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Evaluating Respectful Maternity Care among Postpartum Women in Selected Hospitals in Benin City, Edo State

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Abstract

This study evaluated respectful Maternity Care (RMC) among postpartum women in selected hospitals in Benin City. The objectives were to identify the practices of Respectful Maternity Care (RMC) among postpartum women in selected hospitals in Benin City, Edo state. And to identify factors affecting the practices of RMC in the study area. This study adopted a descriptive design using mixed method approach which involved the use of questionnaire as well as In-depth Interview (IDI) and Focus Group Interviews (FGI). The population were women who gave birth in January to June, 2024, who are in postnatal ward and those who are in immediate postpartum period in the selected private and public hospitals across Benin City. Hence, Random sampling method was used to select 310 participants. Data collected from the quantitative approach were analyzed and presented using tables and charts. Data from the in-depth interview and focus group interview were played, transcribed and analyzed inductively using contents, themes, sub-themes and quotes. The findings revealed that the RMC practices in the hospitals were positive. Among the nineteen highlighted practices, provision of information, respect for patient's cultural values and respect for patient's religious values were leading common positive practices which ranked 1st, 1st and 3rd respectively. In the overall, it was deduced that the RMC practices were positive in selected hospitals in Benin City as the overall mean was 3.26 out of 5.0 maximum rating. This represents 65.2% performance.

Keywords: Evaluating, Post-partum, Maternity Care, Respectful Maternity Care, Hospital

1. Introduction

1.1 Background of the Study

Healthcare Attainment in a respectful and staid manner is a fundamental right for every woman irrespective of their individual status. However, social exclusion, poor psychosocial support, and degrading care during childbirth at health facilities are regular worldwide, especially in low- and middle-income countries (Hameed *et al*, 2021) [11]. Respectful Maternity Care (RMC) means ‘‘the care prepared and rendered to all women in a way so that their privacy, confidentiality and dignity is preserved, ensuring freedom from mistreatment, harm, and enables informed choice as well as continuous assistance during labour and childbirth’’ (WHO, 2018) [37]. RMC also is a vital component in the spectrum of care that should be rendered to women during pregnancy, labour, and after childbirth (Bohren *et al*, 2019) [4]. In addition it is an integral component of excellent quality care in maternity (WHO, 2016) [35]. Labour period are notably susceptible period in the continuum and the prevalence of ill-treatment is increased in the hours prior to birth, there is increased risk for serious problems involving women as well their babies (Vedam *et al*, 2019) [33].

Globally, ill-treatment involving women during delivery in health facility is an urgent public health issue that violates women’s rights and contributes to a suboptimal uptake of lifesaving maternal health services (Bohren *et al*, 2015) [5]. Newborns may experience ill-treatment during immediate period after birth, which encompasses rights of the babies and destroys women’s confidence in the system and utilization of healthcare in future (Sacks, 2017) [29]. Consequently, RMC is capable of reducing worldwide inequities affecting maternal as well as neonatal health when promoted with the view point of

strengthening health system (Asefa, 2021) [2]. Maternal mortality has globally declined astoundingly with 45.2% decrease between year 1990 and 2017. However, a staggering division exist amid low and middle income countries (LMICs) and countries with high income, the LMICs accounts for 99% maternal deaths globally in 2017. The same year, Sub-Saharan Africa was attributed with 66% of the global maternal deaths. Moreover, the bulk of maternal mortality happened in countries that lacked adequate financing of their health care, resulting to poor quality, availability, accessibility, and also reduced utilization of maternal health services that is geared to save life. (WHO, 2019) [36]. The high rate of maternal death in LMICs point to the gap observed in connecting women's access to a high-performing health system and their right to freedom of choice. (UN, 2013) [32].

Interventions to reduce these deaths include; access to Emergency Obstetric Care (EmOC) and Skilled Birth Attendant (SBA) at childbirth. Notwithstanding, all the evidence suggest that positive outcome of women and babies resulting from disrespectful care experienced by women in the course of labour is not dependent on the increased access to SBA and EmOC alone. World Health Organization (WHO)'s guidelines highlighted that Respectful Maternity Care (RMC) is way to achieve positive experiences during birth (Mgawadere and Shuaibu, 2021) [25]. It is to this end that the research seeks to evaluate Respectful Maternity Care among postpartum women in selected private and public hospitals across Benin City.

1.2 Statement of the Problem

Due to the researcher's experience during childbirth as a woman and complaints from various women on disrespect and abuse, it was observed that many women who came for maternal care are dissatisfied with care received and some come up with complications such as postpartum haemorrhage as an outcome of disrespectful care as well as abuse in maternity. Recent studies showed that the incidence of abuse and disrespect of mothers is worse in Sub-Saharan African countries. Four studies: In Ethiopia, Kenya, Nigeria, and Tanzania figured out experiences women have in childbirth as to estimate incidence of abuse and disrespect (78%, 20%, 98%, and 28%) respectively.

Skilled professional assistance during delivery is a bedrock peculiar to worldwide efforts in reducing maternal death, but evidence from low income countries shows when care is perceived as disrespectful or unkind, women are discouraged from facility-based delivery (Seljesko *et al*, 2006; Kumbani *et al*., 2013). In line with these, the researcher seeks to evaluate Respectful Maternity Care among postpartum women in selected hospitals in Benin City, Edo state.

1.3 Objectives of the Study

The main objective of this study was evaluating respectful maternity care among postpartum women in selected private and public hospitals across Benin City, with a view to enhancing and promoting quality health care delivery.

However the specific objectives of this study were set out:

1. To identify the practices of Respectful Maternity Care (RMC) among postpartum women in selected hospitals in Benin City, Edo state.
2. To identify the factors affecting the practice of RMC in the study area.

1.4 Research Questions

1. What is the practice of RMC among postpartum women in selected private and public hospitals in Benin City, Edo state?
2. What is the aspect of Respectful Maternity Care (RMC) commonly practiced among postpartum women in the Study area?
3. What are the factors affecting the practice of RMC in the study area?

1.5 Scope of the Study

This Study focused on respectful maternity care among postpartum women in selected private and public hospitals in Benin City, Edo state. A total number of six hospitals were selected for this study, three public hospitals and three private hospitals. The Study was conducted on postpartum women who delivered and are within 0-6 weeks of delivery in university of Benin tea. This study covers a period of 2months (August to September 2021).

1.6 Significance of Study

The significance of this study on Quality of Healthcare, Health Professionals and to the body of knowledge in the area of study cannot be over-emphasized. This research is an eye opener to the health industry on how to tackle the problem of high rate of abuse and disrespect of women accessing health care, thus preventing associated negative effects. This study revealed the level of practice and effects of respectful maternity care in enhancing health care quality of women thus being of great help to solving problems such as maternal diseases and mortality.

Childbirth is a beautiful experience everyone around the world treasures and the process should be made memorable as possible for mothers and intending mothers. In view of this, the researcher is eager to ponder on the major factors that negate respectful care in maternity and how healthcare workers need to dedicate themselves to work together as a team in providing respectful maternity care.

1.7 Operational Definition of Terms

Evaluation: The process of judging or calculating the quality, importance, amount, or value of something

Respectful: Feeling or showing consideration, deference and respect or regard for someone

Maternity: The state of being a mother as it relates to a period during pregnancy, childbirth and after childbirth.

Care: Protective concern, attention, caution, prudence, responsibility or regard for someone.

Postpartum: Period immediately after birth up to six weeks.

Respectful Maternity Care: This is essential human rights which includes respecting women's beliefs, independence and emotions.

This chapter is the introduction of this research and it describes the background to the study, statement of the problem, aim of the study, specific research objectives, research questions, significance of the study, researcher's motivation for study and definition of terms.

2. Literature Review

2.1 Introduction

This chapter reviewed literature using conceptual review, empirical review and theoretical review.

2.2 Conceptual Review

2.2.1 Respectful Maternity Care (RMC) Concept

The concept of ‘‘respectful maternity care’’ has under gone many changes over the last decades to involve various aspect and frameworks, Rima (2011).

According to United States Agency for International Development (USAID) and MCHIP (2013) the historical background of the concept in relation to respectful care in maternity started spanning from 1975 in Brazil known as “Birth of humanizing Childbirth”. In 1985 World Health Organization (WHO)/Pan American Health Organization PAHO) held a conference to ascertain technology appropriate in birth.

According to Bowser and Hill (2010) [6]. In the United States of America in 1996 there was the Mother – Friendly Childbirth Initiative. The very first worldwide conference on Humanizing Childbirth which was held in Fortaleza in Brazil in 2000. Browser and Hill (2010) [6] under USAID-Traction Project produced a report on the landscape analysis on exploring prove for abuse and disrespect in facility based childbirth. The term Respectful Maternity Care came into being through the collaborative efforts of White Ribbon Alliance (WRA) and other organizations in 2011 and it was coined by the charter women rights during maternity care.

According to World Health Organization, Respectful Maternity Care is a means of providing care to women in a way to honor, esteem or in a special way of regarding their privacy as well as keeping their information secret and also make sure they are not harm or maltreated in any form allowing them to make informed choices with proper and continues support in the course of childbirth (WHO, 2018) [37]. RMC is focused on relationship between the woman and providers of health care. Nonetheless, Asefa *et al*, 2021) [3]. Has it that respectful care will be difficult to achieve when there is no viable system of health. RMC addresses the interpersonal and relational aspects of maternity care (WRA, 2011) and is a relevant efforts to increase utilization and quality of services. It is rounded in a rights-based approach, captured in White Ribbon Alliance report for Safe Motherhood.

