assuming equal weighting of the items. A score of 1 was given for least correct answer and a score of 5 was given for the most correct answer giving a minimum score of 15 and a maximum score of 75. Instances where the negative response were the most correct answer, the reverse was the case. The composite scores were re-scaled to 100% using the formula (actual score – minimum score)/ (maximum score – minimum score)*100.[24] The

RMC composite score was converted to binary scale where ≤50% was classified as "disrespectful maternal care" and >50% was classified as "respectful maternity care". The composite scores were converted to precent and ≤50% was classified as "lack of respectful maternity" and >50% was classified as "respectful maternity care".

RMC and other categorized variables were described using frequency and percentage. The numerical/continuous variables were described using means (standard deviation) if normally distributed or by the median (inter-quartile range) if otherwise. Association between RMC and categorized variables were tested for statistical significance using the chi-square test. The binary logistic regression analysis was modelled to explain the relationships between maternal and pregnancy characteristics with RMC. The level of statistical significance was set at $p<0.05$. Ethical approval (Protocol number ADM/E 22/A/VOL.VII/148246) to conduct this study was sought and obtained from the Ethics and Research Committee, University of Benin Teaching Hospital. A detailed explanation of the survey was given to all eligible respondents and informed consent sought before the administration of the questionnaire. Respondents were informed that they had the right to decline participation or withdraw from the study at any time, and that there were no penalties or benefits for refusal to participate or withdrawal from the study.

RESULTS

A total of 393 mothers with mean age of 33.42 ± 7.4 years participated in this survey. A higher proportion, 178 (45.3%) of mothers were in the 30 - 39 year age group. Three hundred and twenty-three respondents (82.2%) were married, and 201 (51.1%) had attained tertiary level of education. A majority of respondents 315 (80.2%) had given birth at least once and 383 (97.5%) attended antenatal clinic during the last pregnancy. Of these, 225 (58.7%) attended ANC in a public facility, 105 (27.4%) attended ANC in a private facility while 53 (13.9%) attended both public and private facilities. Two hundred and thirty-one (58.8%) accessed delivery services in a public facility while 162 (41.2%) delivered in a private facility (Table 1).

Two hundred and one (51.1%) respondents strongly disagreed that health workers cared for them with a kind approach, while 183 (46.6%) strongly disagreed that health workers spoke to them in a language that they could understand. As regards abusive free care, 84 (21.4%) strongly agreed that the HCWs hit/slapped them during labour and delivery. Concerning timely care, 165 (42.0%), strongly agreed that HCWs kept them waiting for a long time before receiving service. With respect to discrimination free care, 151 (38.4%) strongly agreed that some of the health workers did not treat them well because of some personal attribute. (Table 2) Table 3 shows the composite scores of the domains of RMC and the overall composite score. Only 147 (37.4%) of respondents experienced a friendly care while 211 (53.7%) experienced an abusive free care. Also 252 (64.1%) of respondents experienced timely care, and 124 (31.6%) experienced a discrimination free care. Overall, 141 (25.1%) mothers experienced RMC during child birth. Bivariate analysis showed primiparity/multiparity ($p=0.018$), utilizing a public facility for delivery ($p=0.031$), and caesarean section delivery

(p=0.030) were significantly associated with RMC. (Table 4) With a one year increase in age, the respondents were 1.011 times more likely to experience respectful maternity care. This was however not statistically significant (AOR: 1.011; 95% CI= 0.982-1.042; p=0.445). Mothers who were never married were 1.115 more likely to experience respectful maternal care compared to mothers who were married. This was however not statistically significant. (AOR: 1.115; 95%CI: 0.643-1.932; p=0.698). Mothers with no formal education were 68.2% less likely to experience respectful maternity care compared to mothers with formal education. This was statistically significant (AOR: 0.318; 95% CI=0.106-0.956; p=0.041) at the multivariate level, after controlling for confounders.

Table 1: Socio-demographic characteristics, antenatal and delivery history of respondents

Variable	Frequency (n = 393)	Percent
Age group (years)		
<20	20	5.1
20-29	99	25.2
30-39	178	45.3
40-49	96	24.4
Mean age ± SD	**33.42 ± 7.449**	
Religion		
Christianity	292	74.3
Islam	98	24.9
ATR	3	0.8
Marital status		
Married	323	82.2
Separated	28	7.1
Cohabiting	16	4.1
Single	14	3.6
Widowed	12	3.1
Level of education		
Tertiary	201	51.1
Secondary	106	27.0
Primary	61	15.5
No formal education	25	6.4
Parity		
Nulli-para	78	19.8
Primi /Multi-para	315	80.2
Attended antenatal care		
Yes	383	97.5
No	10	2.5
Type of health facility attended for last antenatal care (n = 383)		
Public only	225	58.7
Private only	105	27.4
Both	53	13.9
Type of health facility attended for last delivery		
Public	231	58.8
Private	162	41.2
Mode of Delivery		
Vaginal	308	78.4
Caesarean	85	21.6

