Respectful Maternity Care and Its Associated Factors at Kitale County Referral Hospital, Trans Nzoia County, Kenya

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Received March 7, 2025, accepted April 26, 2025, published July 1, 2025.

ABSTRACT

Context: Respectful maternity care (RMC) comprises the seven elements as enlisted by the World Health Organization, including harm-free care, consensual care, confidentiality, dignity, non-detention, non-abandonment, and care without discrimination, which ensures that a pregnant mother is accorded respect whenever they seek maternal services at health facilities during pregnancy, labor, delivery and postnatal period. Various factors play a role in respectful maternity care, including maternal factors, singular health provider factors, health system factors, and other systemic factors. These factors have been known to play a critical role when a mother seeks care in a health facility, even determining the kind of care the mother will be offered.

Aim: The study aimed to evaluate respectful maternity care and its associated factors at Kitale County Referral Hospital in Trans Nzoia County, Kenya.

Methods: Institutional-based cross-sectional study design was used. Data was collected using pre-tested questionnaires among mothers (n=260) who had delivered and were in the postnatal ward at Kitale County Referral Hospital, Trans Nzoia County, Kenya.

Results: Most (83.5%) mothers were accorded respectful maternity care while in the health facility. The following factors were significantly associated with respectful maternity care; marital status: Married [OR=1.51 (95% CI: 0.46-2.33), *p*=0.002], residence: Urban [OR=1.46 (95% CI: 0.35-3.01), *p*=0.025], employment type: Housewife [OR=1.83 (95% CI: 1.61-3.26), *p*=0.001], parity: Three [OR=1.74 (95% CI: 0.27-3.28), *p*=0.001], place of last delivery: Hospital [OR=2.01 (95% CI: 1.51-2.45), *p*=0.016], mode of delivery: Spontaneous vertex delivery [OR=1.13 (95% CI: 0.24-3.28), *p*=0.018], occurrence of complication after delivery: Yes [OR=2.17 (95% CI: 0.25-1.26), *p*=0.001], waiting time: Less than half an hour [OR=2.1 (95% CI: 1.32-3.21), *p*=0.003], waiting time was okay: Yes [OR=1.1 (95% CI: 1.46-3.68), *p*=0.018], number of health providers assisting a delivery: Two [OR=1.56 (95% CI: 0.45-1.31), *p*=0.041], intention to deliver in the facility later: Yes [OR=0.7 (95% CI: 1.36-2.19), *p*=0.002], and recommending others to deliver in the facility: Yes [OR=0.71 (95% CI: 0.21-1.34), *p*=0.039].

Conclusion: Most respondents reported respectful maternity care at Kitale County Referral Hospital. Factors such as marital status, place of residence, employment status, parity, previous birthplace, mode of delivery, occurrence of a complication, waiting time, being okay with the time, number of health providers assisting a delivery, intention to use the facility and recommending others to use the facility were significantly associated with respectful maternity care. The study recommends that the county department of health develops an education program so that all pregnant mothers are empowered on respectful maternity care when they seek antenatal services before they come to deliver in health facilities. Further, the hospital management ensures pregnant mothers' privacy in the maternity unit.

Keywords: Associated factors, Kenya, Respectful maternity care

Citation: *Sabwami, G. K., Kipmerewo, M., & Sum, T. P. (2025).* Respectful maternity care and its associated factors at Kitale County Referral Hospital, Trans Nzoia County, Kenya. *Evidence-Based Nursing Research, 7*(3), 1-11. https://doi.org/10.47104/ebnrojs3.v7i3.391

1. Introduction

Pregnancy and childbirth are supposed to be positive periods for the mother, health providers, and the community at large. However, clinical studies globally have shown evidence from all countries that despite the health status of the nation, whether rich or poor, non-RMC of pregnant mothers by health providers is a worrying-developing trend *(Leslie et al., 2021).* Moreover, robust evidence from several studies shows that mothers face non-RMC during pregnancy, labor, and delivery, including verbal, sexual, and physical abuse *(Jolivet et al., 2021)*. This non-RMC tends to happen in all forms of societies and settings *(Ansari & Yeravdekar, 2021; Smith et al., 2020).*

Respectful maternity care (RMC) is the kind of care that ensures the mother's privacy, confidentiality, dignity, and informed choice are upheld without physical harm, detention, abandonment, and discrimination during pre-conception care, pregnancy, labor, birth, and the postpartum period. Moreover, all these aspects should form the basis of care delivery by any skilled birth attendant *(Kawish et al., 2023)*. RMC is a critical strategy that ensures increased utilization of hospital-based skilled

