


## ORIGINAL RESEARCH OPEN ACCESS

# Respectful Maternity Care During Facility-Based Childbirth and Its Predictors in Public Health Facilities in Central Ethiopia: A Multidimensional Communication as a Proximal Predictor: A Cross-Sectional Study

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**Keywords:** childbirth | multidimensional communication, Ethiopia | respectful care

## ABSTRACT

**Background:** The provision of compassionate, respectful, and caring healthcare is an essential component of health workforces because it builds deep relationships between healthcare practitioners and mothers. However, respectful maternity care has received less attention in practice, and existing research is inconclusive as well. Therefore, this study is aimed to assess respectful maternity care and its predictors during childbirth in Siltie Zone, Ethiopia.

**Methods:** We conducted a cross-sectional study on 374 mothers from May 1 to 30, 2021. A systematic random sampling technique was used to select the study participants. A structured questionnaire was used to collect the data. The data was entered into Epi Data 3.1, and the analysis was done using SPSS 24.0. Binary logistic regression was employed to identify candidate variables for multivariable logistic regression. In the multivariable analysis, variables having a *p*-value of less than 0.05 were taken as measures of the degree of association between independent variables and the outcome variable.

**Results:** The result of the study revealed that the overall prevalence of respectful maternal care is 41.0%. Rapport built through communication during antenatal care (AOR = 6.32, 95% CI: 2.81, 16.67), pre-communication of husband and wife (AOR = 2.45, 95% CI: 2.01, 13.69), clearly known communication of family with mother (AOR = 0.35, 95% CI: 0.11, 0.69), caring culturally and appropriately (AOR = 7.45, 95% CI: 2.88, 19.28), perceived length of the stay during labor (AOR = 1.36, 95% CI: 0.230, 0.551), number of ANC received (AOR = 1.98, 95% CI: 0.037, 0.260), and number of deliveries (AOR = 1.36, 95% CI: 0.230, 0.551) were independent predictors of the outcome variable.

**Conclusion:** The study revealed that respectful maternity care was provided very low. Multidimensional communication with the mother was identified as a significant proximal predictor of respectful maternity care. The study suggests that stakeholders should improve respectful maternity care through the provision of professional health training and create guidelines to identify and address challenges to its practice.

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## 1 | Introduction

Working on the reduction of maternal mortality is a global imperative. A compassionate and respectful caring (CRC) attitude among health providers plays a vital impact in enhancing the health-seeking behavior of mothers and clients [1–3]. Respectful maternity care (RMC) is when healthcare services are provided for a woman who receives maternity care with respect for women's autonomy, dignity, feelings, choices, and freedom of discrimination and preferences, such as having a companion wherever possible. To this aim, CRC can assist a person recover from a catastrophic illness, improve chronic condition management, lower client worry and stress, and be vital for optimal medical outcomes [2–6]. According to research, more than 85% of clients and 76% of healthcare personnel agreed on a positive medical outcome [7]. Previously reported studies showed that patients anticipated practitioners to provide companion care [8–13].

The World Health Organization (WHO) issued a statement on the prevention and elimination of disrespect and abuse during facility-based birthing in response to the mounting evidence of women being mistreated throughout the world during pregnancy and childbirth [2, 14]. During labor and delivery at a medical facility, the future well-being of the mother, the newborn, and their family can be significantly impacted by compassionate and RMC [15]. Maternal care that is both compassionate and respectful is characterized by the belief that every woman has a right to the best possible health [3, 4, 8]. According to the WHO definition, this encompasses the right of all childbearing women worldwide to compassionate, respectful, and dignified medical care during their pregnancy, delivery, and postpartum period [2, 14]. In the United States, despite high respectful care expectations, the desired service provision was not achieved. Just 53% of patients and 58% of physicians agreed that the healthcare system offered compassionate treatment [7, 16].

The Ethiopian Federal Ministry of Health has worked to increase the number of health facilities and health professionals in the country and better connect communities to facilities to improve access to and uptake of maternity services. Many Ethiopian professionals are sensitive and aware of the skills required for CRC. To this end, the provision of CRC is a current issue of the Ethiopian Federal Ministry of Health [12, 17]. It also improves the quality of maternal care by reducing the high prevalence of disrespect and abuse during childbirth. Because motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care [18, 19]. However, RMC has received less attention in practice, and existing research is inconclusive as well. Therefore, this study is aimed to assess RMC and its predictors during facility-based childbirth in Siltie Zone, Ethiopia.

