Perspective of Post-Natal Mothers regarding Respectful Maternity Care during Facility-based Child Birth

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Abstract

Respectful maternity care (RMC) is an approach centred on an individual, based on principles of ethics and respect for human rights, and promotes practices that recognise women's preference and women's and newborn's needs. Despite the abundance of research on disrespect and abuse prevalence, few studies have investigated effective measures for reducing and preventing the prevalence of disrespect and abuse behaviour during labour and birth. The study sought to determine women's perception of RMC during facility-based child birth. It was a descriptive cross-sectional study conducted among 100 post-natal mothers admitted to the post-natal ward of New Civil Hospital, Surat. Random sampling technique was used. Data were collected through interview technique. Frequency, percentage, mean score, standard deviation, chi-square test were used to analyse descriptive and inferential statistics. The findings show that 90 percent of the women stated that they had perceived overall dimensions of RMC, the mean score being 82.83 with a standard deviation of 12.83229 whereas rest of the 10 percent didn't perceive it. As for friendly care, the average score of 83.00 is observed with the SD of 14.41187, where 90 percent of the post-natal mothers claimed having received friendly care. The highest average score of 90.00 is observed in the abuse-free care dimension with the SD of 13.6782, where 98 percent of the post-natal mothers claimed having received abuse-free care. As for timely care dimension, the average score of 81.4 is observed with the SD of 16.0609, where 89 percent of the post-natal mothers claimed being received timely care. With respect to discrimination-free aspect, the average score of 88.3 is observed with the SD of 9.54045, where 100 percent of the postnatal mothers claimed being received discrimination free care. The average score of 81.5 is observed in the privacy maintained dimension with the SD of 18.27815, where 89 percent of the postnatal mothers claimed having received privacy maintained. In baby care area, the average score of 82.83 was observed with the SD of 17.5173, where 84 percent of the post-natal mothers claimed having received care of baby.

Key words: Respectful maternity care, Quality maternity care

Respectful maternity care (RMC) is an approach centred on an individual, based on principles of ethics and respect for human rights; it promotes practices that recognise women's preference and women's and newborn's needs (FMOH, 2015; Windau-Melmer, 2013). The World Health Organization has issued a statement on disrespect and abuse during childbirth, which led to focus on the importance of respectful maternity care and women's rights during pregnancy and childbirth and need for direct attention to this global phenomenon (WHO, 2014). The journey toward respectful maternity care began in late 1940s with the Universal Declaration of Human Rights. Since 1950 disrespect and abuse are recognised as a vital issues, but it evolved after human rights organisation evidence on disrespect and abuse in 2007. So the focus shifted from reducing maternal and infant mortality to developing humans right standards on maternal and child mortality and morbidity reduction. In 2010, Bowser & Hill, explored evidence for disrespect and abuse in facility-based childbirth, and summarised the available knowledge and evidence on this topic and described seven major categories for disrespect and abuse including physical abuse, discrimination, non-consented clinical care, non-dignified care, non-confidential care, abandonment of care and detention in health facilities. Over the past decade there has been increased disrespect and abuse during labour and childbirth (Burrowes et al. 2017). The review

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of relevant articles shows that some multifactorial causes including lack of professional work relations, excessive workload, inadequate staff at different levels, and poor infrastructures can contribute to the increased prevalence of disrespect and abuse. Evidences suggest that women may be unwilling to have normal vaginal delivery and also mothers may not seek maternity care if they face disrespect and abuse. The WHO emphasised the important role of RMC in statement entitled "RMC Improves Lactation" and "Recommendations for Improving The Childbirth Experience". Despite the abundance of research on disrespect and abuse prevalence, few studies have investigated effective measures for reducing and preventing the prevalence of disrespect and abuse behaviour during labour and birth. According to the WHO statement on prevalence and elimination of disrespect and abuse during facility-based delivery, "...pregnant women have right to equal in dignity, to be free to seek, receive and impart information, to be free from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health". While disrespect and abuse during delivery does not necessarily mean that respectful care was not provided, it does mean that the fundamental human right of human to receive the highest attainable standard of care was violated. Respectful Maternity care is a rightful expectation of every woman. On the contrary, problems such as disrespect, abuse, ill-treatment, and demand for informal payments, infrastructural issues such as lack of water supply, sanitation, electricity, and crowded rooms are prevalent globally. Another problem highlighted is that women either receive services "too much and too soon or too little and too late." Disrespectful care is therefore a topic of public health concern and has an effect on utilisation of services, affects the progress of the country in terms of healthcare, and affects the mothers physically as well as psychologically.

