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A qualitative inquiry into pregnant women's perceptions of respectful maternity care during childbirth in Ibadan Metropolis, Nigeria

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Abstract: *Women's perceptions of respectful maternity care (RMC) are critical to its definition and measurement globally. We evaluated these in relation to globally defined RMC norms. We conducted a descriptive study involving eight focus group discussions with 50 pregnant women attending antenatal clinic at one primary and one secondary health facility each in the North-west and South-west local government areas of Ibadan Metropolis, Nigeria. One focus group each with primigravidae and multiparas were held per facility between 21 and 25 October 2019. Shakibazadeh et al's 12 domains of RMC served as the thematic framework for data analysis. The women's perceptions of RMC resonated well with seven of its domains, emphasising provider-client inter-personal relationships, preserving their dignity, effective communication, and non-abandonment of care, but with mixed perceptions for two domains. However, their perceptions deviated for four domains, namely maintaining privacy and confidentiality; ensuring continuous access to family support such as birth companions; obtaining informed consent; and respecting women's choices about mobility during labour, food and fluid intake, and birth position. The physical environment was not mentioned as contributing to an experience of RMC. Whilst the perceptions of the Nigerian women studied about RMC were similar to those accepted internationally, there were significant deviations which may be related to cultural differences and societal disparities. Different interpretations of RMC may influence women's demand for such care in different settings and challenge strategies for promoting a universal standard of care.* DOI: 10.1080/26410397.2022.2056977

Keywords: respectful maternity care, perceptions, pregnant women, qualitative study, low-resource settings, deviations, similarities, global norms, respect, women-centred care

Introduction

Childbirth has been described as an intense psychological experience in a woman's lifetime that leaves her with vivid memories which may be positive or negative.[1] Women have described a positive childbirth experience as having control of their birth process and having trustful and supportive relationships during birth.[2,3] Being treated disrespectfully or over-medicalisation of the birth process may result in negative experiences.[4] Negative childbirth experiences may affect a woman's health and wellbeing long after childbirth, influencing the bonding period post-delivery and her future reproductive health decisions. Complications such as post-traumatic stress disorder have also been reported.[5,6]

Respectful maternity care (RMC) received during childbirth can enhance a woman's positive experience. In addition to ensuring the clinical requirements of a safe childbirth process, the

delivery of RMC helps to meet a woman's psychological and emotional childbirth needs. It is a rights-based approach to maternal care.[7] Emphasis has been placed on RMC as a global priority in the last decade because it contributes to the overall quality of childbirth care experienced, and may be the missing link in ensuring continuous health facility delivery.[8] Unfortunately, the basic rights underlying the global RMC norms may not be universally accepted. Local expectations of RMC may be lower, due to cultural differences, low self-perception, and structural power imbalances,[9] factors which could negatively affect women's demand for RMC as currently defined.

There has been no agreed global definition of RMC because it is not simply the absence of mistreatment,[10] and women's voices should contribute to defining it.[11] The World Health Organization defines RMC as "care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth".[12] Shakibazadeh et al[13] defined the 12 domains of RMC from a qualitative evidence synthesis of 67 eligible papers from 32 countries, including 6 from sub-Saharan Africa. By exploring women's perceptions of RMC, this study contributes to its global definitions.

The current global norms around RMC should meet women's demands and expectations. They should be continuously reviewed as women's demands and expectations change and as women and girls continue to challenge the normalisation of their mistreatment during childbirth in healthcare settings. It is assumed that women's expectations of birth should be to receive respectful and dignified care that gives a positive birth experience, and that these expectations can be used to define RMC or improve its current definitions. Evaluating the correctness of this assumption is important for the conceptualisation and measurement of RMC, as well as informing the demand for RMC in different settings. If women's expectations deviate negatively from respectful and dignified care, their supposedly positive childbirth experience may not have been optimal, and this also challenges their ability to define a RMC. This represents a challenge for policymakers and programme implementers promoting RMC as the standard of care for all women during childbirth. Understanding the reasoning behind these deviations is also important.

Several studies have explored women's and providers' perceptions of disrespectful and abusive care.[14] Of recent, there has been a shift in the literature to focus on RMC as a broader, more positive concept beyond the absence of mistreatment or disrespect. Women's perceptions and expectations of RMC during childbirth have been less studied, especially women in low-resource settings such as Nigeria. Thus, this study investigated Nigerian pregnant women's perceptions about RMC, and how these relate to the globally defined RMC domains.

Methodology

Study design and setting

This cross-sectional exploratory qualitative study was conducted in Ibadan North-west and South-west local government areas (LGAs) within the Ibadan Metropolis, South-western Region, Nigeria. There are six public primary health care (PHC) facilities and one secondary health facility (SHF) offering maternal and child health services in the North-west LGA, while there are three public primary and three secondary health facilities in the South-west LGA. The PHC facilities send referrals to the SHFs. The South-West LGA is one of the LGAs with the largest slums in the Ibadan Metropolis,[15] and the main occupation of the people is trading.[16] The North-west LGA is located in the centre of the city and is predominantly urban. The population are artisans and civil servants as well as traders.[17] The character of each LGA is reflected in the socio-demographic characteristics of pregnant women accessing the health facilities within it.

Sampling, study participants, and recruitment

The two LGAs (Ibadan North-West and South-West) were selected purposively (one predominantly urban and one including more slums, though urban). One secondary and one primary public health facility were selected in each of these two LGAs, giving a total of four health facilities. There was only one public SHF in the North-west LGA; otherwise, both primary and secondary health facilities were selected based on their relatively large volume of clients.

The study participants were pregnant women in their first or second trimester who were registered at these health facilities. They were selected

by the research assistants with support from the nursing staff who introduced the research assistants and explained the purpose of the research to them. Pregnant women who were not in any form of distress, had completed their antenatal clinic (ANC) routines for the day and were willing to participate were recruited until predetermined quotas for primigravidae and multiparous women, respectively, were reached. Two focus group discussions (FGDs) were conducted per facility, one with six multiparous women (women who have delivered before) and another with six primigravidae (women with their first pregnancy). This gave a total of eight FGDs. Pregnant women who were ill or in any form of discomfort were excluded.