## 2 | Methods

### 2.1 | Study Setting and Period

We conducted this study in the central part of Ethiopia, in Siltie Zone health facilities. The study was conducted from May 1 to 30, 2021.

### 2.2 | Study Design and Participants

A facility-based cross-sectional study design was conducted. All mothers who had given birth at West Azernet Berbere District's health centers were considered the source population. The study population consisted of all sampled mothers who came to health facilities in West Azernet Berbere for delivery service. As inclusion criteria, all mothers who had given birth within 24 h before discharge and mothers who had been residents of the study area for the past 6 months were included in the study. Mothers who were critically ill and unable to respond during data collection in the postnatal care (PNC) room were excluded from the study.

### 2.3 | Sample Size Determination and Sampling Procedure

The sample size was calculated by using a single population proportion and considering the following assumptions:  $P = 33\%$  (assuming a proportion of women reporting free of disrespect and abuse care during labor and delivery in a health facility) [19], marginal error ( $d$ ) of 5%, confidence interval (CI) of 95%, and  $Z_{1-\alpha/2}$  is the value of the standard normal distribution corresponding to a significant level of alpha ( $\alpha$ ) 0.05, which is 1.96. Finally, to account for contingencies such as nonresponse or recording error, the sample size was increased by 10%, resulting in  $340 \times 10/100 + 340 = 374$ . As a sampling technique, there were four health centers in the district, and all health centers were included in the study. A proportional allocation of sample size was done to each health center based on their estimated number of deliveries. Then, study participants were selected by a systematic random sampling technique with a  $K$ -value of 7 at each health center. The first mother from each health center was selected by the lottery method.

### 2.4 | Measurement of Variables and Operational Definition

The outcome of this study is the prevalence of respectful maternal healthcare. The outcome variable, "any RMC of women," was dichotomous, requiring a "yes" or "no" response. "Yes" was marked if any of the above behaviors were observed. The exposure variables were sociodemographic factors (age, marital status, religion, educational status, socioeconomic status), multidimensional communication with the mother (rapport of mother with health worker, pre-communication of husband and wife, husband relationship with health worker, clearly known communication with family, and cultural uniformity during childbirth), obstetric history-related factors (parity, place of delivery, length of stay in a health center), service delivery-related factors, individual-related factors (like a well-understanding of RMC), and provider-related factors. RMC is when healthcare services are provided for a woman who receives maternity care with respect for women's autonomy, dignity, feelings, choices, and freedom of discrimination and preferences, such as having a companion wherever possible. She will be considered to receive RMC during facility-based childbirth. Abuse-free care is when a woman receives care

without being kicked, pinched, slapped, pushed, or and other methods using seven criteria. Confidentiality and privacy-protected care is when health providers protect the confidentiality of clients' information by not exposing it to others, not discussing health information with non-health staff, and using cover during labor and delivery. Consented care is when health providers communicate with women about force-free procedures like tubal ligation, hysterectomy, abdominal palpation, vaginal examination, episiotomy, and others, measured using seven criteria. Dignified care is when health providers respect women's dignity and value at the time of labor and delivery, measured using two criteria. Non-discriminated care is when women receive equitable care regardless of their personal attributes, measured using three criteria. Timely care is when women receive healthcare services at the right time and achieve the highest attainable level of health, measured using two criteria. Free detention in facilities is when women receive healthcare services without deprivation of liberty, free of self-determination, or coercion, measured using two criteria.

## 2.5 | Data Collection, Quality Management, Processing, and Analysis

Data were collected using pre-tested, structured interviewer-administered questionnaires. The questionnaire was adapted and developed through a review of various relevant literature [2, 4, 6, 20]. Questionnaires were translated into the local language and then back translated to English by another person to maintain internal consistency. A pre-test was carried out on 5% of the sample size in Endegagn Health Center 1 week before the actual data collection, and possible modifications and amendments of the tool were done based on the results of the pre-test. Data were collected by using six diploma nurses and two public health officers as supervisors who were fluent in Amharic and Siltegnna. Two days of training were given for data collectors and supervisors, which focused on the aim of the study, procedures, data collection techniques, the art of interviewing, ways of collecting the data, and clarification on how to manage the data collection process. Supervisors and the principal investigator performed immediate supervision on a daily basis. Every day, the collected data was reviewed and cross-checked for completeness and relevance before data entry. The data were analyzed by SPSS V. 24.0. Before analysis, the data were checked for normality and homogeneity, then analyzed and interpreted by the research team. Inconsistencies and missing values were checked by running frequencies and other data explorations. Descriptive statistics like frequency distributions, mean, and standard deviation were computed. Bivariate analysis was done primarily to check which independent variables had an association with the dependent variable (RMC). Independent variables with marginal associations ( $p < 0.25$ ) in the bivariate analysis, which are plausible and those variables showed significant association in the previous studies, were entered into a multivariable logistic regression analysis to detect association with complete RMC. We used the Hosmer–Lemeshow test to check the appropriateness of the model for analysis. Finally, AOR with a 95% CI was estimated to assess the strength of associations, statistical significance was declared at a  $p < 0.05$ , and results were presented using tables, figures, and texts.