A woman’s childbirth experience can lead to life changes with scars psychologically (Lundgren *et al*, 2009) [22]. Research reveals that a third of women expressed they had traumatic experience when giving birth (Soet *et al*, 2003) [30].

The Oxford dictionary (2015) defines ‘respectful’ as showing deference or a feeling while the synonyms were deferential, reverent, admiring, humble, reverential, dutiful and subservient. The issue of respect also depends on one’s location with cultural implications playing a part on what is a respectful greeting versus professionalism for the care giver, Ethel (2018). Maternity care according to Thesaurus (2013) is the heed, being concerned, bothered worry about motherhood this definition tallies with every woman seeking maternal health services’ expectation of safe motherhood. WRA (2011) defined Respectful Maternity Care as an approach with emphasis on good interpersonal relations of women with health service providers and staff during labour, delivery and the post-partum period. There was an analysis of the existence of maternal care under a continuum of practice without adequate resources, evidence-based standards and the unavailability of care and analysis of bioethics in the maternal health rights respectively (Burnell, 2013; Miller *et al*, 2016; Finlayson and Downe, 2013; Erdman, 2015; Kolinsky *et al*., 2016). As far as respect is concerned, the context and culture play a role, as an example professionally people look at each other in the face yet in some African cultures Nigeria included looking at an older adult or male figure in the face is disrespectful. In concurrence women feared exposing their bodies to males and strangers (Asefa and Bekele, 2015).

RMC is the marker of quality care in maternity and also ensures that basic human rights of individual woman of child-bearing age are protected (Raval *et al*, 2021) [28]. RMC being a vital component of quality care; is a human right. WHO released a statement in 2014, calling for prevention as well as total removal of abuse and disrespect during delivery, stating that ‘attainable maximum health standard is the right of every woman, the right to respectful, dignified care in pregnancy and childbirth inclusive’ WHO also demanded for governments, researchers, programmers, advocates as well as communities mobilization so as to uphold RMC. WHO (2016) [35] published new guidelines to improve quality of care for women and newborns in healthcare centres, which included a continuous and high focus on dignity preservation and respect. Quality of care has eight domains with addition of framework that has six strategic areas to help build evidence-based approach which is systematic for quality care provision:

Clinical guidelines
Standards of care
Effective interventions
Quality measures, and
Significant research and ability building.

2.2.2 Childbirth Experience

Globally in every community and country, pregnancy and delivery of baby are important events in the lives of women and their families it also a season of great vulnerability. The relationship the woman has with providers of maternity care and the care system during pregnancy and childbirth remain very important. These encounters avenues for essential health services that have lifesaving potentials, experiences of women with caregivers during this time have an empowering impact and comfort or it inflict lasting emotional trauma and damage, adding to or lowering from women’s self-esteem and confidence. Whichever way, memories of childbearing experiences live with women throughout life and are often told by them to other women, contributing to their great confidence or uncertainty in childbearing (The White Ribbon Alliance, 2012).

Around the world, pregnancy and delivery remain momentous events, with deep personal and social significance occurring in lives of women, families and communities. Women keep memories of the experiences they had in childbirth and the care giving to their babies throughout lifetime. These they often share with other women, thereby leading to increased doubt or confidence on healthcare systems (White Ribbon Alliance, 2019). A woman’s experience in childbirth can result in permanent psychological trauma (Lundgren *et al*. 2009) [22]. Research has it that a third of women narrated their experience during birth process to be traumatic (Soet *et al*, 2003) [30], such psychological torment during birth process make women uniquely vulnerable and susceptible to negative effects of environmental factors, which include medicalised procedures, and unfamiliar personnel e.t.c (Bohren *et al*, 2017). Poor experiences during care given in obstetrics may

have negative effect on quality and outcome of the woman's delivery experiences thus resulting in psychological disarray (Swahnberg *et al*, 2011) [31] and discouraging her from future utilization of health care facilities (Makumi, 2015) [23].

2.2.3 Growing evidence of Maternal Disrespect and Abuse

Naturally, a woman expects a respectful care from the health providers she has entrusted herself to. Women envisioned relationship that is depicted by empathy, caring, support, empowerment, trust, and confidence, with gentleness, respectful, as well as effective communication to help them in making informed decision, regrettably, several women don't experience care that match these characteristics. An increase knowledge of research evidences, case reports and experiences gathered during care systems in maternity from both wealthy and poor nations globally, creates different but disturbing impression. In fact, abuse and disrespect of women seeking maternity care is becoming a high-priority problem and creates an increasing group of concerns that stretches the domains of research in healthcare, education as well as quality; civil rights and human rights advocacy (The White Ribbon Alliance, 2012).

Increase in the percentage of births that skilled birth attendants (SBAs) attend to remain an important strategy in addressing high maternal/newborn morbidity and mortality rate is the maternal health target of Millennium Development Goal (MDG 5). Progress in realizing MDG 5 has been dragging because improvement requires that financial, geographical barriers needs be overcome in accessing skilled care, and the poor quality of maternity care in units. Little is understood about component of the deficient quality of care that women experienced during health facility childbirth is termed disrespectful and Abusive behaviour of providers of health care along with other staff of the facility (USAID, 2014).

Disrespect and Abuse (D&A) during labour and delivery have increased over the past decade (Burrowes *et al*, 2017) [8]. Report of studies done earlier showed varying prevalence rates which ranges from 20% in Kenya (Abuya *et al*, 2015) [1] and in Nigeria 98% (Okafor *et al*, 2015) [27]. Relevant articles reviewed shows that some multifaceted factors including excessive workload, lack of professional assistance for health care workers, hierarchical work relations, poor staffing at various levels, and insufficient infrastructures can facilitate the increased incidence of Disrespect & Abuse (Freedman and Kruk, 2015). In Ethiopia, 49.4% collective prevalence of disrespectful and abusive care during maternity care and childbirth (Kassa and Husen). Postpartum mothers in Addis Ababa were 78.6% (more than two-thirds), 67.1% in city of Bahir Dar and women in health centers(4) of Amhara and Ethiopia Southern regions which was 21% reported that they experienced one or several classes of disrespect and abuse while in labor and childbirth (Wassihun et a, 2018) [34]. In a cross-sectional study conducted in health facilities was done in forty-three health facilities across fifteen districts in Bangladesh, while 16 and 12 in Ghana and Tanzania respectively. Five and Twenty (7%) Ghanaian women, nine (6%) in Bangladesh while eight (5%) in Tanzania during care were verbally abused (Manu *et al*, 2021) [24]. In Pakistan, cross-sectional survey conducted in August-November 2016 amidst 783 women that delivered in 6 secondary public health care facilities in four neighboring locality of southern Sindh and it was revealed that 15.2% and 14.8% were verbally and physically abused respectively.

2.2.4 Categories of Abuse and Disrespect

Building on analysed landscape of disrespect and abuse globally (Bowser and Hill, 2010) [6] the categories of D&A include:

1. Non-confidential care: Many people perceive non-confidential care as
   a) Examination, delivery and treatment that require undressing without curtains or partitions
   b) Consultation conducted without privacy and
   c) Group counseling and discussions where women are required to give their personal information in public.
2. Non -dignified care: Communities perceive non-dignified care as
   a) Use of harsh words that suggest rudeness and disrespect
   b) Carrying their babies without support and assistance to postnatal unit after childbirth
   c) Health Providers rebuking the client if she ask for assistance
   d) Domestic staff and other junior staff who lacked midwifery skills attending to women idin delivery
   e) Women being requested to undress without providing gowns in the present of other women in the labour wards.
   f) Also women are made to share beds with others.
3. **Non - consented care:** Inadequate information as well as explanation of the required treatment and procedures, such as vaginal examination, physical examination, as well as taking of medication when the client or relatives are in a place to make sound decision as demanded.
4. **Physical abuse:** Human being feel that slapping, pushing and pinching is abusive.
5. **Discrimination:** Community members feel that women who are at an increased risk of discrimination are those that
   a) Have five or more children
   b) Forget to carry or lack the antenatal clinic card
   c) Are poor
   d) Are young women (teenage mothers)
   e) Are living with HIV.
6. **Detention:** Although in many countries detaining women in hospital for lack of funds to pay for treatment is illegal, reports indicate that women are still detained and are subjected to abusive treatment such as
   a) Working in the facilities (washing utensils, toilets and washroom)
   b) Provision of beds for the baby only and none for the mother
   c) Separation from their infants in which mothers are only allowed to breastfeed their babies at fixed times in the nursery.
7. **Abandonment/ Neglect:** Communities perceive their women have been abandoned when
   a) Providers ignore the clients or fail to attend to the clients on time
   b) Providers lock themselves in offices and do not respond to calls for assistance
   c) There are no skilled personnel available and

women have to wait a long time for services like Cesarean section
d) Where there is no assistance until complications develop
e) Women are left to deliver alone
f) Women in severe pain are not given pain relief
g) Women end up giving birth on benches in admission rooms waiting for help.

2.2.5 Drivers leading to Disrespect and Abuse

Drivers of D&A is defined as the reasons that might explain why D&A during childbirth occurs (but should not be used as excuses) and helps communities and health systems work out ways to resolve the issues (USAID, 2014).