FGD guide

The guide explored the women's perceptions of RMC and how these are commonly demonstrated during childbirth. Probing questions included, "*what do you understand by the word respect, and how should this be demonstrated by health providers when you come to deliver?*" The FGD guide was translated into Yoruba and back-translated to English. The FGDs were conducted in English or Yoruba depending on the preferred language of each group. Five FGD sessions were conducted in Yoruba. The FGD guide was pretested for length, adequacy and comprehensibility among separate groups of multiparous pregnant women and primigravidae recruited at the ANC of a primary health facility in Ile-Ife, a neighbouring town.

Data collection

Respondents' socio-demographic data obtained consisted of their age, level of education, occupation, number of pregnancies and deliveries, and their current gestational age. We asked multiparous women if they had ever delivered in that facility, at home, in a church or mosque, or a faith-based organisation (called mission homes).

The FGDs were conducted from 21 to 25 October 2019 in a separate and secluded room away from the nurses and other staff within the facility, during one of their regular antenatal clinic days and after all health education activities had been concluded. The health providers introduced the research team to the women. The principal investigator is a Community Health Physician with expertise in conducting qualitative interviews and a deep understanding of the RMC concept. The FGDs lasted about 50 min on average. The researchers involved in the FGDs were all females, which helped to prevent gender and social desirability bias. Interesting responses were probed. All the FGDs were audio-recorded using a digital voice recorder.

Data management and analysis

The audio-recorded discussions were transcribed verbatim. FGDs conducted in Yoruba were translated into English. Thematic content analysis[18] was done using the NVIVO 11 software. The transcribed FGDs were imported, initially coded using deductive coding guided by the 12 domains of RMC proposed by Shakibazadeh et al[13] as their thematic framework. Afterwards, inductive coding was done for the remaining information not yet coded. Coding was primarily done by the principal investigator, and also by a research assistant whose codes were compared with those of the principal Investigator.

Ethics approval and consent to participate

Ethical approvals were obtained from the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (clearance Number M190658, 2 October 2019), as well as the Oyo State Ministry of Health (Ref. Number AD/13/479/1386, 31 July 2019). Written informed consent for participating and recording of their voices was obtained from each participant. The researchers had no prior relationship with the pregnant women interviewed. They were introduced as researchers; details about their qualifications and positions were not disclosed, to minimise any power imbalance that could coerce the women into participating. There were no inducements given before participation. A stipend of ₦500 (1.4 USD) was given for transportation.

Results

Description of the study participants

Six women participated in six of the groups and seven women in two groups to give a total of 50 women, consisting of 26 primigravidae and 24 multiparous women (Table 1). The majority of the women were of the Yoruba ethnic group, with one Ibo and one Hausa woman. Their ages ranged between 18 and 41 years, the multiparous women being older. Only one (2%) of the women did not have at least a secondary education. There were more artisans and traders among the

Table 1. Socio-demographic characteristics of FGD participants

Socio-demographic characteristics	Primary Health Facility		Secondary Health Facility	
	Primigravida ($n = 14$) Freq (%)	Multipara ($n = 12$) Freq (%)	Primigravida ($n = 12$) Freq (%)	Multipara ($n = 12$) Freq (%)
Age (in years)				
18–24	9 (64.3)	0 (0.0)	2 (16.7)	0 (0.0)
25–35 years	4 (28.6)	9 (75.0)	10 (83.3)	7 (58.3)
>35 years	1 (7.1)	3 (25.0)	0 (0.0)	5 (41.7)
Age in years (median, IQR)	23.5 (20–29)	31 (29–36)	28 (26–31)	34 (33–37)
Highest level of education				
Primary	1 (7.1)	0 (0.0)	0 (0.0)	0 (0.0)
Secondary	10 (71.4)	9 (75.0)	4 (33.3)	3 (25.0)
Tertiary	3 (21.4)	3 (25.0)	8 (66.7)	9 (75.0)
Marital status				
Single	3 (21.4)	0 (0.0)	0 (0.0)	0 (0.0)
Married	11 (78.6)	12 (100.0)	12 (100.0)	12 (100.0)
Occupation				
Student	0 (0.0)	0 (0.0)	0 (0.0)	1 (8.3)
Artisan (tailor, hairdresser, etc.)	8 (57.1)	4 (33.3)	2 (16.7)	1 (8.3)
Trading/Business	4 (28.6)	4 (33.3)	3 (25.0)	7 (58.3)
Civil servant/Private employee	2 (14.3)	4 (33.3)	7 (58.3)	3 (25.0)

primigravidae interviewed at the PHC facilities but more skilled professionals among those at the SHFs. A higher proportion of the multiparous women at the SHFs had previously delivered at the same facility while three at the PHC facilities had previously delivered at home or a faith-based organisation (Table 2).

Women's perceptions of RMC with similarities and deviations from the current RMC definition

The 12 domains of respectful maternity care (RMC) as defined by Shakibazadeh et al and how they compare with the study participant's perceptions of RMC are highlighted in Table 3.

Across the focus groups, we found that most of the women's perceptions of RMC related to the domains defined as "preserving woman's dignity"; "engaging with effective communication"; and "continuity of care". However, their perceptions deviated from the globally defined RMC norms for health providers, that is: "ensuring continuous family support"; "maintaining privacy and confidentiality"; "getting informed consent"; and "respecting women's choices" on mobility during labour and birth position. The women made no

Table 2. Obstetric history of multiparous women

Delivery site history	Primary health facilities (n = 12)	Secondary health facilities (n = 12)
Ever delivered at same facility		
Yes	9 (75.0)	11 (91.7)
No	3 (25.0)	1 (8.3)
Ever delivered at:		
Home	1 (8.3)	0
Church/ Mosque/ TBA	2 (16.7)	0

mention of the "quality of the physical environment and resources" in relation to RMC.