## 2.6 | Ethical Clearance and Consent to Participate

Ethical approval was obtained from the Institutional Review Boards (IRB) of Wachemo University School of Graduate Studies before the commencement of the study, with approval number Ref No./WCU/SGS/1171/2012 and Date 10/09/12 (local date in Ethiopian calendar). A formal letter from the College of Medicine and Health Sciences was obtained and delivered to all appropriate offices in each district to request authorization. All participants' rights to self-determination and autonomy were honored. The purpose of the study was explained to all study participants, and extra information was provided verbally if necessary. Participants can withdraw from the study at any time, without penalty or loss of benefit, without reason or punishment. The participants were also told that their responses would be kept private and confidential that their names would not be revealed. Finally, informed verbal consent was obtained from each participant after thoroughly explaining the objectives and benefits of the study.

## 3 | Results

### 3.1 | Sociodemographic Characteristics

Three hundred and seventy-four mothers were interviewed, yielding a 100% response rate. Table 1 shows the socio-demographic characteristics of the study participants. Accordingly, the mean age of the participants was 26.2 (SD  $\pm$  2.4) years, with a minimum and maximum age of 18 and 47, respectively. The majority of the participants, 170 (45.5%), fall in the 25–29 age group, and the rest of the socio-demographic characteristics of the study population are shown in Table 1.

### 3.2 | Multidimensional Communication With Mother and Obstetric Care History

Table 2 shows multidimensional communications with mother and obstetric care during antenatal care and childbirth. Accordingly, of the total participants, 234 (62.6%) built rapport through communication during ANC, and only 98 (26.2%) of the participants made communication with workers concerning the mother and the process of caring. The majority, 302 (80.7%) of the participants, were pre-communications between husband and wife, and 251 (67.1%) of the participants were going with their husbands for an ANC visit and check-up. Only 91 (24.3%) of the mothers clearly knew how to communicate with family and got help.

Concerning obstetric care history, 373 (99.7%) had a history of ANC follow-up for the most recent delivery. More than half, 250 (67.0%), of the mothers were seen by the midwife for ANC follow-up. Around half, 185 (49.5%), of mothers who received ANC service were seen at health centers, followed by health posts. The rest of the obstetric history of mothers is shown in Table 2.

**TABLE 1** | Sociodemographic characteristics of participants in West Azernet Berbere District, Silte zone, Central Ethiopia, 2021 (*n* = 374).

Category	Options	Frequency	Percent
Age of mother	15–19	16	4.3
	20–24	121	32.4
	25–29	170	45.5
	30–34	57	15.2
	≥ 35	10	2.7
Ethnicity of mother	Silte	351	93.9
	Hadiya	12	3.2
	Garage	9	2.4
	Amara	2	0.5
Educational status of the mother	Cannot read and write	44	11.8
	Read and write	33	8.8
	1–4 grade	140	37.4
	5–8 grade	59	15.8
	9–10	98	26.2
Religion	Muslim	346	92.5
	Protestant	10	2.7
	Orthodox	18	4.8
Occupation status of the mother	Housewife	241	64.4
	Government employee	59	15.8
	Merchant	66	17.6
	Other	8	2.1

### 3.3 | Prevalence of RMC During Facility-Based Childbirth

Figure 1 shows the prevalence of disrespect and abuse by category during facility-based childbirth in West Azernet Berbere district. Accordingly, the study revealed that out of the 374 participants interviewed, only 153 (41.0%) reported having experienced at least one form of RMC during facility-based childbirth, while 221 (59.0%) did not experience any form of RMC (Figure 1).

### 3.4 | Type of RMC Prevalence During Facility Based Childbirth

Table 3 presents the prevalence of RMC during childbirth by type and category in West Azernet Berbere district. Accordingly, based on the verification criteria of RMC in the domain of physically abuse-free care, the majority of mothers who account for 358 (95.7%), respond that healthcare providers never denied food or fluids in labor unless medically necessitated, followed by mothers who account for 301 (80.4%) who didn't separate their mother from their baby without medical indication, and the rest is shown in Table 3 below.