Health system factors

a) Inadequate infrastructure e.g., lack of beds, curtains and drugs at the facilities.
b) Poor supervision and management of facilities; providers miss duties and grave misconduct goes without punishment
c) Increased workload for care providers as well as poor remunerations; work related stress and burnout can make care provider to transfer the anger on mothers and their spouses during delivery.
d) Poor management of human resource existing staff, the high amount of care services in reproductive health pressurizes women to give birth in facilities with poorer quality where women are susceptible to abuse and disrespect.
e) Poor communication and connection between the management of health facility, care providers, and members of community on matters related to childbirth in health facility.

Community-level factors

a) Communities lack obvious understanding of legal mechanisms
b) Perception of community members about expensive cost of legal mechanisms and the processes.
c) Some kind of abuse like slapping are viewed as normal.
d) Abusive activities are seen as safety ensuring process for the woman and baby
e) Communities would rather seek services from care givers of the same ethnic group as a result of socialization and culture
f) Limited opportunities for communities to seek redress if women are unhappy with the treatment they received.

Personal factors

a) Gender inequality in several up to facility to use for childbirth, and may expose women to experience increased disrespect communities, where the man is the final maker of decision from the choice of service provider and abuse
b) Insufficient individual and community's knowledge of rights to get quality care during childbirth health facility.
c) Some women perceived the waiver system as a great favour. Women who use the services are compelled to accept it the way its provided without questioning
d) Traditional practices, beliefs, customs as well as taboos makes discussion of the issues surrounding childbirth difficult to both the health facility staff or any other authority in the community level
e) Depressed socio-economic level make women go to low-quality facilities to seek care but here they become vulnerable to disrespect and abuse

2.2.6 Universal rights of childbearing women

Human rights are fundamental claims rightful for everybody, known by societies, governments that are spelt out in declarations and conventions internationally (The White Ribbon Alliance, 2012). Human rights are inborn rights of all people, with no discrimination, irrespective of age, where they live, sex, ethnic origin or nationality, religion, language or other status. Universal human rights usually are conveyed and assured by legal tools, like international bond. International human rights law controls function and commitment of States to take action in definite ways or to drawback from certain acts so as to protect, respect and fulfill human rights to ensure fundamental liberations of individuals and groups (The White Ribbon Alliance, 2019).

The White Ribbon Alliance, 2012 demonstrates the rightful position of maternal health rights within the larger context of human rights by concentrating on important excerpt from confirmed human right tools. From the categories of disrespect and abuse noted by Bowser and Hill (2010) [6] in a landscape analysis, seven rights were involved and drawn. These rights are described in Table 2.1 below.

Table 2.1:

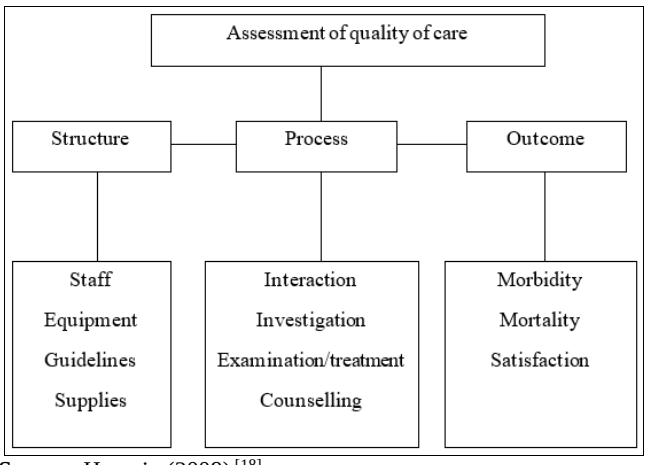
S. No	Category of Disrespect and Abuse	Corresponding Rights
1	Physical abuse	Freedom from maltreatment and harm
2	Non-consented care	Right to adequate information, informed consent also refusal, and respect for choices as preferred, this include presence of companion in maternity care
3	Non-confidential care	Confidentiality, privacy
4	Non-dignified care (like verbal abuse)	Dignity, respect
5	Discrimination due to specific characteristics	Equality, equitable care, freedom from discrimination
6	Abandonment or care denied	Right to quick healthcare and to high attainable rank of health
7	Detention in facilities	Liberty, self-determination, autonomy, as well as freedom from intimidation

The universal rights of mothers and newborn as stated by The White Ribbon Alliance, 2019 are:

1. Everybody have the right to freedom from ill-treatment and harm.
2. Everyone have the right to adequate information, informed consent, and respect for their preferred choices, which include choice of companion in the course of maternity care as well as non-acceptance of medical treatment/procedures.
3. Right to privacy and confidentiality is the entitlement of every person.
4. Everyone is a personality that has the right to be treated with dignity and respect from the time of birth.
5. Everyone is entitled to equality, freedom from discrimination and equitable care.
6. Everyone has the right to access healthcare and to the top-most attainable rank of health.
7. Right to autonomy, liberty, self-determination and being free from irrational detention is everyone's' right.
8. Parents or guardians have custody of their children because is the right of the child.
9. The right to an identity and nationality from birth is every child's entitlement.
10. Everyone has the right to clean water and adequate nutrition.

2.3 Theoretical Framework

2.3.1 The Donabedian Model



Source: Hussein (2009) [18]

Fig 2.1: The diagrammatic representation of the model

Donabedian model is a conceptual representation which sets a framework for checking health care services and evaluates the strength/quality of health care. The model emphasized that information on quality of care could be elicited from three classes: 'structure', 'processes' and 'outcomes'. Structure explains the context of care delivery which include staff, financing, equipment and hospital buildings. Process represents the dealings between providers and patients all through healthcare. Outcomes ultimately pertains to the overall effect that healthcare has on the patients' state of health as well as the populations at large.

Structure

Structure embraces all the elements that influence the condition where delivery of care is carried out and it covers the equipment, human resources, and physical facility besides organizational characteristics like training of staff as well as methods of payment. These elements control the actions of patients and providers in the healthcare system and serve as benchmarks of the middling quality of care existing in a system/facility. Structure is easily observed and measured, it can also be the crucial cause of identified problems in process.

Process

Process occurs as the addition of all procedures that constitute healthcare, it normally entail patient education, preventive care, diagnosis, treatment, and may be extended to involve the patients or their families actions. Furthermore processes can be categorized as technological processes, manner of care delivery, or interpersonal processes, they all include the method used in delivery care. Donabedian opined that quality of care measurement is about the same as the measurement of process as process accommodates all affairs in delivery of healthcare. Direct observations of healthcare visits, patients and care provider's interviews as well as medical records remain sources of obtaining information regarding process.

Outcome

Outcome refers to all the results that healthcare have on patients or people, this include health status changes, conduct, or awareness and patient satisfaction as well as quality of life as it relates to health. Sometimes outcomes are perceived as the most essential indicators of quality because the primary goal of healthcare is to improve health status of patient. However, accurate measurement of outcomes that could be ascribed solely to healthcare is extremely complex. Connections drawn linking process and outcomes oftentimes depend upon large populations sample, accommodation of casemix, and continual monitoring as outcomes could require a long time to become visible.

2.3.2 Application to the Study

The model shows a relationship between 3 components 'Structure, Process and Outcome' which are used to determine the quality of care delivered in a health facility. In determining Respectful Maternity Care in a facility, the three components will be taken into consideration. In terms of Structure, the staff (cadre of staff, number of staff), the equipment available, the supplies to the facility as well as the guidelines will be taken into consideration. In terms of process, which is the pivotal aspect of Respectful Maternity Care is considered. This is where the actions of the health providers are relevant: The interpersonal relationship between the health providers and the pregnant women, respect for who they are, respect for their culture and values as well as religion, provision of privacy and all other interactions between the health providers and the pregnant women. It is in this aspect that the pregnant women develop a mindset about who the health providers are and they also draw conclusion about what the health facility stands for. In terms of outcome, this is the effect of the structure and the process which could be observed in terms of morbidity, mortality, health status of mothers and the newborn, willingness of the women to return back to the facility next time.

3. Methodology

This section addressed the study area, study design, population of the study, selection criteria, duration of study,

sample size determination, sampling method, data collection, data management, data analysis, ethical consideration and limitation to the study.

3.1 Research Design

Descriptive study design was used because it widened the scope of the result thereby giving a broad detailed view of the topic, thus useful information was collected using a well-structured questionnaire, in-depth interview as well as focus group Interview.

3.2 Study Setting

The study was conducted on women in postpartum period who delivered in the period of August to September, 2021, who are in the postnatal care unit and in selected private and public hospitals in Benin City, Edo state. Edo state is among the 36 states of Nigeria and is situated in the southern zone. It came to existence in 1991 from the old Bendel state with Benin City as the state capital town. Its geographic region include Latitude 05degree 44' to 07 34' N and longitude 05 04' and 06 45'E, with 19,794km square as land mass and bothered by Kogi state to the Northeast, Eastward and southward is Delta state and to the West is Ondo state. It has a total population of 3,233,366 according to National population commission (2006).

3.3 Target Population

The target population used in this study were women that put to birth in August to September 2021, who are in postnatal ward and those who are in immediate postpartum period in the selected private and public hospitals in Benin City. Those who participated in the study were chosen using simple random sampling.

3.3.1 Inclusion Criteria

Women that put to birth in August to September 2021, who are in the postnatal care unit and in immediate postpartum period at the selected hospitals.

3.3.2 Exclusion Criteria

Women who may refuse to participate in the study; women who are critically ill and those who are mentally unstable or have a known mental disorder.

