Original Paper

Respectful Maternity Care and Associated Factors Among Women From North of Iran

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ABSTRACT

Introduction: Respectful Maternity Care (RMC), as one of the fundamental rights of women, can be effective in creating a positive experience of pregnancy and childbirth and increasing women's desire to have children and give vaginal birth.

Objective: This study aims to determine the RMC status and its associated factors among women who delivered at public hospitals in Guilan, north of Iran.

Materials and Methods: This is an analytical cross-sectional study. Participants were 317 pregnant women in the postpartum units of public hospitals in Guilan Province, selected via a non-random, multistage sampling method. The data collection tools were a questionnaire surveying sociodemographic/obstetric characteristics and the RMC questionnaire, which was completed 6-8 hours after delivery. Data analysis was done using independent t-tests, one-way analysis of variance, Pearson's correlation test, and multiple linear regression. The significance level was set at 0.05.

Results: The mean ages of women and their husbands were 28.92±5.79 and 33.03±5.63 years, respectively. The education levels of 25.9% women and 21.5% of spouses were at the academic level. The mean total RMC score was 70.4±19.4. The domains of abuse-free care (75.5±19.2) and timely care (66.1±21.8) had the highest and the lowest scores, respectively. Women's educational level (b=-3.62, 95% CI; -6.99%, -0.26%, P=0.035), having a companion during birth (b=2.76, 95% CI; 0.05%, 5.48%, P=0.046), and gestational age (b=0.77, 95% CI; 0.07%, 1.46%, P=0.030) were significant predictors of the RMC score (R^2=0.088).

Conclusion: The pregnant women admitted to public hospitals in Guilan Province receive a relatively high level of RMC. Healthcare workers, especially midwives, should pay attention to the identified factors in providing RMC to women.

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Highlights

- The RMC has received much emphasis in recent years.
- In Guilan Province, pregnant women admitted to public hospitals receive relatively high level of RMC.
- The educational level of women, the presence of a companion during birth, and gestational age are predictors of RMC score.

Plain Language Summary

Providing maternity care services with respect can improve the quality of care and ultimately increase women's satisfaction with health services. In this study, we investigated the level of respectful maternity care (RMC) among women who delivered in public hospitals of Guilan Province, Northern Iran. It was found that women received a relatively high level of RMC, and its predictors were educational level, the presence of a companion during birth, and gestational age. It is recommended that healthcare workers, especially midwives, consider these factors when providing respectful care to pregnant women.

Introduction

Pregnancy and childbirth are important events in women's lives [1]. Access to high-quality, Respectful Maternity Care (RMC) is a basic right for women [2]. Over the last few decades, this accessibility has encouraged women to give birth in hospitals [3]. Achieving the sustainable development goals of reducing maternal mortality to less than 70 per 100,000 births and reducing infant mortality to less than 12 per 1,000 live births by 2030 requires providing safe and high-quality RMC to mothers. Despite the emphasis, considerable progress has not been made toward these goals due to inadequate adherence to aspects of RMC [4]. Women still experience disrespect and abuse during labor and birth [5]. The prevalence of this disrespect and abuse has been reported to be 36.3% in the Netherlands [6], 77.6% in Germany [7], 17.3% in America [8], 71% in India [9], and 75.7% in Iran [10].

Lack of observing the principles of high-quality RMC and existence of physical or verbal abuse, discrimination, vaginal examinations without permission, or procedures such as episiotomy and induction of labor can lead to a sense of worthlessness, induces weakness to the woman, and causes an increase in negative and maternal and neonatal outcomes [3], including postpartum depression [11], reduced desire for subsequent pregnancies, and increased intervals between pregnancies [1]. Generally, owing to the extensive negative outcomes of failing to provide RMC, active organizations in the health sector emphasized this aspect of maternity care as one of the most significant factors in high-quality, standard care and proposed it as an objective and measurable quality of maternal and neonatal care [12].

