

Influential Factors of Respectful Maternity Care and Its Relationship with Women's Future Fertility Decisions

Abstract

Background: The childbirth experience encompasses a complex interplay of physical, emotional, and psychological factors, shaping a woman's overall well-being and potentially influencing her future reproductive plans. The current study aimed to evaluate the influential factors of respectful maternity care and its relationship with women's future fertility decisions. **Materials and Methods:** This cross-sectional study was conducted on 308 postpartum women hospitalized in the postpartum wards of educational hospitals affiliated with Isfahan University of Medical Sciences between April and September 2021. Data were collected using convenience sampling method by a sociodemographic and obstetric checklist and a standard Respectful Maternity Care (RMC) questionnaire and analyzed with descriptive statistics and the linear regression model (95% confidence level). **Results:** Our findings show that 50.65% of participants would like to have another child, and only 26.62% of them reach the desired number of children. The mean score of RMC was 66.55 (7.13), and variables such as duration of hospital stay, oxytocin induction, episiotomy, birth preparation classes, and level of education were the main predictors of RMC (p -value < 0.05). In addition, a positive correlation was found between the total score of RMC, the next intended fertility ($r = 0.24$), and ideal fertility in the best socioeconomic condition ($r = 0.22$). **Conclusions:** This study demonstrates a strong association between hospital stay duration, oxytocin induction, episiotomy, birth class attendance, education level, and RMC. Addressing these factors can enhance maternity care quality, childbirth experiences, and ultimately contribute to optimal fertility outcomes.

Keywords: Maternal child nursing, parturition, population dynamics, respect

Introduction

Pregnancy and childbirth, as an important events in women's lives, require respectful and dignified care.^[1] Respectful Maternity Care (RMC) is a type of customer-oriented care based on respect for women's freedom, expectations, authority, values, culture, and dignity.^[1] The World Health Organization's (WHO) recommendations highlight the importance of the interaction quality between mothers and their healthcare providers, identifying positive interactions as essential for achieving favorable pregnancy and childbirth outcomes.^[1,2]

Evidence indicates a significant prevalence of disrespect and misbehavior during childbirth, encompassing verbal, physical, and sexual abuse, with reported rates of 71.3%, 67%, and 91.7% among women in India, Spain, and Addis Ababa, respectively, as well as an estimated prevalence of approximately 75.7% in the Iranian population.^[3-5] The

observation of many cases of mistreatment of women during pregnancy and childbirth around the world led to the publication of a statement by the WHO on the prevention and elimination of disrespect and abuse during facility-based childbirth.^[6] This statement calls on governments to support programs designed to improve the quality of maternal and newborn health services, particularly respectful maternal care.^[6]

Recognizing disrespect in maternity care as a form of violence against women is crucial because it violates their reproductive health rights and leads to physical and psychological harm during pregnancy, childbirth, and postpartum. Furthermore, it underscores societal perceptions of women's value within social, economic, and political frameworks.^[7-9]

Numerous actions by healthcare providers may be perceived as offensive and

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disrespectful, ranging from a failure to exhibit supportive behavior (such as withholding information or lacking informed consent) to actions that are physically or mentally harmful (such as slapping or beating, verbal abuse, or refusal of pain relief).^[10,11] These behaviors can violate women's fundamental rights, negatively impact their birthing experiences, potentially hinder their future access to medical care, and expose them to unwanted pregnancy.^[8,10] It is proposed that various factors, such as cultural norms, gender dynamics, lack of informed consent, the medicalization of childbirth, and systemic challenges within the healthcare system, contribute to RMC.^[7,12]

The adverse effects of these experiences can have a range of short-term and long-term effects on physical, sexual, and mental well-being as well as on mother–infant relationships. Studies have identified negative outcomes of violence, including postpartum depression, posttraumatic stress disorder (PTSD), difficulties in adapting to the maternal role, breastfeeding challenges, and decreased desire for future pregnancies.^[12,13] RMC not only influences women's willingness to use healthcare services and access postnatal care but can also have lasting implications; thus, this issue may potentially undermine their confidence in pursuing future pregnancies.^[14,15] The results of one study showed that in 6% of Italian women, violence during childbirth was the most important reason for refusing a second pregnancy.^[16] In other words, the fear of experiencing disrespect again can influence women's future fertility decisions, leading them to avoid birthing centers and opt for less midwifery care.^[17]

Fertility decisions are critical to the sustainability and advancement of society and influence a wide range of areas, such as demographics, economics, culture, and social systems. It seems that disrespect in maternity care can influence women's decisions regarding fertility by creating feelings of fear, lack of trust in healthcare providers, and trauma, leading them to reconsider or delay their plans to have children.^[15,18] On the other hand, many individual, social, and childbirth conditions can predict respectful maternity care.

