# **KNOWLEDGE AND EXPERIENCE OF POSTNATAL WOMEN ON ‘RESPECTFUL MATERNITY CARE’ DURING CHILDBIRTH IN SELECTED HEALTH FACILITIES IN NIGERIA**

1. Dunsin Tomisin Adeyemi RN, RM. BNSc. E-mail address: princessdunsin@gmail.com
2. Chizoma Millicent Ndikom RN, PhD, FWACN. E-mail address: [cmndikom@gmail.com](mailto:cmndikom@gmail.com)
3. \*Ifeoluwapo Oluwafunke Kolawole RN, MSc. E-mail address: ifeabolarin2014@gmail.com

Affiliation: 1,2,3 Department of Nursing, Faculty of Clinical Sciences, College of Medicine, University of Ibadan, Nigeria.

\*Corresponding Author

**Background**

About 800 women die from preventable pregnancy or childbirth-related complications around the world every day. Almost all maternal deaths (9 out of 10 women) occur in developing countries. More than half of these deaths occur in sub-Sahara Africa and approximately one-third occurring in South Africa (World Health Organization, 2014). Out of an estimated 303,000 maternal deaths that occurred worldwide in 2015, 99% occurred in low-and middle income countries (WHO, 2015; Alkema, Chou, Hogan, Zhang, Moller & Gemmill, 2015), including Nigeria with a high maternal mortality ratio (MMR) estimated at 814 maternal deaths per 100,000 live births (WHO, 2015).

Ensuring skilled birth attendant for all deliveries is a key strategy to reducing global, regional and national maternal mortality ratio and target three of the Sustainable Development Goals (SDG). While access to routine maternity care is not yet guaranteed for many women during childbirth in Nigeria, studies indicate that women using skilled birth attendants at childbirth are subjected to poor quality of care in form of abusive and disrespectful care (Ishola, Owolabi & Filippi, 2017; Iloh, Ofoedu, Njoku, Odu, Ifedigbo & Iwuamanam, 2012).

Respectful Maternity Care encompasses respect for women’s basic human rights that includes respect for women’s autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care (Rosen, Lynam, Carr, Reis, Ricca, Bazant, and Bartlett, 2015). Women may refuse to seek care from a provider who ‘abuses’ them or does not treat them well, even if the provider is skilled in preventing and managing complications**.** It is worthy of note that disrespect and abuse during childbirth violates the fundamental obligation to provide support and healing. Therefore, interventions should focus on improving the quality of care which RMC is one of its components. To Donabedian, quality of care (QoC) is central to providing health services that respect, protect and fulfil our most basic human right to the highest attainable standard of health (Donabedian 1988 in Xesfingi and Vozikis, 2016). It also involves a well-planned care process (care activities including respectful maternity care) which will result into a positive outcome such as satisfaction. Therefore, care should be based patient-centered and delivered with empathy.

Ensuring facility – based RMC is also essential for improving maternal and neonatal health, especially in Sub-Saharan Africa countries where mortality and non-skilled delivery care remain high (Dynes, Twentyman, Kelly, Maro, Msuya, Dominico et al, 2018). Lack of RMC is not merely an interpersonal problem, but, rather, is driven by health system structures and social norms (Sadler, Santos, Ruiz-Berdún, Rojas, Skoko, Gillen, 2016 & Warren, Njue, Ndwiga and Abuya, 2017). A little understood the component of the poor quality of care experienced by women during facility-based childbirth is disrespectful and abusive behavior of health care providers and other facility staff. Acknowledgment of these behaviors by policymakers, program staff, civil society groups, and community members indicates that the problem is widespread (Bowser and Hill, 2010). In a landscape analysis conducted in 2010, these behaviors were categorized into seven manifestations; Physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities (Bowser and Hill, 2010).