Very limited studies had been conducted in the area of abuse and disrespect towards women in maternity centers in previous decades. Bowser and Hill called for collective action on this issue, which led to greater attention to the mother's experiences during childbirth and expanded the studies in this area [13]. After that, the White Ribbon Alliance formed a community to develop the RMC charter [14]. The World Health Organization (WHO) presented an RMC-related statement to prevent the disrespect and abuse of mothers during birth [15]. Care with respect for the dignity, privacy, and confidentiality of women provides the conditions for continuous support during labor and birth for the mother, and prevents disrespect and abuse [16].

Autonomy is also a crucial part of RMC and means a woman's right to decide how to care for herself [17]. In this regard, an interaction between women and healthcare providers is needed [18], which can improve communication, increase the quality of maternity care, and ultimately increase women's satisfaction with health services [19]. The satisfaction that results from increasing women's willingness to receive health care can reduce maternal mortality and represent an effective step toward achieving the third goal of sustainable development [20]. The fear of being disrespected by healthcare providers has been mentioned as one of the reasons why many women refuse to receive services; women who experience disrespect in healthcare centers may encourage others not to use these

services [21]. Given the significant role of RMC in a positive childbirth experience and the need to identify related factors to improve this experience, this study aimed to determine RMC and its associated factors among women who gave birth in hospitals of Guilan, northern Iran.

Materials and Methods

This analytical cross-sectional study was conducted on 317 women referred to the postpartum department of public hospitals in Guilan Province. As a general rule of thumb for linear regression analysis, at least 10-20 subjects are needed per independent (predictor) variable to conduct the regression analyses [22]. Therefore, the sample size was set at 315, with 15 subjects per independent variable and 21 individual, social, and fertility variables. Multi-stage, non-random sampling was used to select participants. Six hospitals were selected from the east, west, and center of Guilan Province. Sample selection was gradually conducted from each hospital based on the number of childbirths at that hospital The inclusion criteria were consent to participate in the study, normal vaginal delivery, no major abnormalities in the neonate, not taking antidepressants in the last year, not experiencing a stressful event (such as divorce, death of first-degree relatives, or diagnosis of an incurable disease in a family member in the last three months), no mental disability, no deafness, and the ability to speak. These criteria were assessed based on the self-report. Failure to fully answer the questions in the questionnaire was considered an exclusion criterion.

The data collection tools were a questionnaire surveying sociodemographic/obstetric characteristics and the RMC questionnaire [23]. The sociodemographic characteristics included age, educational level, occupation, having a companion during childbirth, ethnicity, place of residence, and household income. The obstetric characteristics included the number of pregnancies, type of pregnancy (planned/unplanned), receiving prenatal care, length of stay in the maternity ward, number of healthcare providers during childbirth, receiving childbirth pain relief medications, the childbirth time (morning, evening, or night shift), and its agent (on-call or resident physician, midwife, midwifery student, gynecological resident). The RMC questionnaire has 15 items and 4 domains, including friendly care (7 items), abuse-free care (3 items), timely care (3 items), and discrimination-free care (2 items). In this study the items are rated as 5 (strongly agree), 4 (agree), 3 (I don't know), 2 (disagree), and 1 (strongly disagree). The high scores indicate a more positive experience of RMC during childbirth. The scores are reported as percentages. The questionnaires were completed 6-8 hours after childbirth through interviews with the women, after explaining the study objectives to them, and ensuring the confidentiality of their information.

The qualitative variables are described as frequency (percentage), and quantitative variables are described as Mean±SD. The Kolmogorov-Smirnov test was used to check the normality of the data distribution. In the univariate analyses, Pearson's correlation test, independent t-test, and one-way Analysis of Variance (ANOVA) were used to investigate the relationship between RMC scores and sociodemographic/obstetric characteristics of hospitalized women. Correlation coefficient values of 0.1-0.3, 0.3-0.5, and >0.5 indicate weak, moderate, and strong correlation, respectively. In a multivariate analysis, linear regression was used to identify factors predicting RMC in hospitalized women. The data were analyzed in SPSS software, version 16, and the significance level was set at 0.05.