In recent years, Iran has experienced population growth below the replacement rate (TFR less than 2.2), signaling a significant concern for policymakers. Therefore, it is crucial to understand the factors that influence individuals' fertility decisions.^[19]

Following the decrease in the global fertility rate, especially in Iran, it is necessary to examine fertility decisions and related factors in women who plan to have a second, third, or more child. Moreover, it is crucial to implement policies that ensure all women receive dignified healthcare and have the opportunity to attain their desired number of children. Given the limited research on the influence of childbirth experiences on fertility decisions, the current study aimed to evaluate the influential factors of respectful maternity

care and its relationship with women's future fertility decisions.

Materials and Methods

This cross-sectional study included 308 postpartum women hospitalized in the postpartum wards of three educational hospitals affiliated with Isfahan University of Medical Sciences—Alzahra, Shahid Beheshti, and Isabn-Maryam—between April and September 2021. Based on the results of the Hajizadeh *et al.*^[5] study, and considering the 75.72% prevalence of disrespectful care, and $P = 0.50$, $Z_{1-\alpha/2} = 1.96$, and $d = 0.05$, the sample size with considering 10% dropout was calculated to be 308 people using G-Power.

The participants were selected using the convenience sampling method with the following inclusion criteria: (a) Iranian nationality, (b) passing less than 7 days after childbirth, (c) being sufficiently literate to be able to understand and answer the questions, (d) not using any psychiatric medications according to self-report, (e) lack of bearing any newborns' abnormalities, and (f) lack of recent stressful events.

Initially, the researcher engaged with the postpartum wards of selected hospitals to recruit participants. Using a convenience sampling method, a cohort of women who had recently given birth and expressed willingness to participate was selected. These participants were subsequently completed a sociodemographic and obstetric checklist. The checklist encompassed a range of variables, including the mother's age, educational level, duration of marriage, both the woman's and her husband's occupation, household income, type of delivery, gravidity, parity, whether the pregnancy was planned or unplanned, history of infertility, place of residence, duration of hospital stay, oxytocin induction, birth attendant, history of episiotomy, use of labor analgesia, presence of a doula at birth, and attendance at childbirth preparation classes.

The RMC questionnaire was used to assess respectful maternal care during childbirth. This scale consists of 15 questions, which are classified into four categories: friendly care (first 7 questions), nondiscriminatory care (questions 8, 9, 10), free care (questions 11, 12, 13), and timely care (questions 14, 15) based on a Likert scale anchored by 1 (strongly disagree) to 5 (strongly agree). The total score was calculated by adding the four domain scores, with higher scores representing better RMC. In the Iranian population, the psychometric properties of this questionnaire were verified by Esmkhani *et al.*^[20] study with α Cronbach equal to 0.839.

The statistical analysis was performed using SPSS version 16 (SPSS Inc., Chicago, IL, USA). Through descriptive and inferential statistics (Pearson or Spearman correlation test and linear regression model). The normal distribution of numeric data was assessed using the

Kolmogorov–Smirnov test. The statistical significance level for all tests was 0.05. To describe qualitative and quantitative variables, the frequency (percentage) and mean (standard deviation) were used, respectively.

To assess the correlation between RMC and women's fertility decisions, the Pearson and Spearman tests were used for normal and non-normal data, respectively. Linear regression models were used to assess the association between each predictor and RMC. Data analysis was performed using multiple linear regression models. In multiple linear regression analyses, the relationship between each predictor and RMC was examined after controlling for other predictors in the model.

Ethical considerations

The protocol of the current study was approved by the Research Ethics Committee of the Isfahan University of Medical Sciences (IR.MUI.NUREMA.REC.1400.172). Written and verbal consent was obtained from all participants. In addition, they all ensured that their information would be kept private and confidential.

