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■ Original Research Article

Respectful Maternity Care Practice: An Assessment of Paturients' Experience at Federal Medical Center Birnin Kebbi, Nigeria

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ABSTRACT

Background: Respectful maternity care (RMC) refers to treating pregnant women with respect when providing care in pregnancy, labour, and delivery. It contributes to a positive maternity care experience. The aim of the study was to assess RMC practice at the study centre. **Materials and Method:** A cross-sectional research where 370 parturients were studied; RMC was assessed through questions on information sharing, consent seeking and staff attitude using a structured questionnaire. Data analysis was with SPSS version 20, results were presented as descriptive statistics. Statistical significance was tested using a chi-square test at a p-value of < .05. **Results:** The respondents were mainly within the 20 – 39 years age category (95.9% N = 355). They were mostly booked (83.5%, N = 309), married (95.1%, N = 352), and multiparous (52%; N = 194), with secondary level of education (50.0%; N = 185). About 83% (N = 298) of them were informed about their clinical state at admission and 71.7% of the 138 who had episiotomy (N = 99) were given prior information about this procedure. About 69%, (N = 255) and 85% (N = 314) of them received information about their fetuses and their progress in labour respectively while 46.2% (171) were told the weight of their babies. Consent for vaginal examination and for episiotomy was sought in 86.8% (N = 321) and 64.9% (N = 91/138) respectively. Labour room staff were attentive in 96% (N = 356), and privacy was adequate in 89.6% (331) of cases. **Conclusion:** RMC practice was assessed to be satisfactory at the study centre.

Key words: Respectful Maternity Care, Labour Care, Staff Attitude, Quality of Care

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INTRODUCTION

The concept of respectful maternity care (RMC) refers to treating pregnant women with respect in the course of interacting with them during pregnancy, labor, and delivery, it is a very important component of quality of care and is viewed as a fundamental human right.[1,2] Shakibazadeh et al described 12 domains of respectful maternity care among which are the rights of women to information, informed consent, privacy, and confidentiality while delivering care to pregnant women during the course of labor and delivery.[2] It is believed that the provision of RMC services in health facilities could improve women's access to maternity care services.[3] WHO considers RMC to be a human

rights issue where every woman is seen to have the right to respectful care during pregnancy and childbirth, and for this reason WHO has called on governments, researchers, and communities to support the practice of RMC.[1]

In line with this call for support, this study was designed to assess the practice of RMC in a federal tertiary center in northwestern Nigeria by looking at paturients' experience of some elements of RMC such as information sharing, consent seeking, and staff attitude. The data generated could provide information about the extent to which these aspects of RMC are practiced in this strategically located tertiary health facility. The content could also serve as a guide to the design and implementation of public health campaigns in support of RMC in health facilities that are concerned with the provision of maternity care services. The study is thus timely as it has the potential to provide information about quality of care provided at this tertiary center. The specific objectives of the study were:

- To assess the demographic profile of women who utilized the services at the facility during the study period.
- To assess the extent of information sharing about processes in labor
- To evaluate client involvement in decision making about labor care processes

MATERIAL AND METHODS

The study was cross sectional in design; it targeted pregnant women who delivered by the vaginal route without complications during the 2-year study period and a total of 370 women who met these criteria during the 2-year frame and were included in the study. The researchers explored the practice of RMC in the study facility by assessing parturients' perception of staff attitude (staff attentiveness during labor), their participation in decision making regarding maternity care processes (consent to vaginal examination and consent to episiotomy), and their perception of the extent to which information about key maternity care processes was provided. These processes included admission into labor room (information about maternal clinical state), labor monitoring (indication for vaginal examination and information about fetal condition), and conduct of vaginal delivery (indication for episiotomy, provision of privacy), fetal outcome (information about the sex and weight of the baby at delivery). Information was also collected about respondents' relevant sociodemographic and clinical data that included age, parity, marital status, level of education, and employment status.

The survey was performed in the labor ward of the study facility and the data collection tool was a structured questionnaire which was administered by the researcher and trained research assistants to all women who had met the inclusion criteria for the study. The data generated was analyzed using SPSS version 20 and presented as proportions. Where applicable, test of significance was performed using chi square test, and p value less than .05 was considered significant.

RESULTS

Four hundred and two women who delivered via the vaginal route during the 2-year study period consented to participate in the study and 370 of them who had complete record were studied. Most of them (95.9% N = 355) belonged to the age group category of 20 – 39 years, 50.0% (N = 185) of them had achieved up to secondary level of education, 35.4% (N = 131) had tertiary level and the rest were not formally educated or had achieved only the primary level of education. The respondents were mostly married women (95.1%, N = 352); 49.7% (N = 184) were not in any formal employment, while the rest were either self- or government employed. About 52% of them (N = 194) were multiparous and 16.2% (N = 60) were grand multiparous; 83.5% (N = 309) had received antenatal care for the index pregnancy. Further details are provided in Table 1.