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deliveries by pregnant mothers and improvement of the quality of maternity care *(Adu-Bonsaffoh et al., 2025).*

Despite RMC significance, there is global evidence of non-RMC in mothers during pregnancy, labor, birth, and postnatal period *(Sudhinaraset et al., 2021).* This evidence paints a disturbing picture as mothers continually face different forms of non-RMC *(Leslie et al., 2021).* There are seven forms of non-RMC encountered by mothers when they seek care in health facilities, as described by *Bowser and Hill (2010)*, and they include physical abuse, non-consensual care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in facilities *(Bowser & Hill, 2010*). These forms of non-RMC have led to negative clinical outcomes for mothers and newborns *(Bulto et al., 2020; Dzomeku et al., 2020*). Additionally, evidence has shown different factors implicated in health facility non-RMC, including but not limited to maternal, health provider, health system and systemic factors *(Ndwiga et al., 2017).*

Sub-Saharan Africa carries the enormous burden of global mortalities (65%), yet it is one of the chief areas where non-RMC of pregnant mothers continues to bloom *(Kiti et al., 2022; Lavender et al., 2021).* Efforts have been made to escalate health facility deliveries to lower maternal mortalities, but the expected results remain elusive *(Kawish et al., 2023)*. Studies in this region show that most pregnant mothers would choose to deliver in health facilities *(Bulto et al., 2020).* However, they do not due to poor quality of care and non-RMC by the health providers in the facilities experienced previously *(Raval et al., 2021).*

The negative experiences mothers face when they come to deliver thus force them to opt not to use skilled birth personnel. These mothers only come to health facilities when facing a complication where it is a case of 'too little too late' to intervene *(Manu et al., 2021).* Besides, a study in low and middle-income countries (LMIC) has shown that health providers practice non-consensual care when giving care to pregnant mothers. Mothers have also reported verbal abuse (16%), physical abuse (3%), and 57% reported non-consensual care by health providers (*Afulani et al., 2019*).

Pregnant mothers coming to deliver in health facilities in East Africa are also still encountering non-RMC. Furthermore, mothers' prediction of how they will be treated in health facilities affects where they will deliver in the next pregnancy *(Jiru & Sendo, 2021).* Previous studies in LMIC indicate that there is a direct correlation between maternal deaths and non-RMC *(Puthussery et al., 2023).* Furthermore, evidence has shown a big gap in the delivery of RMC in health facilities, limiting skilled hospital deliveries *(Smith et al., 2020).*

Non-RMC, incompetent health providers, and poor mother-health-provider interaction have been listed as reasons why pregnant mothers may choose not to deliver in health facilities *(Jiru & Sendo, 2021).*

2. Significance of the study

Respectful maternity care is key to lowering maternal mortality globally (*Dzomeku et al., 2020*). In Kenya, maternal deaths are still high at 530 deaths per 100,000 live births *(World Health Organisation, 2023*). In addition, studies show that 80% of mothers were accorded RMC, while the rest faced various forms of non-RMC during labor and childbirth. The specific forms of non-RMC included 20% were humiliated, 18% received non-dignified care, 8.5% received non-confidential care, and 4.2% were physically abused *(Kiti et al., 2022; Sudhinaraset et al., 2021).* Pregnant mothers, therefore, have chosen to give birth without the help of skilled health providers, as only 65%-89% of mothers give birth in health facilities *(World Health Organisation, 2023).* However, mothers in Kenya have shown that they would easily utilize maternity services but due to non-RMC received from the health providers previously, they are dejected *(Odiase et al., 2021).*

A study in Bungoma County showed various disparities when it comes to RMC. At least 57% of pregnant mothers were accorded RMC during labor and delivery in the health facilities, while the rest faced non-RMC *(Namusonge et al., 2022).* Unless something is done, the quality of maternity care continues to drop daily. There is a dearth of data on RMC in Trans Nzoia County; thus, this study sought to evaluate respectful maternity care and its associated factors at Kitale County Referral Hospital, Trans Nzoia County, Kenya. Also, this study helps to formulate proven maternal policies that are key in lowering maternal morbidities and mortalities. Further, it informs the counties to tailor programs on equipping health providers and pregnant mothers on the importance of RMC.

3. Aim of the study

The study aimed to evaluate respectful maternity care and its associated factors at Kitale County Referral Hospital in Trans Nzoia County, Kenya.

3.1. Operational definition

Respectful maternity care: In this study, a mother was said to have received RMC if they answered Yes to questions on the seven components of respectful maternity care evaluated, which included dignified care, privacy, informed care (consensual care), non-discriminative care, non-abandonment of care, non-physical harm care and non-detention of mothers in health facilities due to lack of fees.