3.4 Sample Size Determination

The sample size for this study was estimated using the Andrew Fischer's sampling technique (Andrew and John 1998)

$$S = \frac{n}{1 + \frac{n}{N}}$$

$$n = \frac{z^2 pq}{d^2}$$

z = Test statistic (1.96) at 95 confidence interval

p = True proportion of factor in the population or expected frequency value (0.50)

d = Maximum difference between sample or value of x = 0.05

N = Total population

$n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$

n = 384.16

N = 1600

$S = \frac{384.16}{1 + \frac{384.16}{1600}}$

S = 309.7, approximately, 310. The sample was therefore 310 subjects across the selected private and public hospitals across Edo state.

3.5 Sampling Procedure

The three private and three public hospitals selected were picked by balloting among that various hospitals in Benin City. The number of deliveries in the last three months per month was taken from the ward registration record the average delivery number was calculated and the sample size was proportionally allocated to the hospitals and postpartum women who we eligible and available during the study period and who satisfy the inclusion criteria were chosen using simple random sampling technique.

3.6 Research Instrument

The research instrument for the study adopted Mixed Method Approach. The quantitative approach comprised of a well- structured Questionnaire and the qualitative approach was in form of in-depth interview and focused group interview using the audio tape recorder which was relied upon during the field work.

The Questionnaire contained both closed-ended and open-ended questions. It was divided into three sections. Section A focused on questions dealing with Socio-demographic data like sex, age, religion, occupation, marital status, etc. Section B contained questions relating to practice of respectful maternity care. Section C was common factors affecting the practice of RM

The qualitative approach through in-depth interview and focused group interview enabled the respondents to deeply express themselves as the questions for interview were obtained from the specific objectives of the study. This served as complementary tools to the quantitative instrument of data collection for this study.

3.6.1 Validity of Instrument

To ensure the validity of the instrument, the questionnaires to elicit responses from the subjects were constructed by literature review, the questions were unambiguous and clear to the participants. The questionnaire was subjected to thorough check by the researcher's supervisor and two experts for corrections, contributions, criticisms and suggestions, to help eliminate and promote content and face validity.

3.6.2 Reliability of Instrument

The reliability of instrument was validated through a pilot study and obtained by means of test-retest reliability method. The questionnaires were administered to 50 postpartum women in the postnatal ward on a particular day (Day 1) and same women were given questionnaires the following day (day 2). The two set of scores were correlated using Pearson product moment correlation and coefficient of 0.894 was obtained indicating high reliability of the instrument. Those used in the reliability test did not participate in the research because they already had idea of the questionnaire.

3.7 Data Collection

Questionnaires were distributed to the women who were willing to participate and it was collected from them immediately after filling them. An in-depth and focus

interview then took place to probe into the responses given by the respondents. The in-depth and focus group interview session was audio-taped to make certain that no information is missed.

3.8 Data Analysis
Data collected from the quantitative approach was analyzed with Statistical Package for the Social Science (SPSS), 22nd version and the data was represented using frequency tables, percentages and charts. Data from the in-depth interview and focus group interview was played and transcribed, after which they were analyzed inductively using contents, themes, sub-themes and quotes.

3.9 Ethical Considerations
During data collection process, the following ethical principles were observed:
Introduction letter was collected from the Department of Nursing Igbinedion University, Okada and same taken to the different hospitals were ethical approval were given after due application.
Informed consent was gotten from willing participants before their involvement in the research work. The participation was voluntary, the subjects were not forced to involve in the research work and withdrawal from participation at any point was allowed.
Autonomy: The subjects were able to participate after due explanation about the reason for the study was made.
Confidentiality and Anonymity: Information provided by the subjects was made confidential. As a result, participants' names were not required while answering the questionnaire. The identities of questionnaire subjects were not disclosed during report writing and article publication.
Non-maleficence: Invasive procedures were not employed during the course of the study. Each respondent was protected from physical harm and unnecessary psychological trauma or embarrassment. Question items in the questionnaires and interview was structured in such a way that protects the integrity and privacy of the participants. Participants were not forced to respond to any question they might not be comfortable with. Trustworthiness was established as the researcher had confidence in research study's finding ensuring credibility by using audio tape recorder.
The Researcher ensured high level of neutrality. This occurs as the findings were construct from respondents and not the researcher's potential bias or personal motivations.

4. Findings
4.1 Introduction
This chapter deals with the presentation of data, and analysis of the results obtained in the field survey. The results presented include the socio-demographic data, answering research questions, and the transcribed interview responses (during In-Depth interviews and Focus Group Interviews).

4.2 Socio-demographic Data of the Subjects
The socio-demographic variables of the subjects (women who delivered in September, 2021, who are in the postnatal care unit and in immediate postpartum period at the selected hospitals) include; age, marital status, duration of marriage, level of education, employment status, religion and parity. These are presented in Tables and charts as follows:

Table 4.1: Socio-demographic status of the subjects

Variables	Category	Frequency	Percent
Age (years)	17-25	32	11.4
	26-35	139	49.6
	36-45	89	31.8
	46-55	14	5
	Prefer not to say	6	2.1
	Total	***280***	***100***
Marital Status	Married	235	83.9
	Single	17	6.1
	Separated	10	3.6
	Cohabiting	5	1.8
	Prefer not to say	13	4.6
	Total	***280***	***100***
Duration (years) of Marriage	1-5	125	44.6
	6-10	90	32.1
	11-15	25	8.9
	16-20	11	3.9
	21-25	7	2.5
	26 & above	2	0.7
	Prefer not to say	20	7.1
	Total	***280***	***100***
Variables	**Category**	**Frequency**	**Percent**
Level of education	None	6	2.1
	Primary	19	6.8
	Secondary	57	20.4
	Tertiary	195	69.6
	I prefer not to say	3	1.1
	Total	***280***	***100***
Employment status	Student	34	12.1
	Civil Servant	90	32.1
	Self-employed	115	41.1
	Unemployed	17	6.1
	Others	10	3.6
	Prefer not to say	14	5
	Total	***280***	***100***
Religion	Christianity	243	86.8
	Islam	28	10
	African Traditional Religion	4	1.4
	Prefer not to say	5	1.8
	Total	***280***	***100***
Parity	1-2 children	141	50.4
	3-4 children	89	31.8
	5 children & above	19	6.8
	Prefer not to say	31	11.1
	Total	***280***	***100***

Source: Field Survey, 2021

The table 4.1 above revealed the socio-demographic status of the subjects. Age, Marital Status, duration of marriage, level of education, employment status, religion and parity across various categories were examined.
While considering the **age of the subjects** in selected hospitals in Benin City, most of the respondents, 139 which accounted for 49.6% were 26-35 years. Others, 32, 89, 14, 63 and 4 respondents which accounted for 11.4%, 31.8%, and 5% were 17-25years, 36-45years and 46-55 years respectively. However, 6 respondents which accounted for 2.1% prefer not to say their age. This implies that the respondents across different age groups were represented in the study.
In addition, while considering the **marital status of the subjects** in selected hospitals in Benin City, most of the respondents, 235 which accounted for 83.9% were married. Others, 17, 10, and 5 respondents that accounted for 6.1%, 3.6%, 1.8% respectively were single-mothers, separated and

cohabiting respectively. However, 13 respondents which accounted for 4.6% prefer not to say their marital status. This implied that the respondents across different marital status were represented in the study.

Also, while considering the **duration (years) of marriage of the subjects** in selected hospitals in Benin City, most of the respondents, 125 which accounted for 44.6% had been in marriage between 1-5 years. Others, 90, 25, 11, 7 and 2 respondents that accounted for 32.1%, 8.9%, 3.9%, 2.5% and 0.7% respectively had been in marriage between 6-10 years, 11-15 years, 16-20 years, 21-25 years, and 26 years & above respectively. However, 20 respondents which accounted for 7.1% prefer not to say their duration of marriage. This implied that the respondents who have spent years in marriage were all represented in the study.

In the categories of the **level of education of the subjects** in selected hospitals in Benin City, most of the respondents, 195 which accounted for 69.6% had tertiary level of education. Others; 19, 57 and 6 respondents that accounted for 6.8%, 20.4%, and 2.1% respectively had Primary, Secondary and no education respectively. However, 3 respondents which accounted for 1.1% prefer not to state their level of education. This implies that the respondents are majorly literate. Hence, their contributions will add values to the study.

While considering the level of **employment status of the subjects** in selected hospitals in Benin City, most of the respondents, 115 which accounted for 41.1% are self-employed. Others; 34, 90, 17 and 10 respondents that accounted for 12.1%, 32.1% and 6.1% respectively were students, civil servants, self-employed, unemployed and other type of employment respectively. However, 14 respondents which accounted for 5.0 % prefer not to state their employment status. This implies that the respondents were of different employment categories. Hence, their contributions from diverse background will add values to the study.

Moreover, while considering the **religion of the subjects** in selected hospitals in Benin City, most of the respondents, 243 which accounted for 86.8% were Christians. Others; 28 and 4 respondents that accounted for 10% and 1.4% respectively were of Islam and African traditional religion respectively. However, 5 respondents which accounted for 1.8% prefer not to state their religion. This implied that the respondents belonged to different religious groups. Hence, their diverse contributions will add values to the study.

Furthermore, considering the **parity (number of children) of the subjects** in selected private and public hospitals across Benin City, most of the respondents, 141 which accounted for 50.4% were mothers of 1-2 children. Others; 89 and 19 respondents that accounted for 31.8% and 6.8% respectively were mothers of 3-4 children and 5 children & above respectively. However, 31 respondents which accounted for 11.1% prefer not to state their number of children or they are pregnant of their first child. This implied that the respondents belonged to different women with various parity. Hence, their diverse contributions based on maternity experience will add values to the study.