Being free from harm and mistreatment

The women's perception of a respectful childbirth was one devoid of verbal abuse or being hit or slapped. This was common to all the groups. They denounced providers who shout at women in labour or are rude to them. They mentioned their disappointment with the sudden change in behaviour of providers who had been pleasant at the antenatal clinic but became hostile when the women presented in labour. They deemed as unnecessary, providers who tell women, "Was I there when you were conceiving?", thus blaming the woman for getting herself pregnant. They explained that this abuse of women prevents them from making their complaints known to the providers, for fear of being shouted at, and some not coming to the hospital when in labour.

"*The manner in which some people will be harsh, you will regret ever going to the hospital*." (Multipara, PHC)

Professional treatment was categorised under the "being free from harm and mistreatment" domain. The women described this as receiving proper attention and quality care, resulting in a safe delivery for both them and their baby.

"*I believe they need to give that woman proper attention … when you came to deliver, some people will be shouting when some will be bringing different attitude, so I think the health attendants (providers) they don't need to be shouting, 'why did you do this!?', they need to give us proper attention.*" (Multipara, SHF)

For a few, receiving proper attention and quality care is what they are most concerned with. They would not mind if it was delivered to them under abusive conditions: "*I will not mind if they abuse me, since I came to seek their assistance. What can prevent me from returning to the facility to deliver is if they don't take proper care of me and my baby*." (Multipara, PHC)

However, women in four FGD sessions believed that women in labour would determine the extent of RMC they received, and two of the groups stated further that some women may deserve being beaten during childbirth. The women perceived to deserve being beaten include those who have not cooperated well with the providers in opening their thighs for vaginal examination or the delivery, as well as teenage mothers, who were mentioned because they were likely to be unmarried rather than because they had done anything wrong. These perceptions came more from the FGDs with older, multiparous women. As one said, "*beat someone (laughs) – when one is not a child! But maybe those girls with unwanted pregnancy can be beaten"*. (Multipara, SHF)

Another woman remarked, *"So, if there are some you cannot allow the baby to die, so if it's slapping you will have to slap the woman, that "oya" you must open your thighs"* (Multipara, PHC). When asked if slapping the woman was disrespectful, she replied by saying *"It is not disrespect, that process is not disrespect"*. Such statements signify perceptions that normalise disrespect for some women and deviate from global definitions which stipulate that all women deserve RMC.

Maintaining privacy and confidentiality

Ensuring privacy as an approach to providing RMC was a controversial issue across the focus groups. In six of the groups, most women believed that ensuring privacy by not unduly exposing their body parts during labour was not a necessity, especially in the presence of other women in labour and attending health professionals.

"*There is nothing like privacy, when you are in labour, the woman will labour to a stage, the nurses will call the doctor to come, as in male doctor, is he not going to do his work and attend to the patient? So that doesn't have any meaning, and even at that*

Table 3. Relating the 12 domains of respectful maternity care to women's perceptions

	Global 12 Domains	Domains' definitions from the literature	Relationship with women's perceptions
1	Being free from harm and mistreatment	Not using loud voice, have a warm and measured manner, give professional treatment	Similar to the norms A few normalised disrespect to women
2	Maintaining privacy and confidentiality	Privacy during examinations and procedures; shield from visitors, other women and men; limit number of attending staff; maintain secrets about their health	Perceptions significantly deviated from the norms. Only a few insisted on ensuring privacy
3	Preserving women's dignity	Positive labour ward atmosphere; make woman feel welcomed, kind attitudes, calm, tactful, warm, smiling, caring, treat woman as an individual with preferences and differences, respect their cultures, values and beliefs.	Women's perceptions on RMC related mainly to ensuring this domain
4	Provision of information and getting informed consent	Provide information ask permissions before procedures, obtain consent	Agreed with provision of information. Obtaining consent was not always seen as necessary
5	Ensuring continuous access to family support	Have birth companions, physical structure should enable companions	Majority didn't see this as necessary
6	Enhancing quality of physical environment and resources	Provide comfortable, clean and calming birth environment; adequate beddings; regular water supply and electricity with medical & non-medical technologies	There were no RMC perceptions relating to this domain
7	Providing equitable maternal care	Availability of services regardless of age, ethnicity, sexuality and religion	Perceptions were similar to the norms
8	Engaging with effective communication	Give verbal praise and encouragement; provide emotional support; talking to & listening to the women; show empathy; practice effective non-verbal communication; provide interpreters	Perceptions were similar to the norms
9	Provision of efficient and effective care	Minimal delays/prompt attention; minimal interventions (episiotomy; vaginal examination, urinary catheter)	Perceptions were similar to the norms
10	Availability of competent and motivated staff	Have adequate and proficient staff; competent and supportive supervision.	Perceptions were similar to the norms
11	Continuity of care	Cared for by familiar staff, available on demand with no abandonment	Perceptions were similar to the norms
12	Respecting women's choices that strengthens their capabilities to give birth	Respecting women's decision on birth positions, mobility during labour and fluid intake during labour.	Women's perceptions deviated from the norms for all the issues raised

time, nobody cares who is watching … " (Multipara, SHF)

There was also a health system perspective to ensuring privacy. All the women in one FGD group conducted at a secondary health facility chorused that privacy cannot be achieved at the public hospitals for women. The lack of this was not perceived as lack of RMC, as it was because of unavailability of space. If a woman desired privacy, she should be ready to pay for it: "*if you want private, pay for private suite"*. (Primigravida, PHC)

Even though there were only a few arguing for privacy, they maintained their stance on the need to respect them and their body by ensuring privacy during labour. One of the women was content with covering her body with a wrapper if screens were not available, while another would not mind paying exorbitant fees at private hospitals to ensure the privacy of her childbirth process. The women's idea of privacy was having a private room or private space with screens; they did not describe privacy in terms of confidentiality.