Objectives

The objectives of the study were to determine women's perception of respectful maternity care (RMC) during facility-based child birth.

Need for the Study

Respectful Maternity Care is a rightful expectation of every woman. On the contrary, problems such as disrespect, abuse, ill-treatment, and demand for informal payments, infrastructural issues such as lack of water supply, sanitation, electricity, and crowded rooms are prevalent globally.

The review of relevant articles shows that some multifactorial causes including lack of professional work relations, excessive workload, inadequate staff at different levels, and poor infrastructures can contribute to the increased prevalence of disrespect and abuse. Hence this study was undertaken.

Review of Literature

Cross sectional survey was conducted on disrespectful and abusive maternity care during childbirth in Bale Zone Public Hospital, Southeast Ethiopia from 1 March to 25 July 2018. Result showed about 124 (60.5%), 32 (28.1%) and 56 (22.8%) women encountered disrespect and abuse at Ginnir, Delomena and Goba Hospital. The incidence of overall status of disrespect and abuse maternity care during childbirth in Bale zone public hospital was at 37.5 percent.

A systematic review and meta- analysis study of respectful maternity care during childbirth in India, July-September 2020 showed that individual study prevalence ranged from 20.9 percent to 100 percent. The overall pooled prevalence of disrespectful maternity care was 71.31 percent. Pooled prevalence in community based studies was 77.32 percent, which was higher as compared to studies conducted in health facilities, this began with 65.38 percent. The highest reported form of ill treatment was non-consent (49.84%), verbal abuse (25.75%) followed by threats (23.25%), physical abuse (16.96%). This condition is correlated with women autonomy, empowerment, co-morbidities, and environmental factors including infrastructural issues, overcrowding, ill equipped health facilities, supply constraints, and health care access.

A qualitative study to assess midwives' and patients' perspectives on disrespect and abuse during labour and delivery care was conducted in Ethiopia in 2017. This study conducted 45 in–depth interviews at four health facilities in Debre Markos, Ethiopia with midwives, midwifery students, and women who had given birth within the past year. Result showed that both health care provider and patients report frequent physical and verbal abuse as well as non-consented care during labour and delivery. Providers reported that most abuse is unintended and results from weaknesses in the health system or from medical necessity. Although health care providers showed good basic knowledge of confidentiality, privacy, and consent, training on the principles of respective and respectful care, and on counselling, is largely absent. Patient responses suggest that women are aware that their rights are being violated and avoid facilities with reputation for poor care.

A systemic review for disrespect and abuse of women during childbirth in Nigeria in 2017. was conducted using the Bowser and Hill landscape analytical framework on disrespect and abuse of women during childbirth. Fourteen studies were included in this review, of these one was a qualitative study and two used a mixed method approach. Result showed that the type of abuse most frequently reported was non-dignified care in form of negative, poor and unfriendly provider attitude and the least frequent were physical abuse and detention in facilities.

A qualitative study was carried out on Midwives' respect and disrespect of women during facility-based childbirth in urban Tanzania in 2018. This descriptive qualitative study involved naturalistic observation of two health facilities in urban Tanzania; 14 midwives were purposively recruited for the one-on-one shadowing of their care of 24 women in labour from admission to the fourth stage of labour. Observations of their midwifery care were analysed using content analysis. Result showed both respectful and disrespectful care and some practices that have not been explicated in previous reports of women's experiences. For respectful care, five categories were identified: (1) positive interactions between midwives and women, (2) respect for women's privacy, (3) provision of safe and timely midwifery care for delivery, (4) active engagement in women's labour process, and (5) encouragement of the mother-baby relationship. For disrespectful care, five categories were recognised: (1) physical abuse, (2) psychological abuse, (3) non-confidential care, (4) non-consented care, and (5) abandonment of care. Two additional categories emerged from the unprioritised and disorganised nursing and midwifery management: lack of accountability and unethical clinical practices.