4. Subjects & Methods

4.1. Research Design

A cross-sectional study design was used to undertake the study among mothers who had delivered within 0-24 hours post-delivery at Kitale County Referral Hospital. The study variables were maternal factors, including marital status, residence, type of delivery, education, parity, complications, previous place of birth, and antenatal clinic attendance, among other factors. The health service factors included waiting time, number of health providers assisting a delivery, the day a mother delivered, sex of the health provider assisting a delivery,

recommending one to deliver in the facility, and intention to deliver in the facility.

4.2. Study setting

The study was conducted at Kitale County Referral Hospital in Trans Nzoia County in the former Rift Valley province. The county has an estimated area of 2469.9 Km^2 with a population of 990,341 people *(Kenya National Bureau of Statistics (KNBS), 2019).* It is a cosmopolitan area hosting various tribes, including Luhyas, Kalenjins, and Kikuyus. The residents of the area practice mainly agriculture as a way of living.

Kitale County Referral Hospital was a public facility that provided medical, surgical, obstetrics, gynecology, and child health services and acted as an attachment site for various medical institutions. It was a busy facility since it was the main referral hospital in the county (its services have since been moved to Wamalwa Kijana Teaching and Referral Hospital), and several patients of different characteristics sought services there.

4.3. Subjects

The health facility was purposively selected since it was the main referral hospital in the county, and most mothers went to this facility to seek maternal services; hence, it captured mothers with various characteristics. Since the number of mothers who gave birth was not constant, maternity registers were checked daily to ascertain the number of mothers who had given birth. Postnatal mothers were approached to ascertain whether they fit the inclusion criteria. If the mother did not fit the criteria, the next mother was approached, repeating the same procedure until one who did fit the criteria was found and interviewed.

The study population was less than 10,000 mothers; therefore, the modified Fishers et al. formula was used to arrive at the sample size of 265 using a study population of 646 mothers ($N = z^2p(1-p)/e^2$) *(Charan & Biswas, 2013).* All mothers who delivered within 0-24 hours in the facility were included in the study, while mothers with obstetric emergencies and those who came and delivered immediately were excluded.

4.4. Tools and Data Collection

4.4.1. Postnatal Mothers' Interview Questionnaire

The postnatal mothers' interview questionnaire was a pre-tested questionnaire used to collect data from postnatal mothers. It was adopted and modified from the MCHIP (Maternal Child Health Integrated Program) tool used by USAID *(Mengistie et al., 2022; Wubetu et al., 2021; Yismaw et al., 2022)* and used to collect data from mothers who had delivered within 0-24 hours in the postnatal wards.

The tool aimed to evaluate RMC and its associated factors. It omitted the exact stage at which the mother came to the facility to deliver. The tool had four main parts: Sociodemographic characteristics of the mother, obstetric characteristics, health service factors, and perceptions of RMC. The questions were closed-ended, and there were forty-three questions.

The questions were divided into Sociodemographic characteristics of the mother (6), obstetric characteristics (9), health service factors (7), and mothers' perceptions of RMC. The tool was written in English, translated to Kiswahili, and back-translated to English.

A mother was said to have received RMC when they answered 'Yes' to the questions about the seven components of RMC. A mother who answered 'No' was assumed to have received non-RMC while they were in the health facility.

The last part of the tool, having 21 questions, was majorly for evaluating mothers' perceptions of RMC. This part had the seven components of RMC. It was divided into: Non-physical harm care (4), right to information and consent (8), privacy and confidentiality (2), dignity (2), non-discriminative care (2), non-neglect of care (2) and non-detention in facilities (1). Each of the 21 questions had a Yes and No option for the mother to choose from them. If a mother scored more than 75% in each of the seven components of RMC, then she was said to have received RMC. The 'Yes' answer was coded as one, while the 'No' was coded as 0. The mother selected a Yes or No answer depending on how they were treated in the hospital.

4.5. Procedures

The study was approved by Masinde Muliro University's Directorate of Postgraduate School and the Institutional Ethics and Review Committee (IERC). Permission to carry out the study was obtained from the hospital research department. Postnatal mothers who participated in the study signed a consent form. Other ethical principles like confidentiality, anonymity, autonomy, justice, integrity, beneficence and non-maleficence were all considered in this study.

The tool was pilot-tested at Kapenguria County Referral Hospital, which had a similar environment as Kitale County Referral Hospital. The pilot study was carried out to test the quality of the tool using 10% of the sample size (27 mothers). For validity, Bartlett's test was done for all the variables under study and was significant at $p<0.05$. Besides, for reliability, the Cronbach alpha value was more than 0.78 for all the study variables. Supervisors and other experts in the field also reviewed the tool.