### 3.5 | Predictors of RMC

Binary logistic regression was performed to assess the association of each independent variable with RMC. The factors that showed a *p*-value of 0.25 or less were added to the multivariate regression model. The result revealed that on the bivariate analysis educational status, occupation, rapport built through communication during ANC, pre-communication of husband and wife, clearly known communication of family with mother, perceived length of the stay during labor, caring culturally and appropriately, number of ANC received, number of deliveries, perceived length of the stay during labor, and polite responses to mothers questions and were significantly associated with RMC.

However, in multivariable logistic regression, this study showed that rapport built through communication during ANC was found to be 6.32 times more likely to get RMC when compared with those who were not (AOR = 6.32, 95% CI: 2.81, 16.67). The findings of this study indicated that pre-communication of husband and wife with health workers had higher odds of RMC than those who did not interact well (AOR = 2.45, 95% CI: 2.01, 13.69). The analysis of this study also revealed that study participants who had clearly known communication of family with mother had lower odds of RMC than those who did not communicate with family (AOR = 0.35, 95% CI: 0.11, 0.69). Caring culturally and appropriately (AOR = 7.45, 95% CI: 2.88, 19.28), perceived length of the stay during labor (AOR = 1.36, 95% CI: 0.230, 0.551), number of ANC received (AOR = 1.98, 95% CI: 0.037, 0.260), and number of deliveries (AOR = 1.36, 95% CI: 0.230, 0.551) also had higher odds of RMC as compared to their counterpart (Table 4).

## 4 | Discussion

According to the findings of the current study, 41.0% of pregnant women received respectful care. The finding is slightly lower than that reported from national health workforce studies, in which RMC was 64.6% [6]. This gap could be explained by the fact that this study was conducted locally in one district of the Siltie Zone, whereas the national study was undertaken at model health facilities throughout the region. However, this result was slightly similar to previous research findings in non-model health institutions in the North Showa Zone, which reported 46.2% for respectful care practice [21]. On the other hand, this figure is higher than the study conducted in Addis Ababa and Arba-Minch Town, which accounts for 22% and 2.82% [18, 19], respectively. This discrepancy might result from time, and the behavior of health professionals is capacitated through capacity building and training.

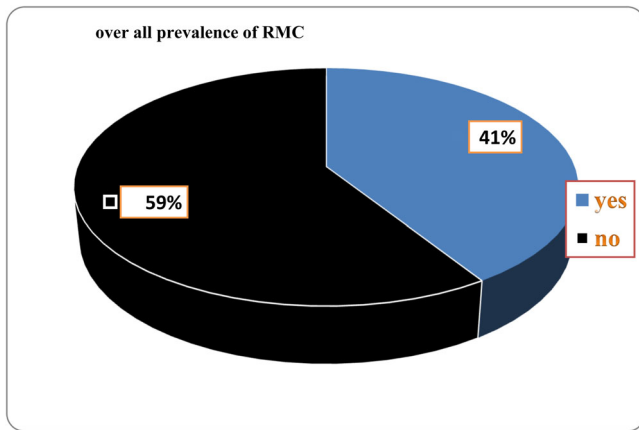
A previous study in Harar Hospital noted that physical abuse-free care was 57% and more in others [22–24]. Our study also found that the prevalence of physical abuse-free care was 57.7%. This discrepancy might be due to study area differences and socio-cultural and socio-economic variation in the study area.

Previous studies noted that smooth communication between clients and healthcare providers increased care-seeking behavior and built mutual respect [25, 26]. The present study also revealed that rapport built through smooth communication

**TABLE 2** | Obstetric care during antenatal care and childbirth and other communication variables in the West Azernet Berbere district, Central Ethiopia ( $n = 374$ ).