A cross sectional study was conducted on service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia (Anteneh Asefa et al. Reprod Health, 2018). It was a facility-based study conducted in August 2013 in one hospital and three health centres. A total of 57 health professionals who had assisted childbirth during the study period completed a self-administered questionnaire. Service providers' personal observations of mistreatment during childbirth and their perceptions of RMC were assessed. The majority (83.7%) of participants were aged <30 years. Almost half (43.9%) were midwives and 77.2 percent had less than five years experience as a health professional. Work load was reported to be very high by 31.6 percent of participants, and 28 percent rated their working environment as poor or very poor. Almost half (50.3%) of participants reported that service providers do not generally obtain women's consent prior to procedures. About one-quarter (25.9%) reported having ever witnessed physical abuse (physical force, slapping, or hitting) in their health facility. They also reported observing privacy violations (34.5%), and women being detained against their will (18%). Violations of women's rights were self-reported by 14.5 percent of participants. More than half (57.1%) felt that they had been disrespected and abused in their work place. The majority of participants (79.6%) believed that lack of respectful care discourages pregnant women from coming to health facilities for delivery.

Materials and Methods

A descriptive cross-sectional survey approach was used in this study to determine the perception of post-natal mothers regarding RMC at post-natal ward, New Civil Hospital, Surat. The sample of 100 post-natal mothers admitted in hospital was selected. The sampling technique used in this study was simple random method. Sample size was calculated by using OPEN EPI software (version-3.01) where previous frequency proportion rate was 71 percent and margin of error was 5 percent with 95 percent confidence interval.

A structured five-point rating scale was prepared. Reliability was calculated by Cronbach's alpha. It was 0.8. Content validity of tool was validated by 10 experts from community medicine, OBG experts and nursing experts. Before starting the actual data, pilot study were conducted at OBG OPD. After that formal permission was taken from concerned authorities under intimation to Medical superintendent of Hospital. Surat. An informed consent was taken from all the post-natal mothers before conducting study. The actual data were collected between May 2021 to October 2021 at post-natal mothers of New Civil Hospital. Their perception was assessed regarding RMC through the five-point rating scale.

Results

Table 1: Demographical data of the samples

Sr No.	Variables	Frequency	Percentage
1	Age (year)		
	18-23	37	37
	24-29	47	47
	30-35	16	16
	>35	00	00

Sr No.	Variables	Frequency	Percentage
2	Religion		
	Hindu	**77**	77
	Muslim	21	21
	Christian	02	02
	Other	00	00
3	Education		
	Illiterate	11	11
	1-8 std	41	41
	9-12 std	41	41
	Graduate & above	07	07
4	Occupation		
	Housewife	95	95
	Government	00	00
	employee	05	05
	Private job	00	00
	Other		
5	Community		
	Urban	84	84
	Rural	16	16
6	Family income		
	(Rs. per month)	02	02
	Below 5000	22	22
	5001-10,000	69	69
	10,001-15,000	07	07
	>15,000		
7	Parity		
	Primipara	32	32
	Multipara	68	68
8	Type of family		
	Nuclear family	54	54
	Joint family	46	46
Total		**100**	**100**

The present study revealed that majority of the sample 37 (37%) belonged to age group of 18-23 years; 47 (47%) to age group of 24-29 years, 16 (16%) belonged (Table-1) to age group of 30-35 years, 00 (00%) belonged to age more than 35 years. Majority of samples i..e. 77 (77%) were Hindu, 21 (21%) were Muslim, 2 (2%) belongs to Christian, none (0%) belonged to others. As regards education, 11 (11%) belonged to illiterate group, 41 (41%) belong to standard 1-8, 41 (41%) to standard 9-12, 7 (7%) belonged to Graduate and above group. As regards occupation, 95 (95%) mothers were housewife, none (0%) of mothers fell in Government employee category, 5 (5%) were in private job, 0 (0%) mothers were in other occupation. As regard to community 84 (84%) mothers were from urban community and 16 (16%) from rural community. As for family income, family income of 2 (2%) mothers was less than Rs. 5,000, 22 (22%) had family income between Rs 5,001-10,000, 69 (69%) mothers had family income between Rs 10,001-15,000 and for 7 (7%) mothers, family income was above Rs 15,000. As to the parity, 32 (32%) mothers were primipara and 68 (68%) were multipara. As regard to type of family, 54 (54%) from nuclear family and 46 (46%) mothers were from joint family. Through this study, we came to know that majority of the sample i.e. 98 (98%) have excellent attitude score and 2 (2%) had very good attitude score.