Results

Our findings showed that the majority of participants were in the age group of 20 to 30 years (44.80%), primiparous (40.26), unemployed (82.79), with diploma, and university education level (63.31%), monthly income between 5 and 10 million Toman (37.66%), and married for less than 5 years (49.35). Based on the mode of delivery, 41.56, 51.62, and 6.82% of women had NVD (natural vaginal delivery), CS (cesarean section), and emergency CS, respectively. Only 15.26% of cases were associated with childbirth complications, and 95.13% of these pregnancies resulted in live births. Most of the participants had received prenatal care in obstetric offices and health care centers (79.22), and 9.09% reported a history of infertility during their current pregnancies [Table 1].

In terms of the next intended parity, 50.65% of participants would like to have another child, and 26.62% of participants reach the desired number of children. In the majority of participants, the ideal number of children before marriage and in the first year after marriage was two. In the best socioeconomic condition, 52.60% of women considered two children, and 37.66% of them three or more, and only 9.74% of the participants considered one child as an ideal number [Table 2].

The mean (SD) of RMC was 66.55 (7.13) and total scores ranged from 15 to 75 [Table 3]. The main predictors of RMC are presented in Table 4. Demographic and underlying factors (e.g. age, duration of hospital stay, parity, income, occupation, oxytocin induction, birth attendant, episiotomy, labor analgesia, dulla, and birth preparation classes) were entered into the linear regression model. In this model, the RMC was affected by the

Table 1: Baseline sociodemographic and obstetric characteristics of participants

Variables	Number (percent)
Age	
Less than 20 years	45 (14.61)
20-30 years	138 (44.80)
30-35 years	42 (13.63)
More than 35 years	83 (26.94)
Parity	
1	124 (40.26)
2	113 (36.69)
3	50 (16.23)
≥4	21 (6.82)
Type of delivery	
NVD	128 (41.56)
CS	159 (51.62)
Emergency cesarean	21 (6.82)
Occupation	
Housewife	255 (82.79)
Employee	53 (17.21)
Education	
Primary school	46 (14.93)
Secondary school	67 (21.75)
Diploma	126 (40.91)
University	69 (22.40)
Monthly income	
1-3 million Toman	51 (16.56)
3-5 million Toman	88 (28.57)
5-10 million Toman	116 (37.66)
≥10 million Toman	53 (17.21)
Husband education	
Primary school	26 (8.45)
Secondary school	65 (21.10)
Diploma	146 (47.40)
University	71 (23.05)
Having complication during childbirth	47 (15.26)
Unplanned pregnancy	197 (63.96)
Infertility	28 (9.09)
Duration of marriage	
Less than 5 years	152 (49.35)
5-10 years	75 (24.35)
≥10 years	81 (26.30)
IUFD	15 (4.87)
Place of prenatal care	
Hospital	19 (6.17)
Midwifery office	45 (14.61)
Obstetric office	136 (44.16)
Health care centers	108 (35.06)

duration of hospital stay ($\beta = -0.21$, $t = -2.92$, $P = 0.004$), oxytocin induction ($\beta = 0.18$, $t = 2.54$, $P = 0.01$),

Table 2: Fertility decision of postpartum women

	Number (percent)
Next intended parity	
0	139 (45.13)
1	156 (50.65)
2	13 (4.22)
Ideal number of children at premarriage	
0	5 (1.62)
1	56 (18.18)
2	208 (67.53)
≥3	39 (12.66)
Ideal number of children at first year after marriage	
0	30 (10.07)
1	82 (27.52)
2	154 (51.68)
≥3	32 (10.74)
The number of ideal children in best socioeconomic condition	
1	30 (9.74)
2	162 (52.60)
3	75 (24.35)
≥4	41 (13.31)
Number of women who reach to desired number of children	82 (26.62)

Table 3: Frequency distribution of respect maternity care in terms of total disrespect and its subcategories

Variables	Mean (SD)
Friendly care (7 questions)	30.64 (4.98)
Nondiscriminatory care (3 questions)	12.99 (1.82)
Free care (3 questions)	13.35 (2.27)
Timely care (2 questions)	9.56 (0.82)
Total respectful maternity care	66.55 (7.13)

episiotomy ($\beta = 0.27$, $t = 4.11$, $P < 0.001$), birth preparation classes ($\beta = 0.24$, $t = -2.38$, $P = 0.02$), and level of education ($\beta = 0.16$, $t = 2.23$, $P = 0.03$). These variables can explain only 55% of the variance in RMC.