Close to 84% (N = 310) of the clients received information about their clinical state at the time of admission (Table 2); all the respondents had vaginal delivery and 98% (N = 362) of them admitted to having had at least one vaginal examination in the course of their labor. One hundred and thirty-eight parturients had episiotomy at delivery, giving an episiotomy rate of 37.3%. Significantly more primiparous women had episiotomy (75.8%, N = 97/128) compared to the multiparous (28.4%, N = 58/204) and grand multiparous women (11.7%, N = 7/60) (X^2 = 98.4, df 2, p < .001). About 82.3% (N = 298) of the women who had a vaginal examination were informed about the indication and 71.7% (N = 99/138) of those who had episiotomy were given information about the indication for the procedure before it was done. Also, most of the respondents

Table 1: Respondents' Sociodemographic Characteristics

Respondent characteristics	Respondents	
	Number	%
Age category		
<20 yrs.	10	2.7
20 - 39yrs	355	95.9
≥40yrs	5	1.4
Total	370	100.0
Educational status		
No Formal education	33	8.9
Primary level	21	5.7
Secondary level	185	50.0
Tertiary level	131	35.4
Total	370	100.0
Marital status		
Single	18	4.9
Married	352	95.1
Total	370	100.0
Parity		
Primipara	116	31.4
Multipara	194	52.4
Grandmultipara	60	16.2
Total	370	100.0
Antenatal booking status		
Booked	309	83.5
Unbooked	61	16.5
Total	370	100.0
Employment status		
Not employed	184	49.7
Self employed	59	15.9
Govt. employed	104	28.1
Not stated	23	6.2
Total	370	100.0

(84.8%, N = 314) received information about their progress and 68.9%, (N = 255) received information about the status of their fetuses in labor. While most of the respondents (93%, N = 344) received information about the sex of their baby, only 46.2% (171) were told the weight of their babies at birth.

Regarding consent to procedure, consent for vaginal examination and for episiotomy was sought in 86.8% (N = 321) and 64.9 (N = 91/138) of cases respectively. About 96% (N = 356) of the respondents felt that the labor room staff were attentive to their needs and 89.6% (331) felt that they were provided with adequate privacy while in labor; details of these are provided in Table 3.

Table 2: Information Sharing on Maternity Care Processes

Clinical Variables for which information was provided to the parturient	Respondents who received information about the Clinical variables		
	YES (%)	NO (%)	Total
Parturient's clinical state	310 (83.8)	60 (26.2)	370
Indication for VE	298 (82.3)	64 (17.7)	362
Progress of Labor	314 (84.8)	56 (15.2)	370
Fetal status in labor	255 (68.9)	115 (31.1)	370
Indication for episiotomy	99 (71.7)	39 (28.3)	138* (100)
Birth weight	171 (46.2)	199 (53.8)	370 (100)
Sex of Baby	344 (93)	26 (7)	370 (100)

Note *Number of parturients who had episiotomy.

Table 3: Respondents' Experience of Respectful Maternity Care

Elements of Respectful Maternity Care	Proportion of Respondents (%)		
	YES	NO	TOTAL
Consent for vaginal examination (N =)	321 (86.8)	41 (11.7)	362* (100)
Consent for episiotomy (N = 138) *	91 (64.9)	47 (35.1)	138* (100)
Attentiveness of labour room staff	356 (96.2)	14 (3.8)	370 (100)
Privacy in labour ward	331 (89.5)	39 (10.5)	370 (100)

Note *Number of parturients who had episiotomy.

DISCUSSION

The demographic profile of the respondents differed from what has been reported by national surveys for the region, this may be attributed to the fact that the study was not only facility-based, but it was also a tertiary level facility in contrast to national surveys that are normally done at the community level. The extent of information sharing between care providers and parturients was adequate because in most cases the parturients received information about important processes in the course of their labor and delivery. Consent was sought from the parturients in almost all the cases where procedures

such as vaginal examinations and episiotomies were to be performed.

Strengths and limitations

The methodology was robust and there was consistency in the mode of questionnaire administration thus limiting the risk for measurement bias. Some of the limitations of the study included the fact that the study was facility-based and so this limits the applicability of the findings to the general population of parturients in the study area. In addition, the demographic profile of the respondents in this study shows that the study population is not representative of the general population of pregnant women in the area with regards to age distribution and antenatal care utilization. This means that the findings may be applied to only women who sought care at the facility that the study was carried out, it may not be generalized to the wider population of women in study region.

Interpretation and Implications

This section covered the demographic and obstetric profile of the respondents, parturients' access to information labor care processes, and parturients' experience of respectful maternity care components.