Two research assistants who were nurses with diploma qualifications were recruited into this study. The research assistants were trained on study objectives, methodology, ethical procedures, and how to administer questionnaires to the mothers. The researcher supervised what was being done during the entire data collection period. Mothers in the postnatal wards who did not present with obstetric emergencies and volunteered to participate in the study were approached, the purpose of the study was explained, and consent was sought; exit interviews were conducted among those who consented. This study was conducted from May to July 2023.

4.6. Data analysis

Data was crisscrossed for completeness, coded, and entered into SPSS version 25.0 software. The use of descriptive statistics like frequency and percentages analyzed quantitative data. Bivariate analysis was used to identify independent variables which were associated with RMC. The *p*-value was ≤0.05 to determine statistical significance at a 95% confidence interval.

5. Results

Table 1 reveals the sociodemographic characteristics of the mothers. Two hundred sixty mothers participated in the study, representing a 98.1% response rate. Most mothers were married (69.6%), while 70.4% were from rural settings. Further, most were Christians (95%), had post-primary education qualifications (55.4%), and were self-employed (35%), while mothers with no disability were 86.9%.

Table 2 shows the obstetric characteristics. Most respondents were first-time mothers (42.3%), most of whom planned the pregnancy (55.4%). The majority began their ANC in the first trimester (78.1%). Most mothers attended 1 to 4 antenatal clinics (53.9%). 96.5% of the mothers intended to use the facility for delivery and delivered through spontaneous vertex delivery (72.3%).

Table 3 describes the status of mothers' perception of receiving respectful maternity care. The majority of the mothers were allowed to take fluids or food in labor (95.4%), were not physically restrained (93.5%), no physical force was used on them (78.9%), were given periodic updates on labor progress (94.2%), were explained what was being done in labor (90.4%). Most of the studied women reported they were spoken to politely (96.5%), and they were never intimidated, threatened, or coerced (99.6%), were spoken to at a language level they understood (100%), and were not left alone unattended to by health providers (98.8%).

However, less than half of the mothers were not given comfort or pain relief in labor (44.6%), consent was not obtained from them (41.9%), were not covered with drapes during delivery (36.5%), health providers did not introduce themselves to them (24.6%), their companions were not encouraged to remain with them (28.5%) and visual barriers were not used during examinations, procedures and birth on them (28.5%).

Figure 1 illustrates the total RMC provided to the studied mothers. Most mothers (83.5%) were accorded RMC at Kitale County Referral Hospital.

Table 4 demonstrates maternal factors associated with respectful maternity care. The next factors were significantly associated with respectful maternity care at Kitale County Referral hospital; marital status: Married [OR=1.51 (95% CI: 0.46-2.33) *p*=0.002], residence: Urban [OR=1.46 (95% CI: 0.35-3.01) *p*=0.025], employment type: Housewife [OR=1.83 (95% CI: 1.61-3.26) *p*=0.001], parity: Three [OR=1.74 (95% CI: 0.27-3.28) *p*=0.001], place of last delivery: Hospital [OR=2.01 (95% CI: 1.51-2.45) *p*=0.016], mode of delivery: Spontaneous vertex delivery [OR=1.13 (95% CI: 0.24-3.28) *p*=0.018] and occurrence of complication after delivery: Yes [OR=2.17 (95% CI: 0.25-1.26) *p*=0.001].

Table 5 demonstrates the frequency and percentage distribution of health service-related factors. Most mothers waited less than half an hour to be served (78.1%), and most were okay with the waiting time (86.5%). The majority delivered during the weekday (63.5%), 55% of the healthcare providers were males, and 55% reported that two providers attended the delivery. The majority intended to deliver in the facility in the future (94.2%). This result was almost similar to those recommending other pregnant mothers deliver in the facility 93.9%.

Table 6 demonstrates health service-related factors associated with respectful maternity care. The table clarifies that factors being significantly associated with RMC included; waiting time: Less than half an hour [AOR=2.1 (95% CI: 1.32-3.21) *p*=0.003], waiting time was okay: Yes [AOR=1.1 (95% CI: 1.46-3.68) *p*=0.018], number of health providers assisting a delivery: Two [AOR=1.56 (95% CI: 0.45-1.31) *p*=0.041], intention to deliver in the facility later [AOR=0.7 (95% CI: 1.36-2.19) *p*=0.002] and recommending delivery in the facility: Yes [AOR=0.71 (95% CI: 0.21-1.34), *p*=0.039].