In summary the highest number of participants were married for about 1 to 5years, majority had tertiary educational qualification, also mainly self-employed with a parity of 1-2 children topping the list.

4.3 Answering of Research Questions

4.3.1 Research question one:

What is the practice of RMC among postpartum women in selected hospitals in Benin City, Edo State?

To answer the question 1 above, questions items B1-B19 of the questionnaire was employed as presented below:

Table 4.2: Practice of RMC among postpartum women in selected hospitals in Benin City, Edo State

Practices		SA	A	U	D	SD	I prefer not to say	Total	Mean ±SEM
B1. respect for patient	n	77	106	6	73	16	2	280	3.56±0.08
	%	(27.5)	(37.9)	(2.1)	(26.1)	(5.7)	(0.7)	(100)	
B2. respect for privacy	n	87	97	12	56	26	2	280	3.59±0.08
	%	(31.1)	(34.6)	(4.3)	(20)	(9.3)	(0.7)	(100)	
B3.keeping of patients' secret	n	81	80	30	52	32	5	280	3.46±0.08
	%	(28.9)	(28.6)	(10.7)	(18.6)	(11.4)	(1.8)	(100)	
B4.physical abuse	n	24	51	27	125	44	9	280	2.58±0.07
	%	(8.6)	(18.2)	(9.6)	(44.6)	(15.7)	(3.2)	(100)	
B5.verbal abuse	n	26	76	21	109	38	10	280	2.79±0.08
	%	(9.3)	(27.1)	(7.5)	(38.9)	(13.6)	(3.6)	(100)	
B6. good reception	n	67	99	27	59	22	6	280	3.47±0.08
	%	(23.9)	(35.4)	(9.6)	(21.1)	(7.9)	(2.1)	(100)	
B7.good interpersonal relationship	n	63	116	22	64	12	3	280	3.56±0.07
	%	(22.5)	(41.4)	(7.9)	(22.9)	(4.3)	(1.1)	(100)	
B8.provision of information	n	75	107	32	51	11	4	280	3.67±0.07
	%	(26.8)	(38.2)	(11.4)	(18.2)	(3.9)	(1.4)	(100)	
B9.prompt care	n	68	109	27	60	14	2	280	3.56±0.07
	%	(24.3)	(38.9)	(9.6)	(21.4)	(5)	(0.7)	(100)	
B10. dignified care	n	54	112	44	54	6	10	280	3.57±0.07
	%	(19.3)	(40)	(15.7)	(19.3)	(2.1)	(3.6)	(100)	
B11. respect for patient's cultural values	n	72	107	35	51	8	7	280	3.67±0.07
	%	(25.7)	(38.2)	(12.5)	(18.2)	(2.9)	(2.5)	(100)	
B12.respect for patient's religious values	n	72	91	47	47	14	9	280	3.59±0.07
	%	(25.7)	(32.5)	(16.8)	(16.8)	(5)	(3.2)	(100)	
B13.neglect and abandonment of care	n	30	68	34	101	36	11	280	2.83±0.08
	%	(10.7)	(24.3)	(12.1)	(36.1)	(12.9)	(3.9)	(100)	
B14. psychological support	n	53	111	39	58	14	5	280	3.48±0.07
	%	(18.9)	(39.6)	(13.9)	(20.7)	(5)	(1.8)	(100)	

B15.asking for consent before patient's care	n	68	95	27	64	16	10	280	3.5±0.08
	%	(24.3)	(33.9)	(9.6)	(22.9)	(5.7)	(3.6)	(100)	
B16.Detention in facilities	n	27	48	47	102	42	14	280	2.68±0.08
	%	(9.6)	(17.1)	(16.8)	(36.4)	(15)	(5)	(100)	
B17. discrimination based on specific patient attributes	n	30	45	41	111	39	14	280	2.76±0.1
	%	(10.7)	(16.1)	(14.6)	(39.7)	(13.9)	(5)	(100)	
B18.inappropriate monetary demand	n	21	49	49	115	36	10	280	2.64±0.07
	%	(7.5)	(17.5)	(17.5)	(41.1)	(12.9)	(3.6)	(100)	
B19.Lack of personal protective equipment for the health providers	n	36	66	40	99	32	7	280	2.91±0.08
	%	(12.9)	(23.6)	(14.3)	(35.4)	(11.4)	(2.5)	(100)	
Overall mean 3.26±0.08									

Source: Field Survey, 2021

Table 4.2 presented the practice of RMC among postpartum women in selected hospitals in Benin City, Edo State.

The RMC practices were subjected to respondents' perceptions which were rated into five categories of impact; strongly Agree, Agree, Undecided, Disagreed and strongly disagreed. The mean and Sandard error of mean(SEM) of the practices were later examined. It was observed that among the nineteen highlighted practices, provision of information (3.67±0.07), respect for patient's cultural values (3.67±0.07) and respect for patient's religious values (3.59±0.07), thus respectful maternity care is practiced in selected hospitals in Benin city,Edo state.

4.3.2 Research question two:

What is the aspect of Respectful Maternity Care (RMC) commonly practiced among postpartum women in Selected Hospitals *in Benin City, Edo State?*

To answer the question 2 above, questions items B1-B19 of the questionnaire was employed as presented below:

Table 4.3: Determine the aspect of RMC commonly practiced among postpartum women in selected hospitals in Benin City, Edo State

Practices		SA	A	U	D	SD	Prefer not to say	Total	Mean ±SEM	Rank
B1. respect for patient	n	77	106	6	73	16	2	280	3.56±0.08	6th
	%	(27.5)	(37.9)	(2.1)	(26.1)	(5.7)	(0.7)	(100)		
B2. respect for privacy	n	87	97	12	56	26	2	280	3.59±0.08	3rd
	%	(31.1)	(34.6)	(4.3)	(20)	(9.3)	(0.7)	(100)		
B3.keeping of patients' secret	n	81	80	30	52	32	5	280	3.46±0.08	12th
	%	(28.9)	(28.6)	(10.7)	(18.6)	(11.4)	(1.8)	(100)		
B4.physical abuse	n	24	51	27	125	44	9	280	2.58±0.07	19th
	%	(8.6)	(18.2)	(9.6)	(44.6)	(15.7)	(3.2)	(100)		
B5.verbal abuse	n	26	76	21	109	38	10	280	2.79±0.08	15th
	%	(9.3)	(27.1)	(7.5)	(38.9)	(13.6)	(3.6)	(100)		
B6. good reception	n	67	99	27	59	22	6	280	3.47±0.08	11th
	%	(23.9)	(35.4)	(9.6)	(21.1)	(7.9)	(2.1)	(100)		
B7.good interpersonal relationship	n	63	116	22	64	12	3	280	3.56±0.07	6th
	%	(22.5)	(41.4)	(7.9)	(22.9)	(4.3)	(1.1)	(100)		
B8.provision of information	n	75	107	32	51	11	4	280	3.67±0.07	1st
	%	(26.8)	(38.2)	(11.4)	(18.2)	(3.9)	(1.4)	(100)		
B9.prompt care	n	68	109	27	60	14	2	280	3.56±0.07	6th
	%	(24.3)	(38.9)	(9.6)	(21.4)	(5)	(0.7)	(100)		
B10. dignified care	n	54	112	44	54	6	10	280	3.57±0.07	5th
	%	(19.3)	(40)	(15.7)	(19.3)	(2.1)	(3.6)	(100)		
B11. respect for patient's cultural values	n	72	107	35	51	8	7	280	3.67±0.07	1st
	%	(25.7)	(38.2)	(12.5)	(18.2)	(2.9)	(2.5)	(100)		
B12.respect for patient's religious values	n	72	91	47	47	14	9	280	3.59±0.07	3rd
	%	(25.7)	(32.5)	(16.8)	(16.8)	(5)	(3.2)	(100)		
B13.neglect and abandonment of care	n	30	68	34	101	36	11	280	2.83±0.08	14th
	%	(10.7)	(24.3)	(12.1)	(36.1)	(12.9)	(3.9)	(100)		
B14. psychological support	n	53	111	39	58	14	5	280	3.48±0.07	10th
	%	(18.9)	(39.6)	(13.9)	(20.7)	(5)	(1.8)	(100)		
B15.asking for consent before patient's care	n	68	95	27	64	16	10	280	3.5±0.08	9th
	%	(24.3)	(33.9)	(9.6)	(22.9)	(5.7)	(3.6)	(100)		
B16.Detention in facilities	n	27	48	47	102	42	14	280	2.68±0.08	17th
	%	(9.6)	(17.1)	(16.8)	(36.4)	(15)	(5)	(100)		
B17. discrimination based on specific patient attributes	n	30	45	41	111	39	14	280	2.76±0.1	16th
	%	(10.7)	(16.1)	(14.6)	(39.7)	(13.9)	(5)	(100)		
B18.inappropriate monetary demand	n	21	49	49	115	36	10	280	2.64±0.07	18th
	%	(7.5)	(17.5)	(17.5)	(41.1)	(12.9)	(3.6)	(100)		
B19.Lack of personal protective equipment for the health providers	n	36	66	40	99	32	7	280	2.91±0.08	13th
	%	(12.9)	(23.6)	(14.3)	(35.4)	(11.4)	(2.5)	(100)		
Overall mean 3.26±0.08										

Source: Field Survey, 2021

Table 4.3; Determined the aspect of RMC commonly practiced among postpartum women in selected hospitals in Benin City, Edo State. The practices identified are positive and include; respect for patient, respect for their privacy, keeping of patients' secret, physical abuse, good reception into the hospital, prompt care and dignified care among others.