Table 2: Findings related to rating score of samples

Score	Percentage	Grade	Frequency	Percentage
<50	<50	Not experienced RMC	10	10
51-100	51-100	Experienced RMC	90	90

Results

Analysis of rating scale shows the mean score and SD of each dimension as well as the overall dimension of RMC. A majority i.e., 90 percent, of the women stated that they had perceived overall

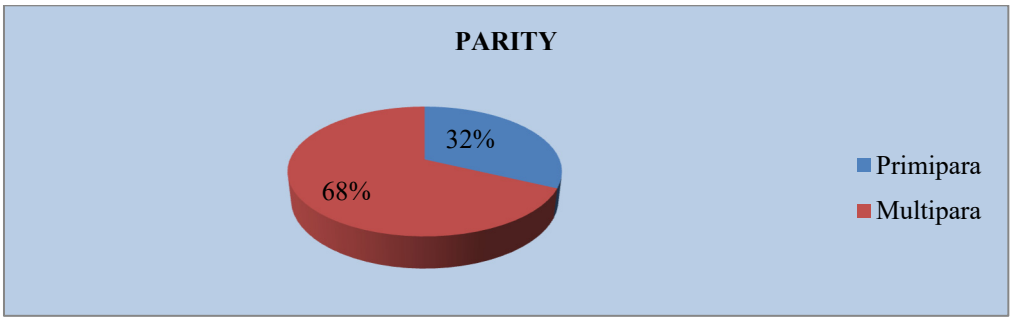

Fig 1: Pie diagram showing percentage distribution of mothers according to PARA.

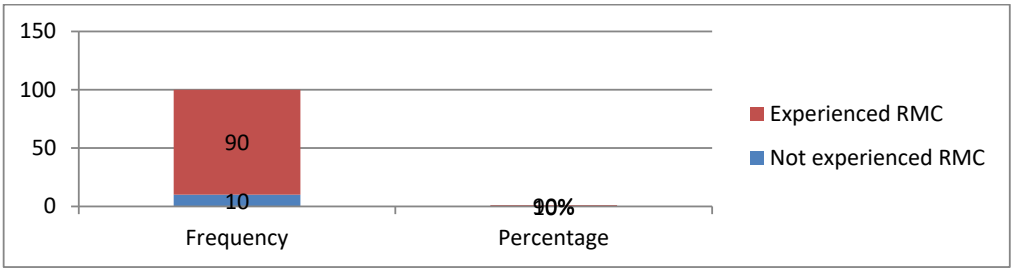

Fig 2: Distribution of post-natal mothers according to experience RMC.

dimensions of RMC with the mean score being 82.83 and standard deviation as 12.83 whereas only 10 percent didn't experienced RMC (Fig 2, Table-2).

Table 3: Findings related to level of perception on overall and six dimension of RMC

Variables	Experienced RMC (%)	Not experienced RMC (%)	Mean	SD
Friendly care	90	10	83	14.41
Abuse-free care	98	02	90	13.68
Timely care	89	11	81.4	16.06
Discrimination free care	100	00	88.3	9.54
Privacy maintained	89	11	81.5	18.28
Care of baby	84	16	73.9	17.51
Overall RMC	90	10	82.83	12.83

Analysis and interpretation of rating scale shows the mean score and SD of each dimension, as well as the overall dimension of RMC. A majority (90%), of the women stated that they had perceived overall dimensions of RMC with the mean score being 82.83 with a standard deviation of 12.83 (Fig 2, Table-3).

Friendly care

Likewise, among the six dimensions of RMC, the average score of 83.00 observed in the friendly care dimension with the SD of 14.41187, where 90 percent of the post-natal mothers claimed having received friendly care.