The Demographic and Obstetric Profile of the Respondents

Three hundred and seventy women were studied and most of them were between the ages of 20 and 39 years with very few teenagers; in the Nigerian National Demographic and Health Survey of 2018, up to 19% of mothers surveyed were teenage mothers.[4] The reason for this difference in distribution may be because in this study the maternal age was an estimate, in most cases neither the parturients nor their relations know the actual age of the parturient.[4] As such there may have been a classification bias arising from inaccurate estimation. The result should thus be interpreted with caution because teenage pregnancy and delivery is associated with higher risk of materno-fetal complication and the findings from our study should not be seen to invalidate this relevance to maternity care outcome in the region. Educational achievement was high as 85% of the respondents had achieved at least a secondary level of education; the finding may be attributed to the facility-based nature of the research. Perhaps the finding would have been similar to the NDHS reported low levels in the area if it had been a community-based study.

Almost all the respondents reported having received ANC for the index pregnancy, so the antenatal attendance rate was high. ANC attendance rate in the region is usually low,[4] the high rate recorded in our study may be explained by the educational level of the study group; almost all the respondents had achieved a minimum of secondary level of education. The positive relationship between maternal education and antenatal care utilization has since been established.[5] So maternal level of education is an important determinant of health seeking behavior among pregnant women and this is so even for the uptake of antenatal and maternity care services.[6]

The high ANC attendance rate may also be related to the fact that we excluded women who were delivered by caesarean sections in our research. Previous studies in the area have shown that most caesarean deliveries are emergencies rather than elective and they are performed in response to complications in labor and complications are seen more often among parturients who did not receive antenatal care in their pregnancy.[7,8] It would therefore be safe to say that the exclusion of caesarean deliveries and the focus on women who were delivered vaginally in this study had automatically deselected women who were likely to have been unbooked, that is those likely not to have registered for antenatal care. So, the finding of high antenatal attendance rate in this study compared to the general population of pregnant women in the area may not be a true representation of the population of pregnant women in the region.

We found a low rate of episiotomy use in this study compared to findings elsewhere. This may be an indication that the practice of routine episiotomy for parturients may be declining. It may also be a reflection of the parity distribution of the study population; there was a smaller proportion of women who were primigravidae in this study population compared to other parities. An episiotomy is usually given to a parturient in order to reduce the risk of occurrence of a spontaneous perineal tear during delivery especially among primigravidae,[9] so it is possible that episiotomy rate would vary positively with decreasing parity. Indeed, further subgroup analysis in this study showed that significantly more primigravidae had episiotomy compared to other parities.

Parturients' Access to Information Labor Care Processes

Information about labor care processes was provided to the parturients by the care providers freely in this study. Most of the clients received information about their clinical state at time of admission; they also received information about the indication for a vaginal examination, and indication for an episiotomy where such was given. They were informed about their progress in labor, the status of their fetuses during the course of labor, and what the sex of their babies were at delivery. Providing information about steps in labor care to women in labor is valued greatly by parturients; in their qualitative study on women's needs and expectations during labor in Iran, Iravani et al[10] identified informational needs as one of the seven major needs categories that emerged from their research. They identified informational need as a major component that contributed to providing women with a "sense of control and empowerment in childbirth". [10] Access to information is therefore key to the achievement of a positive maternity care experience and is considered a measure of quality in maternity care provision.[11]

Parturients' Experience of Respectful Maternity Care Components

The parturients were also involved in the decision-making processes for their care in this study because their consent was sought for during procedures like vaginal examination and the performance of episiotomies. The finding shows that consent seeking and communication as components of respectful maternity care were optimally practiced in this centre. This is contrary to findings by Ige and Cele[3] where they reported that most of the components of RMC were not respected by the midwives who provided care in their study. The researchers attributed this poor practice to a lack of accountability and non-availability of an effective system for women to seek redress when their rights to quality care was not respected. [3]

CONCLUSION

The practice of respectful maternity care as assessed by the components of care explored in our research was satisfactory for most women studied. Staff attitude was perceived to be satisfactory. Health care providers in this study site should be encouraged to continue with the good practice.

Future research directions

Providing maternity care in a respectful manner contributes significantly to achieving a positive pregnancy and delivery experience for pregnant women, the findings from our research indicate that most of the women studied believed that the components of RMC studied were satisfactorily provided except perhaps for providing information about babies' weight at birth. However, the applicability of the research findings to the general population of women of reproductive age in the study site is limited by it being facility-based. Further research could be directed towards assessing how women in the community perceive the practice of RMC in their places of antenatal care and delivery, perhaps their perception differ from what was obtained here. Whatever findings result from these community-based studies may inform the design of interventions that would improve the practice of RMC where it was perceived by women to be poor or consolidate its practice where it was perceived to be good. An acceptable level of RMC practice may be used to advocate for better health facility utilization for a better pregnancy outcome.

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