The RMC practices were subjected to respondents' perceptions which were rated into five categories of impact; strongly Agree, Agree, Undecided, Disagreed and strongly disagreed. The mean, SEM and rank of the practices were later examined. It was observed that among the nineteen highlighted practices, provision of information (3.67±0.07), respect for patient's cultural values (3.67±0.07) and respect for patient's religious values (3.59±0.07) were leading positive practices which ranked 1st, 1st and 3rd respectively. The least and poor rated RMC practices in the selected hospitals include detention in facilities (2.68±0.08), inappropriate monetary demand (2.64±0.07) and physical abuse (2.58±0.07) which ranked 17th, 18th and 19th respectively.

In the overall it could deduced that the RMC practices are positive across the selected hospitals in Edo State as the overall mean was 3.26 out of 5.0 maximum rating. This represents 65.2% performance.

In conclusion this study reveals that the level of practice of RMC is high among postpartum women in the selected hospitals in Benin City, Edo state. Provision of information, respect for patient's cultural value, respect for patient's religious value and respect for privacy are the aspect of RMC that are commonly practice in the selected hospitals.

The following charts presented mean and SEM of the 10 leading RMC practices in Edo State Hospitals.

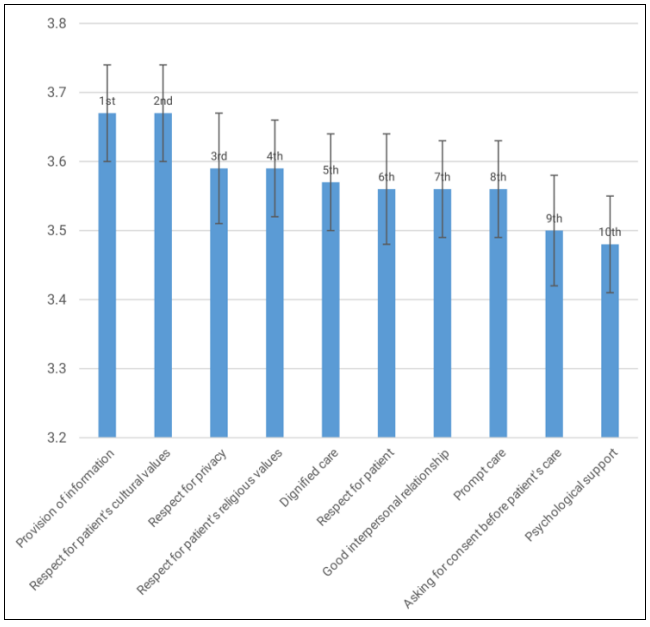


Fig 4.1: The Mean and SEM of 10 leading RMC practices in hospitals across Edo state

The above Fig. 4.1 indicated 10 leading RMC practices which include Provision of information, Respect for patient's cultural values, Respect for privacy, Respect for patient's religious values, Dignified care, Respect for patient, Good interpersonal relationship between patients and health workers, Prompt care, Asking for consent before patient's care and Psychological support that rated 1st to 10th consecutively.

This implied that the leading RMC practices in hospitals in Benin City, Edo State. include; Provision of information, Respect for patient's cultural values, Respect for privacy which ranked 1st, end and 3rd respectively.

4.3.3 Research Question Three:

What are the factors affecting the practice of RMC in the selected hospitals in Benin City, Edo state

To answer the question 3 above, the summary of items C1-C8 of the questionnaire was employed as presented below:

Table 4.4: Factors affecting the practice of RMC in the selected hospitals in Benin City, Edo state

The factors	Frequency	Percent
Poor facilities (I)	33	11.8
Poor facilities (I) & Attitudes of health workers (II)	17	6.1
Poor facilities, Attitudes of health workers & Personality of the patients (III)	20	7.2
I, II & others	100	36.2
I, III	3	1.1
I, III & others	3	1.2
Poor facilities (I) & Low socio-economic status of patients (IV)	4	1.5
I, IV & others	4	1.5
Poor facilities (I) & Health providers' training and supervision (V)	3	1.1
II	8	2.9
II & others	38	14.1
III	4	1.4
III & others	18	6.6
IV	1	0.4
IV &others	2	0.8
Poor communication (VII)	1	0.4
All factors	3	1.1
Prefer not to say	18	6.4
Total	280	100

Source: Field Survey, 2021

Key:
1. Poor facilities
2. Attitudes of health workers
3. Personality of the patients
4. Low socio-economic status of patients
5. Health providers' training and supervision
6. Lack of leadership and supervision
7. Poor communication
8. Poor interpersonal relationship between the health providers and the patients.

Table 4.3 presented the factors affecting RMC in the selected hospitals in Edo state. It was observed that there are multiple factors affecting RMC. The identified factors include poor facilities, attitudes of health workers, personality of the patients, poor communication, among others.

The factors as selected by the respondents revealed that more of the multiple factors than single factors were affecting RMC. The rank of the factors revealed that that among the eight major (key) factors affecting RMC, poor facilities (I) was rated as only single predominant factor representing 11.8% and ranked 3rd. However, multiple factors such as poor facilities (I), attitudes of health workers (II) & others were affecting over one-third (36.2%) of the

RMC practices in Hospitals in Edo state, it also ranked first (1st) above all the factors identified.

Meanwhile, factors such as lack of leadership and supervision (VI) was not predominantly seen among the identified factors affecting RMC in the selected hospitals. More so, factors such as low socio-economic status of patients (IV) & others, and poor communication were rated rare-affecting factors; representing 0.8% and 0.4% and ranked 15th and 16th respectively.

In a nutshell, the multiple factors such as poor facilities (I), attitudes of health workers (II) combined with other leading factors should be critically looked into and addressed appropriately, in order to have a more effective RMC in the hospitals across Edo state.

4.4 Qualitative Analysis

Analysis of In-Depth Interview (IDI)

A total of two participants participated in the In-Depth Interview. The analysis of the In-Depth Interview is as follows and data generated were analysed inductively under 3 themes.

4.4.1 Experience of Respectful Maternity Care

One participant each reported to have experienced Respectful Maternity Care and to not have experienced it.

> *'Well, I will start by saying that mine was actually a respectful maternity being it was my first pregnancy, the doctors, nurses were always wanting to know what I was eating and eventually labour, when I tell them I want to go for a walk they will tell always say I should wait small, they encouraged me, letting me know the first delivery always takes longer that I should be patient and eventually I delivered safely.*
>
> *'Hmmm, never never, it was a bitter one it was my first experience, my first child, I experience a bitter one when I came here when I was in labour all the nurses they abandoned me I was there crying when I shouted they will shout at me and say hey hey your husband is not here, when your husband was doing it were you not enjoying it, please shut up your mouth they were shouting at me, even when in I was in labor with pain they all left me it was a cleaner I called who pet me and say I should not worry at the end of the day it was the cleaner that took my delivery before they knew what was happening, the baby has already come out. They were all shocked and they were surprised it was a painful one'*

Furthermore, the participant who reported not to have experienced Respectful Maternity Care added that the health workers did not apologise for their wrong actions.

> *'They didn't apologized they always feel they are right they are doing the right thing.'*

4.4.2 Analysis of Focus Group Interveiw (FGI)

A total of five participants participated in the interview. The analysis of the Focus Group Interview is as follows and data generated were analysed under 3 themes.

4.4.2.1 FGI: Theme 1: Experience of Respectful Maternity Care

Out of the five participants in the focus group interview, two reported to have experienced Respectful Maternity Care; one reported not to have experienced it and two had a combination of experiencing and not experiencing Respectful Maternity Care as some points in time.

> *'Yes, I have heard about respectful maternity care and in my own case, it was respectful; being it was my first pregnancy. The nurses and doctors actually showed me care, wanting to know what I was consuming, what will be healthy for the child and even myself, the mother and eventually, the labour.'*
>
> *'I want to say in my own case, it was an abuse maternity, because a woman under labour is between this life and the other life, am trying to say nurses look at how am feeling pain. I don't know what is going on there, they are the professionals, they should be the ones to know, rather they will be shouting, Madam, Madam', they didn't even encourage exercises, because it was later discovered that exercises help in the contraction, instead they will just be shouting and shouting and it doesn't even want to make someone get pregnant or eventually go to such a hospital.'*
>
> *'Though in my first delivery, I had that respectful delivery, then the nurses and doctors where all on ground, although it was a delayed delivery, everything went well, the way they pet me, the care, probably, it was because it was my first delivery. The way the matron handled the delivery, I was impressed. But this one, it was God that brought me back to life, I was induced up to six times because the labour started in the office, so on getting to the hospital, the nurses and doctors were just inducing and dripping me without my consent or trying to know what I was going through or passing through.'*

Hence, despite flaws, and in line with the findings in Table 4.2, in the overall, it could deduced that the RMC practices are positive across the selected hospitals in Edo state as the overall mean was 3.26 out of 5.0 maximum rating. This represents 65.2% performance. This study is in line with the findings of Soet *et al,* (2003) [30] who reported in his study that that a third of women described their experience of giving birth as traumatic. In other words, only about 66% had a fair RMC.

4.4.3 FG1: Theme 2: Effects of no Respectful Maternity Care

Participants reported some negative effects of no Respectful Mother Care such as tears, fear as a resulted of being shouted at and having offensive smell from the private part.