Lack of Respectful Maternity Care (RMC) is common and pervasive problem that extremely impacts marginalization of women. Disrespect and abuse of women during childbirth by the attending staff in health facilities has been widely reported in many countries such as Nigeria. As revealed by studies and national surveys, lack of courtesy and respect in health facilities and perceived poor quality of care are linked to low uptake of maternal health care services in almost all geographical regions of the country (Tebekaw, James and Thupayagale-Tshweneagae, 2015). The presence of hostile or insensitive staff and disallowance of birth companions (Tebekaw et al, 2015), disrespectful care, women’s lack of autonomy (Tarekegn, Lieberman and Giedraitis, 2014) and privacy, inadequate facilities in labour ward, and abuse by staff (King, Jackson, Diets & Hailemariam, 2015) are among the constellation of factors that actively deter women from attending for facility-based childbirth. These also denied their rights to high quality childbirth services as declared by the United Nations (United Nations General Assembly, 2012). Detention of women, physical abuse, verbal abuse and lack of informed consent were also reported in Addis Ababa (Mirkuzie, 2014).

In Nigeria, very few studies have explored women’s experiences of disrespectful and abusive maternity care. Two of such explored how mistreatment occurred and its acceptability among service users and providers (Ishola et al., 2017). One study identified scenarios of mistreatment in two health facilities including - verbal abuse, slapping, physical restraint and refusing to help a woman during childbirth. These were seen as perceived as acceptable and appropriate measures to make mothers comply with healthcare providers’ instructions for the safe birth of their child. Meanwhile, in the other study, both healthcare providers and women reported how they had either witnessed or experienced verbal and physical abuse and detainment at health facilities (Bohren, Vogel, Tunçalp, et al, 2017). Beyond these studies, there has been little investigation into women’s experiences of disrespect and abuse in Nigeria. However, there has been a relative lack of public health research documentation on the problem stated above in Nigeria. Hence the need for this study to assess women’s satisfaction and experiences on respectful maternity care.

**Methods**

**Study design and setting**

This is a descriptive cross-sectional survey. Three primary health centers and one tertiary hospital were included in the study, all from Ibadan which is a capital-city of a sub-region in Nigeria and are mainly rendering maternity care.

**Population of the study and sample size**

The target population for this study included postnatal women who had a child or more. The recruitment was done at the selected health facilities either in the lying-in wards or infant welfare clinics. The study population included all women aged 19- 45years. In all, a total of 151 out of the available 206 participants were recruited for the study. A simple random sampling technique was used for the selection. The randomization was done by ballot and these ballot paper consisted of odd and even number. Participants that chose even numbers were recruited for the study.

**Research instrument, data collection and processing**

A semi-structured self-administered questionnaire was used for data collection. It comprises of five categories: A-7 item section which elicited information about participants’ socio-demographic characteristics. A section containing items on the knowledge of postnatal women on respectful maternity care. The mean aggregate score on knowledge was 21. Those who scored 20.9 and below were categorized to have poor knowledge and those who scored 21 and above were categorized to have good knowledge. Another section comprising of the questions about the experience of postnatal women on respectful maternity care during childbirth. The mean aggregate score on women’s experience was 8. Those who scored below 8 were said to have negative experience while those who scored 8 and above were said to have positive experience about respectful maternity care. A section measuring the level of satisfaction of respondents on respectful maternity care andon aspect to improve on respectful maternity care. The mean aggregate score for this section was 47. The respondents who scored below 47 were seen to have low level of satisfied and those whose scored 47 and above were categorized to have high level of satisfaction with the maternity care received. The last section contained the items which enabled the respondents to indicate their intention to patronage the healthcare facilities during the subsequent childbirth.

Following the subjection of the instrument to the scrutiny of research experts with moderate modification, the instrument was pretested among 20 patients and the reliability coefficient of 0.78 was adopted.

Ethical approval for the study was obtained from the UI/UCH ethical committee with assigned number UI/EC/18/0331. Institutional approval was also obtained from the administrative Heads of the selected facilities respectively. Informed consent forms were given to participants providing information on the essence of the study and seeking their consent to take part in the study.

The participants were met in their various wards and clinics. They were selected base on their availability at the time of data collection after which they were randomly selected. Following the explanation on the study purpose, the questionnaires were distributed and an average of 30 minutes was spent to complete the questionnaire. SPSS version 23 software was used to analyze data collected.

**Results**

**Socio-demographic and service related characteristics of participants**

A total number of one hundred and fifty one respondents participated in this study with an average age of 28.60 ± 5.914 years. More than half 88(58.3%) of the respondents were within 18 and 29 years. most of the respondents 89 (58.9%) had a child or 2 children. About half 69(45.9%) of the respondents had up to tertiary level of education (Table 1).