6. Discussion

Respectful maternity care remains the standard of care for pregnant mothers globally. RMC ensures quality care is accorded to pregnant mothers, thus helping to reduce maternal morbidities and mortalities *(Bante et al., 2020).* This study aimed to evaluate respectful maternity care and its associated factors at Kitale County Referral Hospital, Trans Nzoia County, Kenya.

The proportion of respectful maternity care at Kitale County referral hospital was 83.5%. This finding reveals that most mothers seeking care in the health facility received RMC except for the remaining few (16.5%). This finding is similar to those in Norway (79%), Kenya (80%), and Tanzania (85%) *(Hajizadeh et al., 2020; Mengistie et al., 2022).* However, it is higher than previous studies conducted in Southwest Nigeria, 6.8% *(Kedir et al., 2022)*, and Gujrat, Pakistan, 0.3% *(Azhar et al., 2018).* The variance could be due to the methodology used where the first study was conducted among mothers who were attending maternal child health clinic after delivery, while the latter study was among households of mothers who had delivered two months into the postpartum period.

The present study also reveals that most mothers were protected from physical harm, and this finding could be due to the integration of RMC in the Emergency Obstetric and Neonatal Care (EmONC) training; thus, health providers are informed on respectful maternity care. This finding relates to a previous study conducted in Kenya *(Sudhinaraset et al., 2021).* However, almost half of the mothers were not provided with comfort or pain relief while in labor. This finding could be due to the unavailability of pain medications and the large number of mothers seeking care in the facility, overwhelming the number of health providers to offer comfort to the mothers. This finding mirrors previous studies in the LMIC and South Africa that indicated little being done by

Table (1): Frequency and percentages of demographic characteristics of mothers (n=260).

Characteristic	Frequency	%
Marital status		
Single	78	30.0
Married	181	69.6
Divorced/separated	1	0.4
Residence		
Urban	77	29.6
Rural areas	183	70.4
Religion		
Christian	247	95.0
Muslim	13	5.0
Educational status		
No education	3	1.2
Primary level	57	21.9
Post-primary (secondary or vocational)	144	55.4
College and above	56	21.5
Employment status		
Employed	50	19.2
Self-employed	91	35.0
Farmer	7	2.7
Housewife	51	19.6
Student	61	23.5
Do you suffer from any of the conditions below		
HIV/AIDS	20	7.7
Hypertensive condition	14	5.4
Physical disability	0	0.0
None	226	86.9

Table (2): Frequency and percentages of obstetric characteristics of the studied mothers (n=260).

Characteristic	Frequency	Percent
Number of births/parity		
One	110	42.3
Two	65	25.0
Three	54	20.8
Four or more	31	11.9
Previous birthplace		
Hospital	93	35.8
Home	57	21.9
NA, if she is a first-time mother	110	42.3
Was the pregnancy planned?		
Yes	144	55.4
No	116	44.6
When did you begin ANC?		
First trimester	203	78.1
Second trimester	29	11.2
Third trimester	18	6.9
Did not attend	7	2.7
Do not know	3	1.1
Number of ANC visits		
None	9	3.4
1 to 4	140	53.9
More than 4	111	42.7
Did you intend to use the facility for delivery?		
Yes	251	96.5
No	9	3.5
Length of time labored in the facility before delivery		
<24 hours	140	53.8
≥24 hours	120	46.2
Mode of delivery		
Spontaneous vertex delivery	188	72.3
Assisted vaginal delivery	0	0.0
CS	72	27.7
Any complication after delivery		
Yes	55	21.2
No	205	78.8

Table (3): Quantitative analysis of mothers' perceptions of RMC (n=260).