Preserving women's dignity

Overall, the women prioritised this RMC domain relating to dignity as the most important way providers should demonstrate respect during childbirth. Their expectations were about health providers' being caring, showing them love, giving them time and attention, being cheerful with them, treating them as humans, and not looking down on them. When probed on how providers can treat a woman in labour as a human being, one woman responded:

"*This had happened to me before when I went to the clinic for treatment. The way the medical personnel reacted to me, it was like I do not exist. If a patient should arrive, and you, the first treatment is that you smile to the patient, and see her as a human being, she will be relaxed that I am in the right place*." (Multipara, PHC)

The women emphasised how they are received into the labour ward, and how this contributes to their respectful childbirth care experience. The manner of greeting, smiling, and welcoming them helps to get them relaxed and they believe it aids their labour process.

This domain also includes the idea that health providers should respect women's cultural beliefs during labour. However, the women in our focus groups never mentioned respect for their cultural beliefs (such as traditional practices to hasten childbirth) and values as part of the demonstration of RMC. This is probably because there are not many cultural differences between the providers and patients in the study setting, so it was taken for granted. However, many did express demands about meeting their spiritual needs. For example, in one of the FGDs, the women wanted their health providers to pray for them during labour as part of demonstrating RMC as shown in these quotes:

" … *prayers, they should speak blessings*." (Primigravida, SHF)

" … *they should be saying by God's grace, you will deliver safely, and the woman should be saying amen … amen … "* (Primigravida, PHC)

The common practice of detaining women after childbirth when they are unable to pay their childbirth services bill also compromises their dignity. Perceptions relating to this were explored in six FGDs but the women were divided on the issue. Two groups insisted that the woman needs to pay her hospital bills and if she is detained at the facility, it is a necessary disrespect.

"*It's a type of disrespect [detaining women for not paying their bills], but they [the health providers] have to receive their money too*." (Primigravida, PHC)

The other focus groups, however, were sympathetic to the plight of such women, insisting that they should be pardoned or should benefit from a welfare purse that supports women with limited resources for childbirth fees and they should never be detained. We did not probe participants' understanding of national laws relating to detention for non-payment of childbirth fees.

Provision of information and getting informed consent

The majority of women in four of the FGD groups felt that obtaining informed consent was not necessary. They did not see the need to question a provider's judgement on conducting a procedure on them but understood this as part of the provider's job. We did not probe whether this was because they trust providers, or because of established power imbalances between providers and women in labour, or because they do not want to be seen as uncooperative. A few did not see the need for information or consent,

while most wanted information but thought that obtaining informed consent or permission was not always necessary, as shown in this quote.

"*It's not like permission in a way, it's not like they need your permission, but they just want you to know that … so that you will cooperate. See I want to go through a procedure and you take your time to explain to me, yes, even if it's going to be painful, but because you've taken your time, and ehm, maybe they approach you and you are calm with me, it will prepare my mind ahead and then I will be able to cooperate with you. That is just my own kind of person.*" (Primigravida, SHF)

Even for doing an episiotomy, women in two FGD groups felt there was no need for consent:

"*They should do it now, whatever that is right.*" (Primigravida, SHF)

"*Ha! but they will stitch it back. I don't think one needs any permission.*" (Multipara, SHF)

Ensuring continuous access to family support

The need to have a birth companion was only expressed by a few women in one of the FGDs, and not everyone in the FGD agreed with them. The majority of women across the FGDs did not identify being allowed to have a birth companion during labour as demonstrating RMC. Rather they even queried the role of the companion with comments such as these:

"*There is no need for someone to stay with me, when all they do is just watch someone … I don't think so oh, is she the one to hold my legs?*" (Primigravida, PHC)

"*It's not compulsory for someone to be present in the labour room when it's not the person that will deliver the baby.*" (Primigravida, SHF)

Some women dismissed health providers' encouragement of having a birth companion as "*spoiling the woman*" and were concerned that this would result in the woman being lazy and no longer cooperating with the health providers. They also felt it could be safer for some spouses not to be near a woman in labour, as the following quote explains:

"*Apart from* yiyo *[being spoilt], because some women, we are like the way we talk or the way we behave to our husband at home. A woman was like 'I want to see my husband! I want to see my husband!' when the husband came, she just grabbed him and start cursing him during the labour. So because of such experiences, that is why they don't allow.*" (Primigravida, SHF)

Others who encouraged their spouses to be present in the labour room wanted it to be brief, and their main motivation was for the spouses to appreciate the rigours of childbirth that they had to endure. All these ideas deviate from the global RMC norm of not barring women access to a birth companion of her choice if she so wishes.

Engaging with effective communication

This domain was the second most commonly identified by study participants as part of RMC. The women wanted health providers to listen to them, show them empathy, give them words of encouragement such as, "you can do it", crack jokes with them, and try to make them happy. The women repeatedly expressed the desire that providers show them love. In response to a question on how providers can demonstrate love to a woman in labour, a respondent said:

"*The way they talk with someone, and are cheerful towards one, saying things like 'come over here, let us examine you', and not say things like, 'why is your pant like this, why are you like this?' Many do not like them talking to them anyhow. But when they behave well towards her, she also will cooperate, she will be happy that next time, if I want to deliver, I will come back here, so to show love to us is good.*" (Multipara, PHC)

These requests show the women's need for emotional support from providers during labour. However, some women noted that uncooperative women and primigravidae should be given both love and a bit of harshness:

"*They need to be harsh, at the same time, they need to show love. The reason why I said they need to be harsh is because most of us, how will I put it? 'A maa n ke ara', [like to be indulged] they will say 'open your legs' some will be doing the way they like, so they need, at that point, they need to be harsh on us. At the same time, they will still pet us, so, 'yes, small harsh, small love', if there is love in their harshness, we will see it.*" (Multipara, SHF)