Results

The mean age of women and their husbands was 28.92±5.79 and 33.03±5.63 years, respectively. The educational levels of 82 women (25.9%) and the husbands of 68 women (21.5%) were academic. Also, 22.7% of women were employed, and the husbands of 53.6% of women were self-employed. Moreover, 71% of women reported sufficient income, 84.9% were from the Guilak ethnicity, and 63.4% were living in urban areas. Other characteristics are presented in Table 1.

The mean total RMC score was 70.4±19.4, and the median score was 75 (interquartile range: 63.3-85.0). Based on these values, 75% of women reported an RMC score greater than 63.3 (Table 2).

The variables with P<0.2 in the univariate analysis (Table 3) were entered into the multivariate regression model. Based on the regression coefficients, the RMC score of women with an academic education was significantly 3.62 units lower than that of women with lower than high school education (b=-3.62, 95% CI; -6.99%, 0.26%, P=0.035). For every one-week increase in gestational age, the RMC score increased by 0.77 units (b=0.77, 95% CI; 0.07%, 1.46%, P=0.030). The RMC score in women with a companion during birth was significantly higher than that of those without a companion by 2.76 units (b=2.76, 95% CI; 0.05%, 5.48%, P=0.046). The coefficient of determination (R^2) was 0.088, indicating that 8.8% of the variation in the RMC score is explained by the factors mentioned (Table 4).

Table 1. Sociodemographic/obstetric characteristics of the participants (n=317)

Variables		Mean±SD/No. (%)
Age (y)		5.79±28.92
Level of education	Lower than high school	116(36.6)
	High school diploma	119(37.5)
	Academic	82(25.9)
Occupation	Housewife	245(77.3)
	Employed	72(22.7
Satisfaction with married life	Yes	296(93.4)
	No	21(6.6)
Satisfaction with economic status	Yes	227(71.6)
	No	90(28.4)
Spouse's educational level	Lower than high school	128(40.4)
	High school diploma	121(38.2)
	Academic	68(21.5)
Spouse's occupation	Unemployed	14(4.4)
	Worker	61(19.2)
	Farmer	33(10.4)
	Employed	39(12.3)
	Self-employed	170(53.6)
Number of pregnancies	1	133(42)
	2	121(38.2)
	3	44(13.9)
	≥4	19(6)
Receiving prenatal care	Yes	299(94.3)
	No	18(5.7)
Smoking	Yes	4(1.3)
	No	313(98.7)
Alcohol consumption	Yes	1(0.3)
	No	316(99.7)
History of infertility	Yes	45(14.2)
	No	272(85.8)

Variables		Mean±SD/No. (%)
History of abortion	Yes	68(21.5)
	No	249(78.5)
History of fetal death	Yes	17(5.4)
	No	300(94.5)
Having a companion during childbirth	Yes	207(65.3)
	No	110(34.7)
Childbirth time	Morning	126(39.7)
	Evening	94(29.7)
	Night	97(30.6)
Childbirth agent	Resident physician	30(9.5)
	Gynecologist	126(39.7)
	Midwife	127(40.1)
	Midwifery student	34(10.7)
Childbirth complications	Yes	277(87.4)
	No	40(12.6)

Discussion

In this study, more than half of the women reported receiving respectful care, which is higher than in other similar studies [2, 18, 24]. The higher RMC level in our study may be due to the adoption of recent health and treatment policies and the implementation of the "Mother-Friendly Hospital" plan in Iran, which requires healthcare providers to pay closer attention to Providing high-quality maternal services. One component of the "Mother-Friendly Hospital" plan is to respect mothers' rights, preserve their self-esteem, and ensure their autonomy. Observing these principles can improve the RMC level [25, 26]. The level of RMC in our study was lower than that in other studies [27-29]. This discrepancy can be attributed to differences in the number of women, sampling methods, tools used, and the culture and socio-economic status of women.