**Table 1: Socio-demographic characteristics of the respondents n = 151**

|  |  |  |
| --- | --- | --- |
| **Variables** | **Frequency** | **Percent** |
| **Age (in years) n=(151)** |  |  |
| 18-29 | 88 | 58.3 |
| 30-39 | 52 | 34.4 |
| ≥40 | 11 | 7.3 |
| **Level of education** |  |  |
| None | 5 | 3.3 |
| Primary | 14 | 9.3 |
| Secondary | 63 | 41.7 |
| Tertiary | 69 | 45.7 |
| **Number of children** |  |  |
| ≤two | 89 | 58.9 |
| ≥three | 62 | 41.1 |

**Respondents’ level of knowledge on respectful maternity care**

The mean aggregate score for the questions related to the level of knowledge about respectful maternity care was 21. Therefore, those respondents who score below 21 were categorized to have poor knowledge while those who scored from 21 and above were categorized to have good knowledge. This reveals that 69(45.7%) had poor knowledge while 82(54.3%) had good knowledge about respectful maternity care (Figure 1).Also, the respondents’ level of satisfaction with respectful maternity in this study, revealed that most 102(67.5%) respondents had high level of satisfaction on respectful maternity care whole 49(32.5%) had low level of satisfaction (Figure 1).

**Figure 1: Respondents’ level of knowledge, Satisfaction and Experience of respectful maternity care**

**Respondents’ experience of women on respectful maternity care**

Findings from this study reveal that 39(25.8%) had negative experience (Table 2) while 112(74.2%) had positive experience about respectful maternity care.

**Table 2: Respondents’ experience of women on various types disrespectful maternity care n = 39**

|  |  |  |
| --- | --- | --- |
| **Variables** | **Responses** | |
| **Kind of abuse** | **N** | **Percent** |
| Slapping | 4 | 10.3 |
| Hitting | 5 | 12.8 |
| Pushing | 4 | 10.3 |
| Kicking | 4 | 10.3 |
| Shouting | 15 | 38.5 |
| Forcing | 7 | 17.8 |

**Participants’ intention to patronize the healthcare facility during subsequent childbirth**

The results also shows that 127 (84.1%) had intention to patronize the healthcare facility during the subsequent childbirth, while 15(1%) indicated no and only 9(0.6%) were not sure as at the time of data collection (Table 3).

|  |  |  |
| --- | --- | --- |
| **Variables** | **Responses** | |
| **Patronize the hospital** | **N** | **Percent** |
| Yes | 127 | 84.1 |
| No | 15 | 1.0 |
| Not sure | 9 | 0.6 |

**Association between education level and knowledge of respectful maternity care**

As shown in table 4, the study reveals that women’s level of education is not a strong determinant of their knowledge of respectful maternity care (ᵡ= 6.383, p = 0.094).

**Association between participants’ knowledge and experience of respectful maternity care**

This study found respondents’ knowledge about respectful maternity care does not influence the experiences of care they received (ᵡ = 0.328, p = 0.567) (Table 4).

**Association between experience of care received and intention of subsequent use of health facilities for care**

The study shows that participants’ experiences of care received influence their intention of subsequent use of health facilities for care (ᵡ = 8.935, p = 0.011) as found in table 4.

**Association between the number of children and the participants’ experience of respectful maternity care**

Also from table 4, the results show the number of children is not a determinant of the nature of participants’ experience of respectful maternity care (ᵡ = 2.628, p = 0.105).

**Table 4: Association between Selected Variables**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Variables** | **Knowledge category** | | **Total** | **χ2** | **p-value** |
| **Ho1: Education** | **Poor (%)** | **Good (%)** |  |  |  |
| None | 0(0.0) | 5(100) | 5 | 6.383 | 0.094 |
| Primary | 7(500.0) | 7(50.0) | 14 |  |  |
| Secondary | 23(36.5) | 40(63.5) | 63 |  |  |
| Tertiary | 39(56.5) | 30(43.5) | 69 |  |  |
|  |  |  |  |  |  |
| **Ho2: Experience** |  |  |  |  |  |
| Negative | 19(48.7) | 20(51.3) | 39 | 0.328 | 0.567 |
| Positive | 50(44.6) | 62(55.4) | 112 |  |  |
| **Variables** | **Experience category** | | **Total** | **χ2** | **p-value** |
| **Ho3: Patronize the hospital** | **Negative** | **Positive** |  |  |  |
| Yes | 27(21.3) | 100(78.7) | 127 | 8.935 | 0.011\* |
| No | 8(53.3) | 7(46.7) | 15 |  |  |
| Not sure | 4(44.4) | 5(55.6) | 9 |  |  |
| **Ho4: Number of children** |  |  |  |  |  |
| ≤2 | 17(19.1) | 72(80.9) | 89 | 2.628 | 0.105 |
| ≥ 3 | 22(30.9) | 40(69.1) | 62 |  |  |