<b>Variables</b>	<b>Options</b>	<b>Number</b>	<b>Percent</b>
Rapport built through communication during ANC	Yes	234	62.6
	No	143	37.4
Communication of the husband with health workers	Yes	98	26.2
	No	276	73.8
Pre-communication of husband and wife	Yes	302	80.7
	No	72	19.3
Going with husband for ANC visit and check-up	Yes	251	67.1
	No	123	32.9
Clearly known communication of family with mother	Yes	91	24.3
	No	283	75.7
Cultural uniformity mother with health workers	Yes	123	32.9
	No	251	67.1
Cultural practices of mother during delivery	Yes	168	44.9
	No	206	55.1
Having ANC follow-up	Yes	373	99.7
	No	1	0.3
Having discussion with health worker about delivery during ANC	Yes	293	78.3
	No	81	21.7
Number of ANC follow-ups	< 4	113	30.2
	≥ 4 and more	261	69.8
Number of pregnancies	1–2	246	65.8
	3 and above	128	34.2
Staying in the maternity waiting home before labor started	Yes	77	20.6
	No	297	79.4
Perceived length of the stay during labor	Long	303	80.5
	Short	71	19.5
Perceived professional appropriateness who attends during delivery	Appropriate	256	75.9
	Not appropriate	118	24.1
Place of delivery	Health post	185	49.5
	Health center	180	48.1
	District hospital	9	2.4
Mode of delivery	Normal	264	75.9
	Other	110	24.1
Time of delivery	Night time	221	59.1
	Day time	156	40.9
Mother's condition during childbirth	Good	304	81.2
	Bad	70	18.8
Who attended your delivery	Midwives	251	67.1
	HEWs	103	27.5
	Health officers	20	5.4
Sex of the healthcare provider	Male	175	46.8
	Female	199	53.2





**FIGURE 1** | Overall prevalence of respectful maternity care in West Azernet Berbere District, Silte zone, Central Ethiopia, 2021 ( $n = 374$ ).

during antenatal care had a statistically significant association, confirming higher odds of RMC as compared to none. This might be due to the relationship built through transparency and frequent contact with health workers. The husband-wife communication in several family planning and maternal health issues significantly increased the process [26–30]. The present study also found that pre-communication established between husband and wife had higher odds of getting RMC as compared to those who were not. This might mean their communication is not limited to maternal and childbirth issues but also how to approach the health workers during each contact and during childbirth.

An Iranian interventional study on marital communication skills training to promote marital satisfaction and psychological health during pregnancy found that using a focused approach to communication increased the psychological satisfaction of the

**TABLE 3** | Prevalence of RMC during childbirth by types and categories in West Azernet Berbere district, Siltie Zone, southern Ethiopia, 2021 ( $n = 374$ ).

Category and components of RMC	Frequency and percent of types of RMC	
	Yes %	No %
Physically abuse free care		
Health provider(s) never physically hit or slapped laboring mother	72 (19.2)	302 (80.8)
Health provider never verbally insulting me during labor	83 (22.1)	291 (77.9)
Health provider didn't separate mother from baby without medical indication	301 (80.4)	73 (19.6)
Supportive staff never insult me and my companion	290 (77.5)	84 (22.5)
Demonstrating caring culturally in appropriate way	136 (36.4)	238 (63.6)
Receiving necessary pain-relief treatment during and after delivery	273 (73.0)	101 (27.0)
Never denied from food or fluid in labor unless medically necessitated	358 (95.7)	16 (4.3)
Confidential care and privacy during childbirth		
The providers use drapes or covering to protect mother's privacy during labor	154 (41.2)	220 (58.8)
Health providers never discussed your private health information in a way that others could hear	170 (45.4)	204 (54.6)
Inform consented care		
The provider introduces themselves and greeting mother and her support person	34 (9)	340 (91.0)
The providers encourage mother to ask questions	85 (22.8)	289 (77.2)
The provider respond mother's question with politeness	79 (21.1)	295 (78.9)
The provider explains what is being done and what to expect throughout labor and birth	95 (25.5)	279 (74.5)
Provider gives periodic updates on status and Progress of labor	70 (18.8)	304 (81.2)
Providers permit mother to choice of position for birth	106 (28.3)	268 (71.7)
Providers obtain informed consent from labored mothers	23 (6.1)	351 (93.9)
Dignified care		
Health providers never shouted at or scolded labored mothers	147 (39.4)	227 (60.6)
Health providers made positive comments about you	156 (41.8)	218 (58.2)
None abandonment/neglect of care		
Health providers never ignored you when you called for help	215 (57.5)	159 (42.5)
Health providers attended you during the second stage of labor	205 (54.8)	169 (45.2)

**TABLE 4** | Bivariate and multivariable logistic regression to determine independent predictors of RMC in Azernet Berbere District of Siltie Zone, Central Ethiopia ( $n = 374$ ).