Performance indicator	YES (accorded RMC)		NO (not accorded RMC)	
	No.	%	No.	%
The mother is protected from physical harm.				
You were not denied food or fluid in labor unless medically necessitated	248	95.4	12	4.6
You were not physically restrained	243	93.5	17	6.5
You were given comfort or pain relief as necessary	144	55.4	116	44.6
No physical force or abusive behavior was used on you, including slapping, pinching, or hitting	205	78.9	55	21.1
Total	210	80.8	50	19.2
Right to information, informed consent, and choice				
The health provider introduced her/himself to you and your companion	196	75.4	64	24.6
The companion was encouraged to remain with you as much as possible	186	71.5	74	28.5
You and your companion were encouraged to ask questions	161	61.9	99	38.1
You were explained what was being done and what to expect in labor and birth	235	90.4	25	9.6
You were given periodic updates on the progress and status of labor	245	94.2	15	5.8
You were allowed to move about freely in labor	245	94.2	15	5.8
You were allowed to assume the position of choice during birth	259	99.6	1	0.4
Consent was obtained from you prior to the procedures	151	58.1	109	41.9
Total	208	80.0	52	20.0
Confidentiality and privacy				
Visual barriers were used on you when exams, procedures, and birth were conducted	186	71.5	74	28.5
You were covered with drapes at birth	165	63.5	95	36.5
Total	176	67.7	84	32.3
Dignity and Respect				
You and your companion were spoken to politely	251	96.5	9	3.5
Neither you nor your companion were ever intimidated, threatened, or coerced	259	99.6	1	0.4
Total	255	98.1	5	1.9
Equitable care, free of discrimination				
You were spoken to at the language level you understand well	260	100.0	0	0.0
You were not disrespected based on an attribute you had	256	98.5	4	1.5
Total	258	99.2	2	0.8
The mother is never left without care				
You were encouraged to call if needed	202	77.7	58	22.3
You were not left alone or unattended to all the time	257	98.8	3	1.2
Total	230	88.5	30	11.5
The mother is detained due to a lack of fees				
You were not detained in the facility because you lacked fees	260	100.0	0	0.0

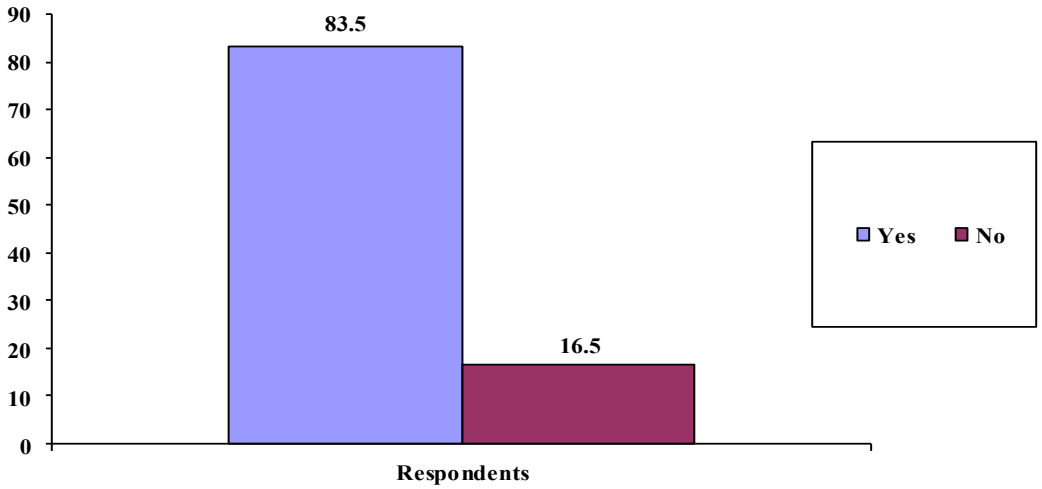

Figure (1): Mothers' perception of the status of RMC (n=260).

Table (4): Association of maternal characteristics with RMC (n=260).

Variable	RMC		AOR	95% CI	p-value
	Yes	NO			
Marital status					
Single	56	22	1.22	0.47-2.51	
Married	138	43	1.51	0.46-2.33	0.002
Divorced/separate	1	0	0.11	0.31-1.16	
Residence					
Urban	57	20	1.46	0.35-3.01	0.025
Rural areas	45	138	0.62	0.22-1.28	
Educational status					
No education	2	1	2.65	0.81-1.90	
Primary level	47	10	2.58	1.06-4.32	0.073
Post-primary (secondary or vocational)	110	34	1.40	0.38-4.12	
College and above	36	20	1	0.31-1.60	
Employment status					
Employed	39	11	1.62	0.41-2.27	
Self-employed	78	13	1.40	1.20-3.20	
Farmer	5	2	1.42	0.43-2.39	0.001
Housewife	41	10	1.83	1.61-3.26	
Student	52	9	1.04	0.52-0.91	
Wealth status					
Low	53	20	1.41	0.81-1.65	
Medium	137	45	1.23	0.75-1.02	0.421
High	4	1	0.28	0.16-0.83	
Number of births/parity					
One	79	31	1.24	0.24-1.62	
Two	48	17	1.33	0.81-2.17	0.001
Three	43	11	1.74	0.27-3.28	
Four or more	25	6	0.81	0.62-1.80	
Previous birthplace					
Hospital	72	21	2.01	1.51-2.45	
Home	39	18	1.97	1.34-3.28	0.016
NA, if she is a first-time mother	42	68	1.12	1.07-2.06	
Was the pregnancy planned?					
Yes	113	31	4.45	1.12-2.70	0.053
No	82	34	2.62	1.04-2.03	
Number of ANC visits					
None	5	4	1.34	0.36-2.13	
1 to 4	103	37	2.52	0.39-2.25	0.584
More than 4	87	24	1.94	0.28-1.85	
Did you intend to use the facility for delivery?					
Yes	190	61	1.13	0.27-3.23	0.281
No	5	4	0.82	0.16-2.24	
Length of time labored in the facility before delivery.					
<24 hours	108	32	1.41	0.25-1.3	0.072
≥24 hours	87	33	1.28	0.16-0.94	
Mode of delivery					
Spontaneous vertex delivery	151	37	1.13	0.24-3.28	0.018
Cesarean section	44	28	1.03	0.34-2.18	
Any complication after delivery					
Yes	42	13	2.17	0.25-1.26	0.001
No	113	92	1.96	0.42-1.12	