\* Significant at p-value less than 0.05

**Discussion**

This study was conducted to examine the knowledge and experience of women about respectful maternity care received during childbirth. The results show that the mean age of the participants was 28.60 years and many had tertiary education as their highest level of education. This is in contrast to the findings of Moore, Alex-Hart & George, (2011) in a study conducted in Southern region of Nigeria where most women studied had no formal education.

Good knowledge found about respectful maternity care among women in this study could be attributed to the urban location of the healthcare facilities where they have access to health information including those related to the care of a woman during childbirth. This supports the findings of Mathew (2006) in Bangalore.

Findings from the study revealed that women had positive experience with the maternity care they received. This shows that their expectations were met as they were able to leave the health facilities without complications to both the mothers and the babies and probably because they did not want to discuss the conducts of health personnel in the public. This contradicts the what Ishola et al. (2017) found in their study conducted in Nigeria that women experienced disrespect and abuse during childbirth due to the failure of health system. Same could be found in Sheferaw, Menesha & Wase, 2016; Warren et al. 2017 and Balde, Bangoura, Sall, Balde, Niakate, Vogel & Bohren, 2017).

Maternal satisfaction is one of the most frequently reported outcome measures for quality of care, and it needs to be addressed to improve the quality and efficiency of health care during pregnancy, childbirth, and puerperium to provide quality maternal-friendly services. The current study shows that mothers were satisfied with the service delivery. This corroborates the findings of a study conducted in Nepal which shows that a greater percentage of participants were highly satisfied with the manner of maternity care (Paudel, Mehata, Paudel, Dariang, Aryal, Poudel, King & Barnett, 2015).

To a greater extent, the level of education of participants was not a determinant of their level of education. This contradicts what Mathew reported in 2006 that mothers’ education was a strong determinant of their knowledge about respectful maternity care. Also, the participants’ knowledge is by no means influence the nature of their experience about respectful maternity care received. This is in line with the findings of Warren et al. in 2017 that women tend to experience disrespect and abuse during labour and childbirth at health facilities regardless of their knowledge and personal characteristics. Considering the influence of participants’ experience on their intention to patronize the healthcare facilities during the subsequent childbirth, this study found that their positive experience made them to have a strong intention to patronize the health facilities in the future. This supports what Taebekaw et al. (2014) had earlier documented.

**Conclusion**

The study participants had good knowledge and positive experience on respectful maternity care. They also had high level of satisfaction of RMC they received at the health facilities and were willing to patronize the centers in the future. Regardless of the commendation, it is important that nurses take out time to develop and comport themselves professionally in order to uphold the basic tenets of the nursing profession and also preserve their individual esteem and respect. Women who are respectfully cared for in the labor room will experience extreme satisfaction and better quality outcome of maternity care. This will also enhance their chance of participating in their care. In view of the above, all efforts to improve on provision of RMC should be encouraged in addition to those instituted to prevent mortality and morbidity to achieve safe motherhood. Also, global health leaders, researchers, advocacy groups and other key stakeholders must collaborate to develop a global definition of the mistreatment of women during childbirth.

Such efforts are necessary to put the mistreatment of women during childbirth on the global agenda, especially in the context of Sustainable Development Goals 3 (ensure healthy lives and promote well-being for all at all ages) and 5 (achieve gender equality and empower all women and girls). Finally, any intervention to prevent mistreatment will need to be multifaceted, and researchers where and when necessary, implementers and policy-makers should consider lessons learned from related interventions, including audit and feedback, labor companionship and stress-coping mechanisms for providers.

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