In this study, the highest score was in the domain of abuse-free care, which is consistent with the results of Sethi et al. [30]. Contrary to our results, Yosef et al. [31] reported that abuse-free care had the lowest score. This discrepancy may be due to differences in sample size, inclusion criteria, and demographic characteristics. The need to improve RMC has been emphasized in Iran through train-

Table 2. Descriptive statistics of the RMC domains (n=317)

Variables	Possible Range	Observed Range	Mean±SD	Median (Interquartile Range)
Friendly care	0-100	0-100	69±22.7	75 (58.9-85.7)
Abuse-free care	0-100	0-100	75.5±19.2	83.3 (66.7-91.7)
Timely care	0-100	0-100	66.1±21.8	66.7 (50-83.3)
Discrimination-free care	0-100	0-100	74±23.7	75 (62.5-100)
Total RMC score	0-100	3.3-100	70.4±19.4	75 (63.3-85)

RMC: Respectful Maternity Care.

Table 3. The RMC scores based on sociodemographic and obstetric characteristics (n=317)

Variables		r/ Mean±SD	P
Age (y)		-0.01	0.853*
Spouse's age (y)		0.064	0.256*
Gestational age (w)		0.151	0.007*
Duration of hospitalization in the maternity ward (h)		0.029	0.612*
History of childbirth (y)		0.059	0.291*
Ethnicity	Guilak	57.4±11.5	0.535**
	Non-Guilak	56.3±12.5	
Place of residence	City	57.3±11.6	0.896**
	Village	57.1±11.8	
Educational level	Lower than high school	59±10.6	0.031***
	High school diploma	57.4±11.3	
	Academic	54.5±13.2	
Occupation	Housewife	57.4±11.4	0.673**
	Employed	56.7±12.5	
Smoking history	Yes	49.0±22	0.155**
	No	57.3±11.4	
Satisfaction with married life	Yes	57.2±11.7	0.848**
	No	56.7±9.9	
Satisfaction with economic status	Yes	57.9±11.6	0.089**
	No	55.4±11.4	
Average monthly income adequacy	Low	56.7±11.9	0.63***
	Moderate	57.4±11.5	
	High	0±0	
Spouse's education	Lower than high school	57.7±11.3	0.426***
	High school diploma	57.5±11.2	
	Academic	55.6±13	
Spouse's job	Unemployed	54.5±16.6	0.222***
	Worker	58.1±10	
	Farmer	56.9±11.6	
	Employed	53.6±13.6	
	Self-employed	58±11.1	

Variables		r/ Mean±SD	P
Child's gender	Boy	58.4±10.5	0.054**
	Girl	55.8±12.7	
Satisfaction with the child's gender	Yes	57.3±11.4	0.455**
	No	55.5±13.5	
Number of pregnancies	1	55.9±12.9	0.12***
	2	57.6±10.9	
	3	57.8±10.8	
	≥4	62.4±5.3	
Receiving prenatal care	Yes	57.1±11.7	0.806**
	No	57.8±9.7	
Planning to become a parent	Yes	57.8±11.5	0.299**
	No	56.4±11.8	
History of infertility	Yes	58.1±12.4	0.577**
	No	57±11.5	
History of abortion	Yes	58.1±10.5	0.446**
	No	56.9±11.9	
History of fetal death	Yes	53.5±12.6	0.178**
	No	57.4±11.5	
Having a companion during childbirth	Yes	58±11.1	0.09**
	No	55.7±12.4	
Delivery time	Morning	58.2±11.3	0.458***
	Evening	56.8±11.6	
	Night	56.3±12	
Childbirth agent	Resident physician	57.2±12.1	0.424***
	Gynecologist	56.1±11.9	
	Midwife	58.5±11.5	
	Midwifery student	56.6±10.2	
Childbirth complications	Yes	56.9±11.8	0.194**
	No	59.4±10.1	