Table 2: Respondents experiences of respectful maternity care

	RESPECTFUL MATERNITY CARE (n = 393)				
	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
Friendly care					
I felt that health workers cared for me with a kind approach	50 (12.7)	80 (20.4)	2 (0.5)	60 (15.3)	201 (51.1)
The health workers treated me in a friendly manner	49 (12.5)	81 (20.6)	4 (1.0)	78 (19.8)	181 (46.1)
The health workers talked positively about pain and relief	54 (13.7)	51 (13.0)	18 (4.6)	105 (26.7)	165 (42.0)
The health worker showed his/her concern and empathy	69 (17.6)	58 (14.8)	6 (1.5)	88 (22.4)	172 (43.8)
All health workers treated me with respect as an individual	63 (16.0)	70 (17.8)	6 (1.5)	81 (20.6)	173 (44.0)
The health workers spoke to me in a language that I could understand	66 (16.8)	71 (18.1)	4 (1.0)	69 (17.6)	183 (46.6)
The health provider called me by my name	41 (10.4)	84 (21.4)	46 (11.7)	76 (19.3)	146 (37.2)
Abuse free care					
The health worker responded to my needs whether or not I asked	83 (21.1)	51 (13.0)	2 (0.5)	93 (23.7)	164 (41.7)
HCWs hit/slapped me during labour and delivery	84 (21.4)	54 (14.5)	37 (9.4)	92 (23.4)	123 (31.3)
The health workers shouted at me because I haven't done what I was told to do	85 (21.6)	52 (13.2)	17 (4.3)	98 (24.9)	141 (35.9)
Timely care					
I was kept waiting for a long time before receiving service	165 (42.0)	73 (18.6)	9 (2.3)	52 (13.9)	94 (23.2)
I was allowed to practice cultural rituals in the facility	85 (21.6)	52 (13.2)	72 (18.3)	60 (15.3)	124 (31.6)
Service provision was delayed due to the health facilities' internal problems	122 (31.0)	67 (17.0)	74 (18.8)	50 (12.7)	80 (20.4)
Discrimination free care					
Some of the health workers did not treat me well because of some personal attribute	151 (38.4)	112 (28.5)	27 (6.9)	41 (10.4)	62 (15.8)
Some health workers insulted me and my companions due to my personal attributes	133 (33.8)	105 (26.7)	31 (7.9)	32 (8.1)	92 (23.4)

Mothers who were nullipara were 47.3% less likely to experience respectful maternity care compared with primiparous/multiparous mothers. This was statistically significant (AOR: 0.527; 95% CI=0.294-0.945; p=0.032). Mothers who used public health facilities for their last delivery were 62.3% times more likely to experience respectful maternity care compared with mothers who used private health facilities. This was statistically significant (AOR: 1.623; 95% CI: 1.047-2.516; p=0.03). Women who had given birth by a vaginal delivery were 39.3% less likely to experience respectful maternity care. This was however not statistically significant (AOR: 0.607; 95% CI=0.366-1.007; p= 0.053) at the multivariate level. (Table 5)

DISCUSSION

Maternal mortality ratios remain among the least equitable of all health indicators, ranging from less than five maternal deaths per 100 000 live births in high-income countries to more than 500 per 100 000 live births in several countries in sub-Saharan Africa.[25] In view of the importance of RMC and its role in the achievement of Sustainable Development Goal 3,[26] this study was carried out to assess the experiences of women who delivered in health care facilities and the predictors of RMC in Benin City. This study builds on current literature by validating the 15-item RMC scale in a Nigerian population. The socio-demographic findings showed that respondents had a mean age of 33.42 ± 7.4 years with a higher proportion of respondents in the age group 30 – 39 years.

This is consistent with findings from similar studies conducted to assess RMC among women accessing facility based delivery in Enugu,[19] and Ile-ife,[27] Nigeria. Evidence indicates that this age group has the highest mortality ratio[25] and so, interventions that ensure that they obtain quality care through facility-based deliveries with skilled birth attendants will impact positively in lowering maternal morbidities and mortality. Formal education is considered particularly important for women, given that it leads to economic empowerment. Nine in ten women studied had formal education. Level of education was a significant predictor of RMC after controlling for confounders in this study.

Table 3: Composite domain and overall score on experience of respectful maternity care among respondents

Domains	Frequency (n = 393)	Percent
Friendly care		
Yes	147	37.4
No	246	62.6
Abusive free care		
Yes	211	53.7
No	182	46.3
Timely care		
Yes	252	64.1
No	141	35.9
Discrimination free care		
Yes	124	31.6
No	169	68.4
Respectful maternity care		
Yes	141	35.9
No	252	64.1

Table 4: Association between respondents' socio-demographic/pregnancy-related characteristics and respectful maternity care