Our findings also show a positive correlation between the total score of RMC, next intended parity ($r = 0.24$, p -value < 0.001), and ideal fertility in the best socioeconomic condition ($r = 0.22$, p -value < 0.001) [Table 5].

Discussion

In the current study, it is attempted to identify predictors of RMC using a linear regression model and explore how RMC influences women's future fertility decisions. Our findings show that the ideal fertility in most women is more than two children, and approximately 3/4 of them have not reached their ideals. In this regard, the result of one systematic review of 37 papers indicates that the mean

ideal fertility of Iranian women was 2.25, and factors such as age, actual fertility, and the economic costs of children were the main predictors of ideal fertility.^[21]

Moreover, we find a positive correlation between women's fertility decisions and respectful maternity care in terms of free, timely, friendly, and nondiscriminatory care. Only a few studies have examined the correlation between maternity care quality and future childbearing decisions. Only one Italian study has highlighted violence during childbirth as a significant factor that leads to the refusal of a second pregnancy. Their study solely focused on the correlation between these two variables without employing an appropriate tool to assess childbirth violence. Another systematic review revealed that a negative childbirth experience is linked to a decreased likelihood of having another child, a decision to postpone the birth of a subsequent child, and a maternal request for a cesarean section in a subsequent delivery. This review focuses solely on childbirth experiences, indicating that these negative experiences may be attributed to individual factors rather than disrespectful care.^[18]

Respectful maternity care is influenced by various factors. Our findings demonstrate that some factors such as longer hospital stays, oxytocin induction, episiotomy, nonattendance to birth preparation classes, and lower educational level are associated with disrespectful maternity care.

Our findings revealed that length of hospital stay was the main predictor of RMC. Consistent with our findings, Bulto *et al.* reported that a duration of hospital stay exceeding 13 h was associated with a 2.15-fold increase in the odds of disrespect maternity care.^[22] Prolonged hospital stays during maternity care can contribute to understanding obstetric violence and disrespect through the increased likelihood of unnecessary interventions, exposing individuals to disrespectful treatment from healthcare providers, and worsening feelings of vulnerability and disempowerment. This can create an environment that undermines the birthing person's autonomy and dignity.

In our study, the performance of procedures such as oxytocin injections and episiotomies was associated with an increase in perceptions of disrespectful maternal care. Nevertheless, the administration of analgesia during labor, the presence of a doula, and participation in childbirth preparation classes were not correlated with enhanced perceptions of RMC. It seems that performing procedures such as oxytocin administration or episiotomy can significantly influence women's perceptions of respectful maternity care, as these interventions are invasive and may cause discomfort or pain. When conducted without sufficient explanation, consent, or consideration of the woman's preferences and well-being, it can result in feelings of disrespect, rights violations, and loss of autonomy. In this regard, a study by Hajizadeh *et al.*^[23] revealed that some childbirth experiences, such as the presence of a doula,

Table 4: Regression analysis for determining predictive factors of respectful maternity care

Model		Number (Percent)	Unstandardized beta	Standardized beta	t	p	95% CI	
(Constant)		63.53 (8.37)	65.39		10.92	<0.001	53.53	77.25
Age*	mean (SD)	27.25 (6.43)	-0.03	-0.03	-0.36	0.72	-0.23	0.16
duration of hospital stay	mean (SD)	1.68 (1.27)	-1.36	-0.21	-2.92	0.004	-2.29	-0.44
Parity	mean (SD)	1.76 (1.02)	-0.08	-0.01	-0.13	0.89	-1.28	1.12
Income	mean (SD)	2.38 (0.90)	-0.99	-0.11	-1.65	0.11	-2.19	0.20
Oxytocin induction	Yes	58 (45.31)	3.10	0.18	2.54	0.01	0.69	5.52
	No	70 (54.69)						
birth attendant	Midwife	52 (16.88)	-0.54	-0.07	-1.10	0.27	-1.50	0.43
	Resident	168 (54.54)						
	Gynecologist	67 (21.75)						
	Instructor midwifery	21 (6.82)						
Episiotomy (NVD)	Yes	42 (32.81)	5.07	0.27	4.11	<0.001	2.62	7.51
	No	86 (67.18)						
Labor analgesia (NVD)	Yes	32 (25.00)	-1.79	-0.09	-1.22	0.22	-4.69	1.11
	No	96 (75.00)						
Dulla in NVD	Yes	24 (18.75)	-0.49	-0.02	-0.025	0.80	-4.42	3.43
	No	104 (81.25)						
Birth preparation classes	Yes	93 (30.20)	-4.31	-0.24	-2.38	0.02	-7.90	-0.72
	No	215 (69.80)						
Level of education	Primary	46 (14.93)	1.62	0.16	2.23	0.03	0.18	3.05
	Secondary	67 (21.75)						
	Diploma	126 (40.91)						
	University	69 (22.40)						
Occupation	House wife	283 (91.88)	-0.49	-0.04	-0.62	0.54	-2.07	1.08
	Employee	25 (8.12)						
Model index	R=0.74, R ² =0.55, Adjusted R ² =0.50, F=11.61, P<0.001							