Provision of efficient and effective care

The women in the FGDs did not mention any contradictions to the global definitions for this domain. Their emphasis was on being attended to promptly on arrival. They also stated the consequences of not being attended to promptly as reported here:

"*I once lost a baby and this was very painful. I was coming from church and felt I was having labour pains. I branched at the health facility to tell them I am feeling labour pains. They just looked at me and said, 'see the person who is in labour smiling, is it possible that the pregnant woman should just be shouting for no reason?' Well I lost the baby and I have vowed that I will never go back there. There are no charms that they can give to make me go back there.*" (Multipara, PHC)

Effective pain management during labour was not mentioned by the women as a perceived component of RMC. However, the majority of women in one FGD lamented the pains they experience during vaginal examinations and would prefer that this be reduced to a minimum. One participant even explained this as a reason for women presenting late in labour. They seemed not to know that they can refuse the procedure rather than presenting late in labour to avoid it. The quote below corroborates this.

"*You see that insertion of fingers during vaginal examination? It is worse than delivering the child. This is because, when someone has delivered the baby, you will now be passing through the pain of the vaginal examinations. Especially with all those nurses in training that are using you to learn their practice (laughs). In your life, you won't consider presenting too early. The best is you have labour pains and the child comes out the moment you get to the hospital.*" (Multipara, PHC)

Providing equitable maternal care

The women in our study agreed that equitable care is part of RMC. The FGD respondents recounted provider discriminatory behaviours towards teenage mothers. They also reflected that women who were known to providers, such as friends, relatives, or colleagues, would get better treatment than those without such connections. They further reported that some women "buy" preferential treatment by giving larger tips to health providers. Some also commented on the need for equitable care irrespective of women's socio-economic status (for example, those who present in labour without all the required delivery materials): "*It's disrespect, you don't know anybody in the hospital, maybe you don't have money, you are not a kind of person that gives out something to them, the way they will treat you, you won't even like it.*" (Multipara, SHF)

Inequitable care based on ethnicity and religion was not prominent among the issues raised.

Continuity of care

The women's perceptions of RMC were often related to this domain, focusing mainly on neglect or abandonment of care. They described the abandonment of care during childbirth by providers as being common, especially by public health facility providers. One woman described it as the most important RMC issue to address:

"*Hmm negligence of duty, in most general hospitals, negligence of duty is much. They will just abandon you, even if someone is at the point of delivery, in some general hospitals, I am a civil servant, but within the same general hospital, you see them, negligence of duty is the most important thing they should work on.*" (Multipara, SHF)

Availability of competent and motivated staff

The perceptions of the participants on having competent and motivated staff to ensure RMC were not mentioned directly, but could be inferred from some of the discussions. For example, they mentioned the heavy workload of health providers as a reason for their being disrespectful.

"*Sometimes ehn, work load. Because WHO say one nurse to four patients. But when you see one nurse taking care of twenty patients, and the nurse is a human being with her own problems too and her own family issues too.*" (Primigravida, SHF)

They also stated the need for well-motivated staff and the government ensuring that salaries get paid and that staff are provided with the equipment needed to do their work. They stressed that a nurse who is paid performs differently to one who has not been paid.

A few believed that more competent staff would attempt vaginal deliveries rather than

referring the woman for surgical deliveries even when there are indications for it.

"*What I will like is for example a situation where the woman has been 'condemned' to delivery by operation, but we see some nurses with lots of experience of what one is passing through at that moment, and they come and help the woman to deliver by herself. So, such a situation where the nurse can help, one will be happy to come back again.*" (Multipara, PHC)

Respecting women's choices that strengthen their capabilities to give birth

The FGDs explored participants' perceptions about their intake of fluids or foods, mobility during labour, and choice of birth position. The majority of participants felt that all these decisions should be left to the health provider, and that being denied their own choices or preferences did not constitute disrespect.

Not being allowed to walk around during labour was justified by most women, across the FGDs. They felt women need to conserve energy to push the baby out.

"*I'm just saying that if you are fit to walk about and the nurses agree with you that you can, you can walk about. But if they say that it is not good for you for now, you just follow their instruction because that is their duty they know better, they know why.*" (Primigravida, SHF)

As for the choice of birth position, the women felt that this is entirely the prerogative of the health provider. A few mentioned that the presenting part of the baby during delivery may not even allow for such a birth. They stated that anyone who desires an alternative birth position, besides lying on one's back with both knees bent, should rather go to a private hospital to deliver. Only one of the women was familiar with squatting to deliver or other alternative birth positions, and she had booked at both a private and a public hospital to ensure she could choose her position during childbirth. In general, attitudes to alternative birth positions were of disapproval and disbelief: "*They won't accept, I've not seen it happen, you will have to lie down to deliver your baby.*" (Multipara, SHF)

Similarly, none of the women thought it was disrespectful to deny access to oral fluid or food during birth. The general response to this domain is captured in this quote:

"*In my own opinion, the summary of it is cooperate with your health professional because they are the ones taking care of you and the success of your delivery, they are also a part [i.e. have an interest in a successful delivery outcome].*" (Primigravida, SHF)

Enhancing quality of physical environment and resources

There was no reference in any of the FGDs that related to this domain as part of RMC. The women were more interested in the actual service delivery than in the infrastructure when discussing respectful care during childbirth.

We further qualitatively analysed their perceptions in relation to their parity and whether they were attending a primary or secondary health facility. More primigravidae than multiparas would prefer that their opinions were respected for the RMC domains regarding ensuring mobility during labour, obtaining informed consent, preserving their dignity, having access to family support and ensuring their privacy. The FGD participants at the primary health care facilities were predominantly concerned with continuity of care, being free from harm and mistreatment, provision of efficient and effective childbirth services and providing effective communication, as they expressed most of the perceptions on these. Those at the secondary health facilities expressed most of the perceptions on ensuring their privacy, providing equitable care, providers obtaining informed consent, and pregnant women's choices being respected as regards mobility during labour and their birth positions.