> *'Yes Ma, the baby had to force itself out and this resulted to a tear.'*
>
> *'Well though there wasn't any, but with that kind of shout, being that it was my first pregnancy, their talk and shout will really scare you and create fear and itx was really an abuse.'*
>
> *'On getting home weeks later I was hearing offensive smell and it was embarrassing which I have to go back to the hospital and face another theatre only for them to notice they forget conflict pad which I have to*

push to bring it out it was very painful and a experience.'

4.4.4 FGI: Theme 3: Aspect of RMC commonly practised

A number of suggestions were reported by the participants which were given towards improvement of Respectful Maternity Care.

The suggestions reported by the participants were health workers to be kind to women in labour, encouragement to health workers, proper orientation, the health workers should be instructed by their Head of Department and avoidance of play/gist that could lead to forgetfulness of foreign bodies in women.

'Well it is going to be a suggestion to them because I believe they went to school and they were taught all these things, so it should be their primary focus, they have come to serve humanity irrespective of the person's wealth or class, they should encourage them and be trained and head of department should always instruct them.'

'For the health care providers, it's not like they are not trying, but they should put in their best, when a woman comes with pregnancy, they should try and pamper such a person. Though, some women are harsh during pregnancy labour, they should not just take it out on them. They should be kind to them, because it's not easy to go through such pain.'

It could therefore be deduced that the findings of the present study was in line with the earlier reports of other researchers; (Swahnberg *et al*, 2011) [31] and (Makumi, 2015) [23]. According to (Swahnberg *et al*, 2011) [31]. Poor encounters during obstetrical care may adversely affect the quality and outcome of a woman's birthing experiences leading to psychological disorders and deterring her from seeking health care in the future (Makumi, 2015) [23].

5. Discussion of Findings

5.1 Introduction

This study evaluated respectful Maternity Care (RMC) among postpartum women in selected hospitals in Benin City. The study identified that there was positive practice of RMC among postpartum women in selected hospitals in Benin City, They include; respect for patient, respect for their privacy, keeping of patients' secret, physical abuse, good reception into the hospital, prompt care, and dignified care among others. It was observed that among the nineteen highlighted practices, provision of information (3.67±0.07), respect for patient's cultural values (3.67±0.07) and respect for patient's religious values (3.59±0.07) were leading commonly practiced RMC as they ranked 1st, 1st and 3rd respectively. However, the least and poor rated RMC practices in the selected hospitals include detention in facilities (2.68±0.08), inappropriate monetary demand (2.64±0.07) and physical abuse (2.58±0.07) which ranked 17th, 18th and 19th respectively. Hence, despite flaws, and in line with the findings in Table 4.2, in the overall, it could deduced that the RMC practices are positive across the selected hospitals in Edo state as the overall mean was 3.26 out of 5.0 maximum rating. This represents 65.2% performance with provision of information and respect for patient's cultural and religious beliefs ranking very high. This study does not correspond with the findings of Soet *et al*, (2003) [30] who reported in his study that that a third of women described their experience of giving birth as traumatic.

To collaborate the findings on research question one, the IDI and FGI of the interviewees were presented shows that Out of the five participants in the focus group interview, two reported to have experienced Respectful Maternity Care; one reported not to have experienced it and two had a combination of experiencing and not experiencing Respectful Maternity Care as some points in time.

Hence, this did not rule out the cases of abuse of women seeking RMC. This study has also identified with the findings of The White Ribbon Alliance (2012) who reported that disrespect and abuse of women seeking maternity care is becoming an urgent problem and creating a growing community of concern that spans the domains of healthcare research, quality, and education; human rights; and civil rights advocacy.

On the other hand, factors affecting the practice of RMC in the selected hospitals in Benin City, Edo State were identified as seen in Table 4.4. It was observed that there are multiple factors affecting the practice of RMC. The identified factors include poor facilities, attitudes of health workers, personality of the patients, poor communication, among others. The factors as selected by the respondents revealed that more of the multiple factors than single factors were affecting RMC. The rank of the factors revealed that that among the eight major (key) factors affecting RMC, poor facilities (I) was rated as only single predominant factor representing 11.8% and ranked 3rd. However, multiple factors such as poor facilities (I), attitudes of health workers (II) & others were affecting over one-third (36.2%) of the RMC practices in Hospitals in Edo state, it also ranked first (1st) above all the factors identified.

Meanwhile, factors such as lack of leadership and supervision (VI) was not predominantly seen among the identified factors affecting RMC in the selected hospitals. More so, factors such as low socio-economic status of patients (IV) & others, and poor communication were rated rare-affecting factors; representing 0.8% and 0.4% and ranked 15th and 16th respectively.

Hence, this study disagreed with the findings of Burrowes *et al*, (2017) [8], Okafor *et al*, (2015) [27], (Freedman and Kruk, 2015) among others. According to Burrowes *et al*, (2017) [8], disrespect and abuse (D&A) during labor and childbirth have increased over the past decade. Early studies have reported different prevalence rates ranging from 20% in Kenya (Abuya *et al*, 2015) [1] to 98% in Nigeria (Okafor *et al*, 2015) [27]. In the same vein, the review of relevant articles showed that some multifactorial causes including lack of professional support for health care staff, hierarchical work relations, excessive workload, inadequate staff at different levels, and poor infrastructures can contribute to the increased prevalence of D&A (Freedman and Kruk, 2015).

In a nutshell an improved RMC will be determined by the application of multiple approach such as improving health providers' training (I) good interpersonal relationship between the health providers and the patients (II) and educating women of their rights (III) combined with other leading suggested ways across the hospitals in Edo state.

From the foregoing, it could be deduced that more approach should be adopted to uphold the practice of RMC experience

among the women at child birth more importantly, their universal rights should be upheld. This study therefore was in line with the stand of previous researchers. According to the White Ribbon Alliance, (2019), the universal rights of mothers and newborn should include; right to freedom from ill-treatment and harm, the right to adequate information, informed consent, and respect for their preferred choices, which include choice of companion in the course of maternity care as well as non-acceptance of medical treatment/procedures; and the right to be treated with respect and dignity at their own moment of births.

6. Conclusion and Recommendations

This chapter is the concluding chapter of the study and it has presented; summary, conclusion, contribution of the study, implication for further research, limitations of the study and its recommendation for policy research and further research. It is expected that while the findings of this study will aid further research, the recommendation will aid policy makers and other stakeholders of maternity care.

6.1 Summary

This study adopted a qualitative and a quantitative approach which involved the use of questionnaire as well as In-depth Interview (IDI) and Focus Group Interviews (FGI). The population were women who delivered in August to September 2021, who were in postnatal ward and those who were in immediate postpartum period in the selected private and public hospitals across Benin City. 310 questionnaires were distributed and 280 were retrieved, thus 280 subjects (participants) were chosen using simple random sampling. Data collected from the quantitative approach were analyzed using Statistical Product for Social Science (SPSS version 22) and the data was represented using tables and charts. Data from the in-depth interview and focus group interview were played, transcribed and analyzed inductively using contents, themes, sub-themes and quotes.

6.2 Contribution to knowledge

This study by its findings has added to broad pool of knowledge on RMC in Nigerian hospitals. More so, the empirical findings will be a valuable resource for similar studies in clinical sciences across the world. Hence, this study remains one of the current findings in the area of respectful maternity care (RMC) among postpartum women in selected hospitals in Benin City, Edo State.

6.3 Implication for Further Research

The further research are expected to build on the inferences of the present study to explore other areas excluded in the present study such as RMC and its related factors in maternal and child health. Also further researchers can delve into RMC and its related factors in maternal health as well.

6.4 Limitations of the Study

This study is limited by geographical, financial and time factors. Geographically, all the findings reported are from subjects who attends selected public and private hospitals in Benin City, Edo State. Financially, more aspects of RMC would have been examined, but for the sake of the funding of the study was sponsored by an individual, such could not be achieved.

In addition, time frame for the study was a factor that limits the size of the sample and restrict the researcher to certain aspect of the study.

6.5 Conclusion

This study had examined respectful maternity care (RMC) among postpartum women in selected hospitals in Benin City, Edo State. The research findings from questionnaires, IDI and FGI were complementary and it could be deduced from all the methods of data gathering that the RMC practices in Edo State hospitals was positive They include; respect for patient, respect for their privacy, keeping of patients' secret, physical abuse, good reception into the hospital, prompt care, and dignified care among others. Among the nineteen highlighted practices, provision of information, respect for patient's cultural values and respect for patient's religious values were leading positive practices which ranked 1st, 1st and 3rd respectively. The least and poor rated RMC practices in the selected hospitals include detention in facilities, inappropriate monetary demand and physical abuse which ranked 17th, 18th and 19th respectively. In the overall, it could deduced that the RMC practices are 'positive' across the selected hospitals in Edo state as the overall mean was 3.26 out of 5.0 maximum rating and represents 65.2% performance.

There are factors affecting RMC in the selected hospitals in Edo State which are identified. The factors as selected by the respondents revealed that more of the multiple factors than single factors were affecting RMC. The rank of the factors revealed that among the eight major (key) factors affecting RMC, poor facilities was rated as only single predominant factor representing 11.8% and ranked 3rd. However, multiple factors such as poor facilities (I), attitudes of health workers & others were affecting over one-third (36.2%) of the RMC practices in Hospitals in Benin city Edo state, it also ranked first above all the factors identified. In a nutshell, the multiple factors such as poor facilities, attitudes of health workers combined with other leading factors are of great concern.