Variable	Respectful Maternity Care		Test statistics	p–value
	Yes (n = 141)	No (n = 252)		
Age group as at last birthday (in years)				
<20	9 (47.4)	10 (52.6)	$\chi^2 = 4.473$	0.215
20-29	28 (28.0)	72 (72.0)		
30-39	66 (37.1)	112 (62.9)		
40-49	38 (39.6)	58 (60.4)		
Marital status				
Married	4 (28.6)	10 (71.4)	$\chi^2 = 3.022$	0.554
Separated	114 (35.3)	209 (64.7)		
Cohabiting	10 (35.7)	18 (64.3)		
Widowed	7 (58.3)	5 (41.7)		
Single	6 (37.5)	10 (62.5)		
Religion				
Christainity	104 (35.6)	188 (64.4)	$\chi^2 = 0.048$	0.976
Islam	36 (36.7)	62 (63.3)		
ATR	1 (33.3)	2 (66.7)		
Highest level of education			$\chi^2 = 6.223$	0.101
No formal*	4 (16.0)	21 (84.0)		
Primary	27 (44.3)	34 (55.7)		
Secondary	39 (36.8)	67 (63.2)		
Tertiary	71 (35.3)	130 (64.7)		
Parity				
Nulli-para	19 (24.4)	59 (75.6)	$\chi^2 = 5.613$	**0.018**
Primi/Multi-para	122 (38.7)	193 (61.3)		
Antenatal care in last pregnancy				
Yes	138 (36.0)	245 (64.0)	$\chi^2 = 0.154$	0.489
No	3 (30.0)	7 (70.0)		
Health facility used in last delivery				
Public Hospital	93 (40.3)	138 (59.7)	$\chi^2 = 4.677$	**0.031**
Private Hospital	48 (29.6)	114 (70.4)		
Mode of delivery				
Vaginal	102 (33.2)	206 (66.8)	$\chi^2 = 4.719$	**0.030**
Caesarean section	39 (45.9)	46 (54.1)		

Table 5: Predictors of respectful maternity care among respondents

Variables	B (regression coefficient)	p value	Odds ratio	95% C.I. for Odds ratio	
				Lower	Upper
Age (years)	0.011	0.445	1.011	0.982	1.042
Marital status					
Never married	0.109	0.698	1.115	0.643	1.932
Ever married*			1		
Level of education					
No formal	-1.147	**0.041**	0.318	0.106	0.956
Formal*			1		
Number of Children					
Nullipara	-0.641	**0.032**	0.527	0.294	0.945
Primipara/Multipara*			1		
Facility used for last delivery					
Public	0.484	**0.030**	1.623	1.047	2.516
Private			1		
Mode of delivery					
Vaginal	-0.499	0.053	0.607	0.366	1.007
Caesarean *			1		

**Reference category, R^2 (coefficient of determination) = 5.1% to 7.0%*

This finding is congruent with the finding of a study conducted in four countries which showed that younger, less educated women were most at risk of lack of RMC, suggesting inequalities in how women are treated during childbirth.[20] However, being educated alone is not a sufficient cause to receive RMC. Provision of culturally-appropriate services, which takes account of the preferences and aspirations of individuals and the cultures of their communities, is also an important component of RMC.[18] As such, health care providers who lack cultural competences when providing maternity care services can affect the decisions of women, educated or not, and their families on the use of skilled maternity care.[28] In line with this, the World Health Organization (WHO) made a recommendation supporting 'culturally-appropriate' maternity care services to improve maternal and new born health.[29]

While women recall childbirth experiences accurately within twenty years[30], this study assessed women who had given birth within 3-months to minimise recall bias. Consistent with the literature,[19,20,27,30,31] our survey revealed a low proportion of respondents experienced RMC during facility-based childbirth. This finding further highlights the pervasive nature of a poor RMC in healthcare facilities, exposing a crucial gap in quality of care. Quality maternal and newborn care requires more than just access to interventions, drugs and commodities.[32] A fundamental component of quality care is respectful and inclusive care. There is thus the need for an urgent public health response through

targeted interventions to provide facility based deliveries that must include respect, be tailored to women's needs, and importantly must be provided by health workers who can combine clinical knowledge and skills with interpersonal and cultural competence.[32] In contrast to findings of a study conducted in Ethiopia,[24] respondents who gave birth at public facilities experienced a significantly higher proportion of RMC, compared with those who gave birth in private facilities. This may be due to the high expectations of mothers who give birth in private facilities, considering that they pay more than their counterparts in public facilities in accessing maternal and child-health services. It is important to note that respectful maternity care is not merely the absence of mistreatment. As such, they desire more attention and RMC.[32] In addition, a higher proportion of nulliparous mothers experienced a lack of RMC, compared to multiparous mothers. This may be explained by the fact that as new mothers undergoing labour and childbirth for the first time, the experience may be daunting especially if they have been deprived of pain medication or a support base in the form of close relative to be present. Mothers who had vaginal births were also less likely to experience RMC. This finding is consistent with a systematic review conducted in 2014.[8] A lack of supportive attendance during birth and being subjected an excessive number of intrusive vaginal examinations and fear of being cut (an episiotomy) are experiences a mother having a vaginal delivery has to contend with.[32] Further research is needed to understand how institutional structures and processes can be reorganised to provide better RMC.

In conclusion, this study revealed a low proportion of RMC among the respondents. Predictors of RMC were formal education, multi-parity and use of public facility, Multi-level interventions at the facility level such as policy formulation, setting up quality improvement teams, monitoring of disrespect and abuse, as well as effective communication and engagement of health care providers is essential for the provision of RMC in all contexts and settings.

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