Discussion

This study explored the perceptions of women in Ibadan Metropolis, South-western Region, Nigeria about respectful maternity care (RMC) and evaluated how these corresponded with the 12 domains of RMC defined by Shakibazadeh et al.[13] The study participants' perceptions about RMC deviated for four of the defined RMC domains, namely: maintaining privacy and confidentiality; ensuring continuous access to family support; obtaining informed consent; and respecting women's choices about mobility during labour, food and fluid intake, and birth position. The women's perceptions resonated well for five of the RMC domains, and there were mixed perceptions for

two domains. The physical environment domain was not mentioned as contributing to RMC.

RMC domains where women's perceptions deviated from globally defined norms

The study participants seemed more concerned with the outcome of their delivery than their privacy or comfort. From their perceptions, having a private cubicle or a private space during childbirth is a luxury, accessible at extra cost by registering at private hospitals, and was not a basic requirement for RMC in public hospitals. Being exposed during labour and not enjoying privacy has become a norm for them. This is unusual, especially as women may not be comfortable if unduly exposed elsewhere, outside the childbirth process. This normalisation of lack of privacy during childbirth has also persisted because the structural design of local health facilities does not allow for individual private space.

This finding differs from those of other studies, such as those from Abuja (Nigeria),[19] Guinea[20] and Mbale in Uganda,[6] where women criticised the violation of their privacy resulting from hospital structural deficiencies. The lack of privacy did contribute to the negative childbirth experience for the respondents in those studies. One possible explanation for the different perceptions of women in this study may be that our FGDs were held with pregnant women whereas the other studies interviewed postnatal women. Pregnant women may be more anxious about the delivery and the wellbeing of their babies, and less concerned about issues such as privacy. Even though the women in our study did not feel that privacy and confidentiality were essential to RMC, these are established ethical and human rights principles[21] that should not be violated even if women do not demand for them.

It is also a universally accepted medical ethical principle that health providers should obtain informed consent from women during childbirth, and ensure that women maintain some control over their birth process.[3] It was surprising that the pregnant women in our FGDs seemed content with receiving information only, did not regard giving informed consent as essential, and trusted healthcare workers to make the right decisions for them. Their disinterest in granting informed consent may also be linked to not wanting to be perceived as a difficult or uncooperative patient, as they associated that with negative consequences such as abandonment of care or abuse. These perspectives are evidence of the entrenched power imbalance between health providers and clients, particularly in low-resource settings.[22] In contrast, Swedish women described their childbirth process as respectful when they were fully engaged and participated in the decisions regarding their birth.[2] A study of post-partum women in Nigeria reported that many had not given consent for episiotomy during labour and they judged this as mistreatment.[23]

Having a birth companion has been linked to better pain management, shorter births, lower levels of mistreatment of women during childbirth, more satisfaction during labour, and early breastfeeding initiation.[24,25] The World Health Organization has emphasised that global efforts at reducing maternal morbidity and mortality should not end with increasing health facility delivery. Rather, women's preferences during childbirth, such as having a birth companion of their choice, must be known and supported.[26] Despite these established benefits, our study participants across the groups did not consider allowing birth companions during labour an essential component of RMC, thus deviating from the global definitions. The implication of this is that women may not demand birth companions and stand to lose its associated benefits.

Spousal participation during labour is low in Nigeria, attributable to low education levels, cultural and religious beliefs that see labour as a women's affair.[27] Poor male involvement during the pregnancy[28] may also explain why their presence during labour seemed unnecessary to the women in our study. Study participants who supported having a birth companion opted either for their mother or their spouse for that role. This is similar to the perceptions of women receiving ANC at a tertiary health facility in Ibadan, Nigeria.[28] In addition, the design of many facilities has no provision for private cubicles which prevents birth companions being present in the labour room. If not addressed, these challenges may limit implementation of this RMC domain in low-resource settings.

The study participants seemed largely unconcerned about their lack of delivery choices. Denial of foods and fluid intake was not common in their experience. In contrast, not being able to move around during labour and delivering in the lithotomy position are routinely enforced, but the women were used to these restrictions and accepted them as normal. Not only were they

not aware of the advantages of alternative approaches, such as walking around during the active phase or squatting for delivery, but they viewed these suggestions as strange and even potentially dangerous. We did not probe if delivering using alternative birth positions was culturally acceptable or not, though to the best of our knowledge, there is no evidence to suggest that it is culturally unacceptable. This could be investigated in further research.

RMC domains that resonated well with the women's perceptions but with mixed feelings

The women's perceptions of RMC focused more on the inter-personal skills of healthcare providers than their medical or technical skills. Thus, their interpretation of RMC mainly emphasised the preserving dignity domain, and wanting to be treated as individual human beings. The women also desired more love and spiritual support from their providers, even requesting prayers. It has been found that one of the reasons women often visit traditional birth attendants (TBA) in Africa is because the TBAs pet, pamper and pray for them during labour.[29] This perception on the need for spiritual support for women during childbirth raises other ethical questions, considering that women and health providers alike may have different religious backgrounds and the ethical rights of both must be preserved. Health providers may need to incorporate the concept of "demonstrating love" in the form of compassion and emotional support to women in labour, as recommended in the literature.[30] The use of professional doulas as birth companions in health facilities may also be encouraged as these are known to provide physical, emotional (love), and spiritual support to women during birth.[31]

The mixed perception in this RMC domain is that a few of the women suggested that some form of abuse is acceptable for uncooperative women, supporting the contention that disrespectful and abusive care for women in labour has been normalised.[32] This deviates from what RMC stands for. Moreover, it is similar to the findings among women in Ethiopia who recently delivered and their family members.[33] Women who had described the abuse of women during antenatal care and delivery as normal behaviour by health providers in government-owned facilities in Nigeria also defended the providers by saying those behaviours were unintentional.[34] Normalisation of disrespect by providers and clients alike are critical targets to eradicate through interventions promoting RMC.[35]