Furthermore, there were possible ways to ensure and improve implementation of RMC in Edo State Hospitals. The rank revealed that among the ten major (key) ways that can improve implementation of RMC, 'improving health providers' training' was rated as best only single predominant factor representing which ranked 3rd.

6.6 Recommendation

Recommendation for policy research and further research

This study had examined respectful maternity care (RMC) among postpartum women in selected hospitals in Benin City, Edo State. Since good RMC practices will lead to a more comprehensive and productive maternity care for women, other poor practices such as inappropriate monetary demand and physical abuse should be strongly discouraged especially among hospital management and health workers as it will yield an effective RMC in the hospitals across Edo state.

In addition, the identified prevailing multiple factors such as poor facilities, attitudes of health workers combined with other leading factors affecting RMC should be critically looked into and addressed appropriately, in order to have an effective RMC in the hospitals across Edo state.

Furthermore, a better approach should be adopted to avoid lack of RMC to avoid the multiple devastating effects during pregnancy and labour, Death of and other complications to the baby exclusively; and delayed lactation, among others, in the hospitals across Edo state.

All stakeholders; hospital management, health workers, government, private organizations and Non-Government Organizations must work towards positive prospects of RMC. This is dependent on the application of multiple approach such as improving health providers' training, good interpersonal relationship between the health providers and the patients and educating women of their rights, among others, across the hospitals in Edo state.

Most importantly, across all the hospitals in Edo State, the universal rights of women and newborn as stated by the White Ribbon Alliance, 2019 should be adopted and keenly considered. These have no limit but include; everyone should have right to freedom from ill-treatment and harm, the right to adequate information, informed consent, and respect for their preferred choices, which include choice of companion in the course of maternity care as well as non-acceptance of medical treatment/procedures; and the right to be treated with respect and dignity especially in their own moment of births.

Further research should extend focus on the hospitals in other states within Nigeria to ascertain if there are similarities with the present study and its findings in Edo state hospitals.

7. References

1. Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, *et al*. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PLoS One. 2015; 10(4):e0123606.
2. Asefa A. Unveiling respectful maternity care as a way to address global inequities in maternal health. BMJ Global Health. 2021; 6(1):e003559.
3. Asefa A, Semaan A, Delvaux T, Huysmans E, Galle A, Sacks E, *et al*. The impact of COVID-19 on the provision of respectful maternity care: Findings from a global survey of health workers. medRxiv, 2021.
4. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, *et al*. How women are treated during facility-based childbirth in four countries: A cross-sectional study with labour observations and community-based surveys. Lancet, 2019.
5. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, *et al*. The mistreatment of women during childbirth in health facilities globally: A mixed methods systematic review. PLoS Med. 2015; 12(6):e1001847. Discussion e.
6. Bowser L, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a landscape analysis. USAID, 2010.
7. Bulto GA, Demissie DB, Tulu AS. Respectful maternity care during labor and childbirth and associated factors among women who gave birth at health institutions in the West Shewa zone, Oromia region, Central Ethiopia. BMC Pregnancy Childbirth. 2020; 20:443. Doi https://doi.org/10.1186/s12884-020-03135-z
8. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. BMC Pregnancy Childbirth. 2017; 17(1):263.
9. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. Lancet. 2014; 384:e42-4.
10. Hajizadeh K, Vaezi M, Meedya S, *et al*. Respectful maternity care and its related factors in maternal units of public and private hospitals in Tabriz: A sequential explanatory mixed method study protocol. Reprod Health. 2020; 17:9-0. Doi: https://doi.org/10.1186/s12978-020-0863-x
11. Hameed W, Uddin M, Avan BI. Are underprivileged and less empowered women deprived of respectful maternity care: Inequities in childbirth experiences in public health facilities in Pakistan. Plos one. 2021; 16(4):e0249874.
12. Hazarika L, Konwar G. Respectful Maternity Care (RMC): Safe Mother Hood. EPRA International Journal of Multidisciplinary Research (IJMR). 2021; 164.
13. https://www.google.com/url?q=http://www.who.int/woman_child_accountability/ierg/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf&sa=U&ved=2ahUKEwjb1uzSiNnxAhVNyaQKHRlUAR4QFjABegQICRAB&usg=AOvVaw13UgvgOV3MJNA-EKNz3Lsg
14. https://www.google.com/url?q=https://en.m.wikipedia.org/wiki/Donabedian_model&sa=U&ved=2ahUKEwiY58jghODxAhVMtKQKHXNyAPEQFjARegQIBxAB&usg=AOvVaw3P9kmnNZJfUw6ivG9JIAOi
15. https://www.google.com/url?q=https://www.aft.org/hc/spring2021/taylor&sa=U&ved=2ahUKEwjc487Qi9nxAhUTg_0HHTUKDPU4ChAWMAB6BAgEEAE&usg=AOvVaw2bn13O3XHi_njbFBP24ooS
16. https://www.google.com/url?q=https://www.healthynewbornnetwork.org/hnncontent/uploads/Respectful-Maternity-CareCharter2019.pdf&sa=U&ved=2ahUKEwjb1uzSiNnxAhVNyaQKHRlUAR4QFjAKegQICxAB&usg=AOvVaw1djJTdnVKmMR45cq4zvTi-
17. https://www.google.com/url?q=https://www.popcouncil.org/uploads/pdfs/2014RH_RMC_CommunityBasedGuideTrainers.pdf&sa=U&ved=2ahUKEwjb1uzSiNnxAhVNyaQKHRlUAR4QFjAOegQIAhAB&usg=AOvVaw1KkYxrbn4RjTgAPZTWkWip
18. Hussein LK. Improving quality of perinatal care through clinical audit; A study from tertiary hospital in Dares Salaam, Tanzania, 2009. https://www.researchgate.net/publication/279499157
19. Kassa ZY, Husen S. Disrespectful and abusive behavior during childbirth and maternity care in Ethiopia: A systematic review and meta-analysis. BMC Res Notes [Internet]. 2019; 12(1):2-7. Available from: https://doi.org/10.1186/s13104-019-4118-2.
20. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLoS One. 2017; 12(3):e0174084. ISSN 1932-6203 Doi: htttps://doi.org/10.1371/journal.pone.0174084
21. John ME, Duke EU, Esienumoh EE. Respectful Maternity Care and Midwives' Caring Behaviours During Childbirth in Two Hospitals In Calabar, Nigeria. Africa Journal of Biomedical Research. 2020; 23(2). ISSN 1119_5096. https://www.ajol.info/index.php/ajbr/issue/view/19226
22. Lundgren I, Karlsdottir SI, Bondas T. Long-term memories and experiences of childbirth in a Nordic context-a secondary analysis. International Journal of Qualitative Studies on Healthand Well-being. 2009; 4:115-128.

23. Makumi Ishmael Wango. Disrespect and Abuse of Women during Facility based Deliveries and its Effects on Intent to Use Maternity Services in Uringu Division Meru County [dissertation]. University of Nairobi, 2015.
24. Manu A, Zaka N, Bianchessi C, Maswanya E, Williams J, Arifeen SE. Respectful maternity care delivered within health facilities in Bangladesh, Ghana and Tanzania: A cross-sectional assessment preceding a quality improvement intervention. BMJ open, 11(1), e039616.ine and Primary Care. 2021; 10(4):1699.
25. Mgawadere F, Shuaibu U. Enablers and Barriers to Respectful Maternity Care in Low and Middle-Income Countries: A Literature Review of Qualitative Research. International Journal of Clinical Medicine. 2021; 12(5):224-249.
26. Namusonge LN, Ngachra JO. Respectful Maternity Care Interventions: A Systematic Literature Review. East African Journal of Health and Science. 2021; 3(1):45-58.
27. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low income country. Int J Gynaecol Obstet. 2015; 128(2):110-113.
28. Raval H, Puwar T, Vaghela P, Mankiwala M, Pandya AK, Kotwani P. Respectful maternity care in public health care facilities in Gujarat: A direct observation study. Journal of Family Medic, 2021.
29. Sacks E. Defining disrespect and abuse of newborns: A review of the evidence and an expanded typology of respectful maternity care. Reproductive Health. 2017; 14(1):66.
30. Soet JE, Brack GA, DiIorio C. Prevalence and Predictors of Women's Experience of Psychological Trauma During Childbirth. Birth. 2003; 30:36-46. Doi: https://doi.org/10.1046/j.1523-536x.2003.00215.x PMID: 12581038
31. Swahnberg K, Wijma B, Siwe K. Strong discomfort during vaginal examination: Why consider a history of abuse? Eur J Obstet Gynecol Reprod Biol. 2011; 157:200-205. Doi: https://doi.org/10.1016/j.ejogrb.2011.02.025 PMID: 21470763
32. United Nations. Maternal mortality and morbidity and human rights. Human Rights Office of the Commissioner, 2013.
33. Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, *et al*. The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Health. 2019; 16(1):77.
34. Wassihun B, Deribe L, Worede N, Gultie T. Prevalence of disrespect and abuse of women during child birth and associated factors in Bahir Dar town, Ethiopia. Epidemiol Health. 2018; 40:e2018029.
35. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. World Health Organization, 2016.
36. World Health Organization. Trends in maternal mortality: 2000 to 2017: Estimates by who, UNICEF, UNFPA, world bank group and the United nations population division. Geneva, Switzerland, 2019.
37. World Health Organization. Who recommendations: intrapartum care for a positive childbirth experience, 2018.