health providers to alleviate mothers' pain in labor *(Afulani et al., 2019; Malatji & Madiba, 2020).*

Moreover, another positive aspect is that most mothers explained what was being done while in labor, spoke politely and were not threatened, intimidated, or coerced during maternity care, spoke to the language level they understood, and gave periodic updates in labor. On the contrary, at least half were not asked for consent before procedures. This finding could be due to the emphasis on the communication aspect of RMC during hospitals' continuous medical education (CME) and training; hence, health providers have embraced the practice. On the other hand, the low level of consent from mothers by the health providers could be due to an overwhelming number of pregnant mothers who sought services in the facility This finding is higher than that of a study in Tanzania (16%) and four other nations whose overall score was 44% *(Das et al., 2021; Leslie et al., 2021).* The differences could be due to study methodologies between the studies where the first was an observational study that was more objective than the

Table (5): Frequency and percentage distribution of health service-related factors (n=260).

Health service-related factors	Frequency	Percent
Length of time (waited) to be attended to once in the facility		
Less than 30 min	203	78.1
About one hour	30	11.5
More than one and a half hours	27	10.4
Was the waiting time okay for you?		
Yes	225	86.5
No	35	13.5
Day delivered		
Weekend	95	36.5
Weekday	165	63.5
Sex of the provider who conducted the delivery		
Male	143	55.0
Female	117	45.0
Number of providers assisting in the delivery of care		
One	49	18.9
Two	143	55.0
Three or more	68	26.1
Intending to deliver in the facility in the future		
Yes	245	94.2
No	15	5.8
Recommending any pregnant mother to deliver here		
Yes	244	93.9
No	16	6.1

Table (6): Association of health service factors with RMC (n=260).

Characteristic	RMC		AOR	95% CI	p-value
	Yes	No			
Length of time (waited) to be attended to once in the facility					
Less than 30 min	187	16	2.1	1.32-3.21	0.003
About one hour	21	9	1.04	0.61-1.75	
More than one and a half hours	20	7	0.98	0.41-1.02	
Was the waiting time okay for you?					
Yes	165	60	1.1	1.46-3.68	
No	30	5	0.85	0.91-1.16	0.018
Day delivered					
Weekend	65	30	1.13	0.27-3.23	
Weekday	130	35	1.01	0.11-1.83	0.261
Sex of the health provider who conducted the delivery					
Male	115	28	1.2	1.21-3.26	
Female	80	37	0.92	0.83-1.75	0.183
Number of providers assisting in the delivery of care					
One	35	14	0.7	1.38-2.16	
Two	120	23	1.56	0.45-1.31	0.041
Three or more	40	28	0.8	0.72-1.11	
Intending to deliver in the facility in the future					
Yes	180	60	0.7	1.36-2.19	0.002
No	10	5	0.6	0.73-1.62	
Recommending any pregnant mother to deliver here					
Yes	184	60	0.71	0.21-1.34	0.039
No	11	5	0.62	0.13-1.01	

current study, which is subjective. The latter study was conducted as community surveys among discharged mothers from health facilities.

Further, more than half of mothers were accorded privacy while in the facility. The low number of mothers accorded privacy could be due to the large turnover of mothers versus the little resources. These circumstances strain the little resources in the maternity unit, like small spaces, curtains, and screens. This finding is higher than a study conducted in Gujarat, which showed that no mother was accorded privacy during their stay in the hospital *(Raval et al., 2021).* This finding could be because the latter study was mainly observational compared to the current subjective one.