RMC domains that resonated well with the women's perceptions without exception

The continuity of care and effective care domains were strongly supported as critical to the participants' perceptions of RMC during childbirth. Not being attended to promptly and being abandoned during labour were linked to serious negative outcomes such as loss of the baby or maternal complications. Such consequences would dominate any other considerations of RMC, and would probably result in women not returning to the same health facility for delivery in future, or even avoiding institutional delivery completely.[36]

The women in our FGDs assumed that staff who were not paid well would not be motivated to provide RMC. In a systematic review of disrespect and abuse of women during childbirth in Nigeria, the de-motivation of health workers was attributed to their being understaffed, overworked, poorly remunerated, and lacking training on improving quality of care.[37] Our FGD participants felt that governments should ensure healthcare workers are paid well and on time to improve their motivation and performance. Ensuring that they are competent at what they do, and being intrinsically motivated to provide RMC, however, was not mentioned as part of the providers' role by the women.

Ensuring equitable provision of maternal care is a global health priority for the attainment of Sustainable Development Goal 3,[38] but our respondents provided examples of how poorer women in Ibadan received less RMC. The health system should ensure RMC for all women, irrespective of their socio-economic status or demographic characteristics. The costs associated with childbirth, even in the public sector, are not inconsiderable, and the out-of-pocket expenses are not affordable for many women, further worsening inequities. In a recent study, only 10% of 524 pregnant women studied in Lagos had health insurance,[39] and 52% of reproductive-aged women in Nigeria had problems accessing health care for themselves, with 46% of these having challenges with getting money for treatment.[40] Hence, there is a need to ensure better financial protection for pregnant women.

The social health insurance programme for vulnerable groups in Nigeria was meant to cater for pregnant women; however, many have described gains from the programme as poor.[41] Some states

in Nigeria provide free maternity care services but poor communication affects uptake.[41] Other maternity health care financing options may include compulsory or voluntary contributory schemes for women in the reproductive age group. Paid maternity leave is also an essential component of a social protection package given only to women working in formal settings. Women could also receive social grants or state subsidies during pregnancy,[42] in the form of cash or vouchers, to ensure their financial access to essential health care and to cover additional costs associated with caring for themselves and their baby.

RMC domains that were missing from the women's perceptions

The women did not mention the health facility's physical environment, such as having constant electricity, adequate and safe water, or good toilet facilities, as components of RMC. This is contrary to the perceptions of women in Guinea, who listed poor physical conditions contributing to mistreatment.[20] This may be because specific questions on these were not asked. Rather, the women were asked about their perceptions on respect and respectful childbirth care, and these were then related to the RMC domains by Shakibazadeh et al.[13] This implies that the facility's physical environment is not a priority for them. They may also have normalised and accepted the current state of the facilities, either good or bad.

The management of pain during labour is not a separate domain in the Shakibazadeh et al[13] framework, but is an important part of providing effective care in RMC. For example, the World Health Organization has emphasised that proper pain management is crucial for ensuring a positive childbirth experience for women.[12] Pain relief was not mentioned by FGD participants as necessary for the delivery of RMC during childbirth. The reason for this could be that the women saw pain as a natural part of the childbirth process, and not being able to endure pain is interpreted as a sign of weakness. This is similar to the perceptions of some Ghanaian women on labour pains.[43] Probably, the women did not imagine a childbirth without pain, and so did not identify this as part of RMC.

Strengths and limitations of the study

The study was limited in its spread, having been confined to one geographical region in Nigeria. A more holistic perspective from women across several educational and ethno-cultural backgrounds may be needed. The awareness of the health providers' presence within the facility may have influenced the respondents' responses. To ameliorate this, the study was conducted in a separate and secluded room away from possible interference from the providers. Studying pre-pregnant women or women post-pregnancy may have yielded different results. We chose to study pregnant women because we assumed they would have reflected more on their expected childbirth experiences compared to pre-pregnant women. Women who have recently delivered should be considered as the study population in future research.

This study suggests a potential inequity in childbirth experiences across different cultural settings as some health providers in some settings strive to attain an RMC practice while others do not.

The findings of this study have implications for the overall quality of care women receive during childbirth, as well as women's ability to define RMC and demand it during institutional deliveries. The findings also imply that the extent of RMC received during childbirth may be dependent on women's interpretations and expectations of RMC.

Measurement of RMC received cannot be compared accurately across different settings until women have the orientation and expectation of the kind of RMC that they should receive during childbirth in accordance with global standards.

Conclusions and recommendations

Respectful maternity care is a fundamental right of women during childbirth that should be universally accessible to all irrespective of their cultural setting. Pregnant women are critical stakeholders in the implementation of RMC and their expectations and perceptions about RMC should inform its definition. However, when women's perceptions do not align with the current globally defined basic RMC standards, this could challenge an effective implementation process. Nigerian women's perceptions of RMC in this study deviated significantly from globally defined norms. Their definitions of RMC may exclude granting of privacy, labour companions, obtaining informed consent, but would include demonstration of love, trusting health providers solely for decisions on their birth position, and mobility during labour.

This suggests that local interpretations of RMC are clearly influenced by cultural practices and societal norms in different settings. Additional research exploring how and to what extent these influence women's interpretations of RMC is required, considering various contexts. Quantitative research to measure women's perceptions of RMC on a larger scale across settings is also needed.

Nevertheless, pregnant women's human rights, represented by the emerging norms of RMC, should always be upheld by health providers. These include the right to dignity, privacy, choice, informed consent, and not being mistreated, even where some women believe that violations of some of these are sometimes acceptable. We should promote a nurturing and caring RMC environment in maternity units as this builds trust between patients and healthcare workers. In many low-resource settings, birthing facilities need to be better designed to protect women's privacy and dignity, and to support RMC. A strengthened health system with well remunerated, competent, and motivated staff is critical to meeting women's expectations of RMC during childbirth. A respected health provider, whose needs have been met by the employers, should be willing to give the best care and respect to their clients. There is also clearly still much that needs to be done in low- and middle-income countries to inform women about their rights, empower them in their relationships with healthcare providers, and educate them about RMC.