Abuse-free care

Among the six dimensions of RMC, the highest average score of 90.00 was observed in the abuse-free care dimension with the SD of 13.6782, where 98 percent of the postnatal mothers claimed having received abuse-free care.

Timely care

Among the six dimensions of RMC, the average score of 81.4 was observed in the timely care dimension with the SD of 16.0609, where 89 percent of the post-natal mothers claimed having received timely care.

Discrimination free care

Among the six dimensions of RMC, the average score of 88.3 was observed in the discrimination free care dimension with the SD of 9.54045, where 100 percent of the postnatal mothers claimed having received discrimination free care.

Privacy maintained

Among the six dimensions of RMC, the average score of 81.5 was observed in the privacy maintained dimension with the SD of 18.27815, where 89 percent of the post-natal mothers claimed having received privacy maintained.

Care of baby

Among the six dimensions of RMC, the average score of 82.83 was observed in the care of baby dimension with the SD of 17.5173, where 84 percent of the post-natal mothers claimed being received care of baby.

Discussion

The findings of current study indicated that overall, 90 percent of women received RMC during labour and childbirth at Government hospital whereas one-third of the women received RMC at public health institutions in the West Shewa Zone. These data were impressive although this is higher than the study done in Addis Ababa where 21.4 percent of respondents received respectful and non-abusive care. This variation might be due to the difference in the study setting and study population since Addis Ababa's study was limited only to the town and the mothers who had an elective or emergency cesarean section were excluded. A study done in Bahirdar indicated that; providing a discrimination-free, friendly and abuse-free care to be the commonly practiced category of RMC.

Recommendations

- A similar study can be replicated with larger sample with different demographic characteristics.
- The similar study can be done (a) in different settings, (b) using experimental group and control group, (c) using different modalities.
- The comparative study can be conducted to determine the attitude of (a) different age groups on RMC, (b) urban and rural postnatal mothers.

Nursing Implication

Implications for Nursing Practice

Nurses can play an important role on imparting preventive health care. Health education conducted by the nursing personnel in the hospital setting helps in imparting knowledge regarding RMC. Staff Nurses can also educate the post-natal mothers who visit the outpatient department or inpatient department and also do awareness programmes regarding RMC. This education will help the post-natal mothers to understand in-depth about their fundamental rights.

Implication for Nursing Education

Nursing education should prepare effective future nurses. Active participation of student nurses in conducting educational programmes to provide information regarding importance of RMC during facility-based childbirth. The nursing curriculum focuses more on the preventive aspect, the nurse must therefore, be prepared to identify the areas of knowledge deficit through the assessment of learning needs of post-natal mothers. Health information can be impaired through various methods like lecture, incidental teaching and mass media which would help to gain adequate knowledge. Nurses have to involve themselves in the areas of health practices which help to lead a healthy life.

Implication for Nursing Administration

Nurse administrators are responsible to identify the nature of the problem and organise programmers related to health promotion to the target people. The study assists the nursing administrative authorities to initiate and carry out health education programmes in health care settings. Nurse administrator can also take the initiative in imparting health information through different effective methods. They need to support and encourage the nursing students to participate in health promotion activities. Individual and group teaching can be arranged for post-natal mothers.

Implications for Nursing Research

Nurses being the major focus in the health care delivery system must take the initiative in conducting research on significant health care problem among the vulnerable groups in community, especially post-natal mothers. This research will help to prevent mortality and morbidity due to disrespect and abuse, poor quality of care, undignified care etc. Nurse researcher can conduct studies to determine the effectiveness of education in terms of RMC. Researches can be done on prevention of innovative methods of teaching preparation of effective teaching materials, focusing on interest, quality and cost effectiveness.

Conclusion

The proportion of RMC area was insufficient. There are crucial factors like type of institution, discussion during ANC, time of delivery, duration of stay, involvement in decision-making, the number of health workers, waiting time and consent, identified in the study. So, giving priority to creating awareness of health care providers on the quality care and categories of RMC, improving care provider-mother discussion, observation and responsibilities for health workers to avoid maltreatment during labour and childbirth were recommended; the focus should be on developing RMC quality care.

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