The findings of the current study also reveal that marital status was significantly associated with RMC, where married mothers were more likely to receive RMC compared to those who were not. Married mothers have the advantage of a spouse who provides a support system. This finding could be emotionally, monetarily and other aspects

yet also act as the mothers' 'advocate' during labor and delivery. This finding is analogous to those in LMIC (Ghana, Kenya, and India) and Ethiopia *(Afulani et al., 2019; Mengistie et al., 2022).*

Besides, place of residence was also significantly associated with RMC. Mothers from urban areas were more likely to receive RMC than rural ones. This outcome reflects those of (*Afulani et al., 2019*) in LMIC. Mothers from urban areas have the advantage of better infrastructure in terms of roads, hospitals, and better networks; thus, they are more enlightened and may be economically stable due to many employment opportunities. Due to all this, the urban mother is empowered and hence can advocate for their rights singlehandedly compared to the rural mother, who may be disadvantaged.

Further, findings also show that employment was significantly associated with RMC, where housewives were more likely to receive RMC than students. This finding could be due to the respect earned being a married woman as housewives have their partners when visiting the hospital who act as their 'advocates' compared to students who may be demeaned at the time by their significant others as they are expected to be in school rather than being pregnant, and this contradicts the findings of *(Yismaw et al., 2022*). This finding could be due to the difference in study setting and mothers' ability to report RMC events.

Additionally, parity was significantly associated with RMC where mothers with a three parity were more likely to receive RMC. This finding could be due to the experience these mothers have compared to those with fewer deliveries. However, as mothers move up the parity ladder, they may neglect health providers' instructions by the assumption of being knowledgeable and, thus, may be recipients of non-RMC. The finding reflects that in Ethiopia where a higher parity meant receiving RMC (*Amare et al., 2022*).

Moreover, the place of previous delivery was also significant, where those who had delivered previously in a health facility were two times more likely to be accorded RMC than those who were not. Mothers who have delivered previously in a hospital have the experience and knowledge of the requirements, processes, language, and hospital environment. Thus, they may not struggle to follow instructions regarding delivery, unlike those who have not delivered in a health facility before. This finding is similar to *Azhar et al. (2018) and Yosef et al. (2020)* in Pakistan and Ethiopia.

Mode of delivery was also significant where those who delivered via Spontaneous Vertex Delivery (SVD) were more likely to receive RMC than those who delivered through cesarean section. This finding could be due to the time spent in the health facility after delivery. Mothers who deliver through SVD may spend less time within the facility and thus may not have adequate time to detect non-RMC occurrences, unlike those who delivered via cesarean section, who spent more time in the facility and thus can take note of the events of non-RMC. This finding correlates to that of *(Ferede et al., 2022*) in Northwest Ethiopia.

In addition, the occurrence of complications after delivery was also significant, as mothers who had complications were more likely to receive RMC than those who were not. Mothers who have a complication in delivery will have close monitoring and care to avoid further complications. Although the mother may view this close unplanned care as RMC, RMC may be omitted in other instances. This finding controverts those of *(Hughes et al., 2022*) in Malawi. The dissimilarity in the findings could be credited to the methodology used in the two studies, where the latter used a different tool to study RMC and was done on a higher scale.

Furthermore, the present study also shows that most mothers waited for less than half an hour and were okay with the waiting time. Besides, these mothers were more likely to receive RMC, possibly due to timely care, leading to satisfaction with the service given. On the other hand, mothers who were attended to by two health providers were more likely to receive RMC than those whom three or more health providers assisted. The possible explanation could be that the gold standard of a procedure requires two health providers, usually one performing and one assisting. Thus, mothers may not want a crowded delivery room as they may feel their privacy is infringed. This finding relates to that of (*Bulto et al., 2020*) in the North Shewa zone.

Besides, mothers who intended to deliver in the facility in the future and those who would recommend others to deliver in the facility were more likely to receive RMC. This finding could be due to early planning, positive attitude, and interaction with the health system, thus building confidence and the ability to champion their rights. This finding is comparable to findings in Bahir Dar (*Wassihun & Zeleke, 2018*).

7. Conclusion

The level of RMC at the facility was commendable at 83.5%. The factors that were found to be significantly associated with RMC included marital status, residence, employment status, parity, previous birthplace, mode of delivery, occurrence of a complication, waiting time, being okay with waiting time, number of providers assisting a delivery, intention to deliver in the facility in future and recommending other mothers to deliver in the facility.

8. Recommendations

The study recommends that the Ministry of Health and the county health department develop an education program to enlighten pregnant mothers on RMC when they attend antenatal clinics and be empowered before they visit health facilities to deliver.

The facility management should be encouraged to ensure increased space and privacy within the maternity unit.

The maternity unit should assign skilled birth attendants to ensure comfort and pain relief care to pregnant mothers in labor.

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