Acknowledgements

We appreciate the Consortium for Advanced Research and training in Africa (CARTA) for all the human and material resources made available towards this research and publication. I specifically appreciate CARTA facilitators Dr Stephen Wandera, Dr Kudus Adebayo and Prof. Oladapo Olayemi for their inputs into the data analysis and drafting the manuscript. The second author is funded by the South African Medical Research Council's Mid-Career Scientist Award.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research was supported by the Consortium for Advanced Research Training in Africa (CARTA). CARTA is jointly led by the African Population and Health Research Centre and the University of the Witwatersrand and funded by the Carnegie Corporation of New York (Grant No—G-19-57145), Sida (Grant No:54100113), Uppsala Monitoring Centre and the DELTAS Africa Initiative (Grant No: 107768/Z/15/Z). The DELTAS Africa Initiative is an independent funding scheme of the African Academy of Sciences (AAS)'s Alliance for Accelerating Excellence in Science in Africa (AESA) and supported by the New Partnership for Africa's Development Planning and Coordinating Agency (NEPAD Agency) with funding from the Wellcome Trust (UK) and the UK government. The statements made and views expressed are solely the responsibility of the Fellow.

Availability of data and materials

The coded transcripts and codebook from the study have been deposited into the Mendeley Data Repository cited as Esan, Oluwaseun (2021), "Similarities and deviations to RMC", Mendeley Data, v1. Available at: http://dx.doi.org/10.17632/sx5mkydrh8.1

Authors' contributions

OTE, DB and TSM all contributed to the design of the study, the development and finalisation of the tools. OTE collected and analysed the data, and also developed the draft manuscript. All the authors contributed to and approved the final manuscript for submission.

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Résumé

Les façons dont les femmes voient les soins de maternité respectueux est essentielle pour définir et mesurer ces soins dans le monde. Nous les avons évalués par rapport à des normes de soins de maternité respectueux définies au niveau mondial. Nous avons mené une étude descriptive comportant huit discussions par groupe d'intérêt avec 50 femmes enceintes fréquentant une consultation prénatale dans un centre de santé primaire et secondaire situés chacun dans les zones de gouvernement local du nord-ouest et du sud-ouest de la métropole d'Ibadan, Nigéria. Chaque centre a organisé un groupe de discussion avec des primipares et un autre avec des multipares. Les 12 domaines de soins de maternité respectueux de Shakibazadeh ont servi de cadre thématique pour l'analyse des données. La manière dont les femmes concevaient des soins de maternité respectueux cadrait bien avec sept de ses domaines: relations interpersonnelles prestataire-cliente, respect de la dignité des femmes, communication opérante, et non-abandon des soins, mais avec des sentiments nuancés dans deux domaines. Néanmoins, les façons de voir des femmes divergeaient pour quatre domaines, à savoir le maintien du respect de la vie privée et de la confidentialité; la garantie d'un accès permanent au soutien familial, avec par exemple l'accompagnement à la naissance; l'obtention d'un consentement éclairé; et le respect du choix des femmes quant à la mobilité pendant le travail, la prise d'aliments et de liquides, et la position lors de l'accouchement. L'environnement physique n'a pas été mentionné comme contribuant à une expérience de soins de maternité respectueux. Si la manière dont les Nigérianes conçoivent des soins de maternité respectueux était similaire aux approches acceptées au niveau international, des écarts importants ont été observés, qui peuvent être liés aux différences culturelles et aux disparités sociétales. Différentes interprétations des soins de maternité respectueux peuvent influencer la demande des femmes dans différents environnements et remettre en question les stratégies de promotion de ces soins comme norme universelle de traitement.

Resumen

Las percepciones de las mujeres sobre la atención respetuosa de la maternidad son fundamentales para su definición y medición a nivel mundial. Evaluamos esas percepciones con relación a las normas de la atención respetuosa de la maternidad definidas mundialmente. Realizamos un estudio descriptivo que consistió en ocho discusiones en grupos focales con 50 mujeres embarazadas que asistieron a una clínica prenatal en una unidad de salud de atención primaria y en otra de atención secundaria, en zonas gubernamentales locales del noroeste y sudeste de la Metrópolis de Ibadan, en Nigeria. En cada unidad de salud, se realizó un grupo focal con primigrávidas y otro con multigrávidas. Los 12 dominios de la atención respetuosa de la maternidad, por Shakibazadeh, sirvieron como marco temático para el análisis de datos. Las percepciones de las mujeres sobre la atención respetuosa de la maternidad resonaron bien con siete de los dominios, haciendo hincapié en las relaciones interpersonales entre prestadores de servicios y usuarias, preservación de su dignidad, comunicación eficaz y no abandono del cuidado, pero con percepciones mixtas para dos dominios. Sin embargo, sus percepciones se desviaron para cuatro dominios: mantener privacidad y confidencialidad; garantizar acceso continuo a apoyo familiar, tal como acompañantes durante el parto; obtener consentimiento informado; y respetar las decisiones de las mujeres sobre movilidad durante el trabajo de parto, ingesta de alimentos y líquidos, y posición de parto. El entorno físico no fue mencionado como contribuyente a la experiencia de atención respetuosa de la maternidad. Aunque las percepciones de las mujeres nigerianas estudiadas sobre la atención respetuosa de la maternidad fueron similares a aquellas aceptadas internacionalmente, hubo desviaciones significativas que podrían estar relacionadas con diferencias culturales y disparidades sociales. Diferentes interpretaciones de la atención respetuosa de la maternidad podrían influir en su demanda por las mujeres en diferentes entornos y cuestionar las estrategias para promoverla como estándar universal de atención.