Table 5: Correlation between respectful maternity care and fertility decision of women

	1	2	3	4	5
1-Total respect maternity care	1.00				
2-Nondiscriminatory care	0.60**	1.00			
3-friendly care	0.86**	0.27**	1.00		
4-Free care	0.64**	0.32**	0.37**	1.00	
5- Timely care	0.61**	0.39**	0.44**	0.62**	1.00
6-Next intended parity	0.24**	0.14*	0.21**	0.20**	0.16**
7- Ideal fertility in best condition	0.22**	-0.17*	-0.23**	-0.10	-0.21**
8-Ideal fertility at this time	-0.09	-0.20*	0.01	-0.09	-0.10

*P<0.001, ** P<0.05

birth attendant, augmentation for labor, and the length of stay in labor, are not related to the perception of RMC. However, the consistent support of the mother or father during labor and being a housewife was associated with a higher level of respectful maternal care. Another study demonstrated that variables such as women's age, type of delivery, occupational status, complications during labor and childbirth, unplanned pregnancy, and respectful care training were the main predictors of RMC in the maternity ward.^[10] In addition, Sheferaw *et al.*^[24] reported a higher RMC score in health centers compared to hospitals, male healthcare providers, and midwives compared to other cadres, employed women, and those accompanied by a

companion. Therefore, managers of maternal and newborn health programs and educational institutions that train health professionals should consider the role of gender and the profession in RMC services.

We identified educational level as the main predictor of RMC perception. In line with our findings, Birie and Niguse demonstrated a higher risk of receiving respectful maternity care among educated women.^[25] Individuals with higher educational level often have a greater understanding of maternal rights and expectations during childbirth, which can shape their perception of the care received. Furthermore, higher education levels may empower individuals to effectively advocate for their needs and

preferences, resulting in a more positive perception of the care provided.

Maternity care providers play a crucial role in shaping women's experiences, given their close interactions with women during labor and childbirth. They have the dual potential to either contribute to disrespect and misbehavior or act as agents of positive change to promote RMC.^[26] Therefore, RMC should be highlighted as a central and significant focus in preservice training programs for maternal health providers, including all those working in labor and delivery units.

Provider-level interventions are essential to promote positive changes in provider behaviors within clinical settings and health systems, ultimately guaranteeing respectful care for all women.

In this study, we attempted to identify the predictive factors influencing respectful maternal care within the Iranian setting, while also examining the correlation of these variables with fertility ideals. Acknowledging the presence of certain limitations in this research endeavor is essential. First, the design of this study is cross-sectional, which limits the ability to establish temporal precedence between exposure and outcome. Future research using a cohort design is recommended to explore the temporal sequence. Second, this study was performed out in hospitals affiliated with the University of Medical Sciences. Nonetheless, the distinction between the types of hospitals (private versus public) could serve as a significant predictor. Furthermore, we used a checklist with open-ended questions to explore attitudes toward and decision making regarding fertility.

Conclusion

Our results highlight that the notable relationship between variables such as hospital stay duration, oxytocin induction, episiotomy, attendance at birth preparation classes, and educational level is associated with respectful maternity care. Identifying and resolving these issues can improve the quality of maternity care and childbirth experiences. In addition, a positive correlation was identified between the overall RMC score and both the intention for future fertility and the desired fertility level under optimal socioeconomic conditions. These findings highlight the importance of these factors in shaping RMC and highlight the need for targeted interventions based on these predictors.

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Conflicts of interest

Nothing to declare.

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