*Pearson's correlation test, **Independent t-test, ***One-way ANOVA,

Table 4. Regression coefficients for the factors predicting the RMC score

Variables		Unstandardized Coefficient (b)	Standard Error	95% CI Lower, Upper	Standardized Coefficient (β)	P
Educational level	Diploma vs lower than high school	-1.49	1.51	-4.46, 1.47	-0.062	0.322
	Academic vs lower than high school	-3.62	1.71	-6.99, -0.26	-0.136	0.035
Smoking	Yes vs no	-8.8	5.73	-20.08, 2.48	-0.084	0.126
Satisfaction with married life	Yes vs no	-0.96	2.61	-6.1, 4.18	-0.02	0.715
Gestational age		0.77	0.35	0.07, 1.46	0.122	0.030
Child gender	Girl vs boy	-2.17	1.3	-4.73, 0.39	-0.093	0.097
Number of pregnancies	2 vs 1	1.65	1.46	-1.21, 4.52	0.069	0.258
	3 vs 1	1.82	2.3	-2.7, 6.34	0.054	0.429
	≥4 vs 1	6.45	3.34	-0.14, 13.3	0.131	0.055
History of fetal death	Yes vs no	-4.75	2.99	-10.64, 1.14	-0.092	0.114
Having a companion during childbirth	Yes vs no	2.76	1.38	5.48, 0.05	0.113	0.046
Childbirth complications	Yes vs no	0.25	2.43	-4.53, 5.02	0.007	0.920

Coefficient of determination (R^2)=0.088.

ing workshops for midwives to enhance their knowledge and practice [32]. It can be one of the reasons for the high level of abuse-free care in our study. In the present study, the lowest score was in the domain of timely care, which includes items related to delays in care or keeping mothers waiting. This result is consistent with the findings of other studies [24, 33, 34]. However, according to the WHO, timely care is one of the standards for achieving high-quality RMC, such that maternal and neonatal outcomes can be improved through it [35].

We found a significant difference in the total RMC score based on maternal education and the presence of a companion during birth, and the gestational age had a significant relationship with the total RMC score. The score of RMC in mothers with an academic education was significantly lower than that in women with lower than high school education. This is in line with the results of other studies [6, 36-38]. A reduction in the RMC score with increasing women's educational level may be because higher educational attainment raises expectations for service quality. Additionally, women with higher levels of education are more aware of their rights and have a greater capacity to report disrespectful behavior. The results are not consistent with the results of some studies [39, 40]. The possible reason may be differences in the tools used, the number of samples, the sampling method, and environmental and socio-economic factors. In the present study, the RMC score among women with a companion during childbirth was significantly higher than among those without a companion. This result is consistent with findings from similar studies [41-43]. The presence of a companion can reduce the anxiety, fear, and perceived pain of childbirth through emotional support and improve the labor experience [41, 44]. In the study by Mirzania et al. [45], the presence of a companion was associated with increased reports of disrespectful behaviors, attributed to limited knowledge of the childbirth process in the woman and her companion. In the present study, higher gestational age was associated with increased RMC score. As gestational age increases, interactions between women and healthcare providers increase, which can improve their relationships and foster trust in healthcare providers [46]. However, no significant relationship between gestational age and RMC score was found in some studies [24, 28, 47].

This study had some limitations. Since the data collection was done in the hospital, there may be a fear of reporting abusive care and a social desirability bias. Also, because the data were collected in the early postpartum period, some women were too exhausted to answer certain questions.

Based on the results, the pregnant women admitted to the postpartum department of public hospitals in Guilan Province receive a relatively high level of RMC. The effective factors are women's educational level, the presence of a companion during birth, and gestational age. Hospitals and health centers should provide education to care providers on the rights of pregnant women and the respectful treatment they should receive, with a focus on the key factors identified in this research. More research is needed to assess the quality of RMC services in Iran.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Guilan University of Medical Sciences, Rasht, Iran (Code: IR.GUMS.REC.1402.189). Written informed consent was obtained from the respondents to participate in the study.

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Authors' contributions

Study design and supervision: Zahra Bostani Khalesi; Data collection: Roya Chatraei; Data analysis: Saman Maroufizadeh; Draft preparation: Roya Chatraei, Zahra Bostani Khalesi, and Mona Rahnavardi; Final approval: All authors.

Conflict of interest

The authors declared no conflict of interest.

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