Variable	Options	COR (95% CI)	AOR (95% CI)
Rapport built through communication during ANC	Yes	7.34 (3.45, 17.85) <sup>a</sup>	6.32 (2.81, 16.67) <sup>a</sup>
	No	1	1
Pre-communication of husband and wife	Yes	4.11 (2.62, 19.17) <sup>a</sup>	2.45 (2.01, 13.69) <sup>a</sup>
	No	1	1
Clearly known communication of family with mother	Yes	1	1
	No	0.44 (0.23, 0.78)	0.35 (0.11, 0.69)
Caring culturally appropriately	Yes	9.77 (3.77, 22.32)	7.45 (2.88, 19.28) <sup>a</sup>
	No	1	1
Perceived length of the stay during labor	Long	5.58 (2.23, 12.66)	6.58 (3.29, 13.11) <sup>a</sup>
	Short	1	1
Number of ANC follow-up	< 4	2.21 (0.51, 0.74)	1.98 (0.037, 0.260) <sup>a</sup>
	≥ 4	1	1
Number of pregnancies/delivery	1–2	1.53 (0.670, 0.741)	1.36 (0.230, 0.551) <sup>a</sup>
	3 and more	1	1

<sup>a</sup>Statistically significant; 1 stands for reference groups.

mother [26]. Similarly, our study found that having clear communication with family members about childbirth statistically increased the association with RMC. This might mean that communication has universal importance in changing the behavior of individuals.

In this study, the number of ANC received before delivery was positively associated with RMC compared to those who were not. This finding was also consistent with a study conducted in Northern Ethiopia. The concept is similar to the notion that building rapport with clients facilitates the healing process [25]. It was previously documented that studies in Ethiopia and abroad had shown the influence of the mother increased with the increased relationship between healthcare providers (doctors) [25, 26, 30–32]. In the current study, the number of deliveries given by healthcare professionals was also positively associated with RMC.

Our study found that the perceived length of the stay during labor had a significant association with RMC. This is inconsistent with the study conducted in various places [33, 34]. This might be due to the length of the labor, which has a positive influence on understanding the burden and empathy the health professional has for the mother. The care given, keeping cultural context, appropriate treatment, and caring had higher odds of RMC as compared to those who were not. Previous studies also documented that respectful care given to patients honoring the cultural context was more effective than others [24, 35–37].

As strength, adding multidimensional communication as proximal predictor of maternity care is an additive input for intervention. The other is that the data was obtained from study participants within 24 h before discharge in the PNC room, which avoids recall bias. As a limitation, since a cross-sectional design was used for the study, it is difficult to predict the relationship between the variables: the predictive variable or the

behavior (RMC). Another limitation is, in frequentist statistics, a CI is an interval that is predicted to include the parameter being evaluated. However, in the case of keeping cultural context and appropriate treatment, the CI was broader, indicating that the sample did not provide an exact representation of the population mean, despite the fact that the right sampling method was applied.

In conclusion, the likelihood of achieving the desired results in promoting facility-based RMC in low-income countries is unlikely to occur unless there is a strong focus on building relationships and rapport for health-seeking behavior. Most importantly, rapport built through communication during antenatal care, pre-communication of husband and wife with health worker, clearly known communication of family with mother, caring culturally and appropriately, perceived length of the stay during labor, number of ANC received, and number of deliveries was independent predictors of the outcome variable. The findings of this study revealed that RMC received less attention in the study area. The study suggests that stakeholders should improve RMC through the provision of health professional training, and create guidelines to identify and address barriers to its practice. The study also concluded that further longitudinal research is required to determine cause-and-effect relationships, and action must be strengthened and customized to culturally appropriate information.

#### Author Contributions

J.A. conceived and designed the study. F.D.A., A.H., and J.A. made substantial contributions to conceptualization, acquisition of data, analysis, and interpretation of data; contributed to drafting the article or revising it critically for significant intellectual content. F.D.A. wrote the manuscript. All authors have read and approved the final version of the manuscript. The first author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported, that no important aspects of the study have been omitted, and that any

discrepancies from the study as planned (and, if relevant, registered) have been explained.

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### Disclosure

The authors have nothing to report.

### Conflicts of Interest

The authors declare no conflicts of interest.

### Data Availability Statement

All relevant data are available from the corresponding author upon reasonable request. [Corresponding author] had full access to all of the data in this study and takes complete responsibility for the integrity of the data and the accuracy of the data analysis.

### Transparency Statement

The lead author, Feleke Doyore Agide, affirms that this manuscript is an honest, accurate, and transparent account of the study being reported, that no important aspects of the study have been omitted, and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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