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Original Research Article

Status of respectful maternity care among postnatal women availing delivery services at a tertiary care centre: a cross-sectional study

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ABSTRACT

Background: There are numerous reports of disrespectful, abusive, or neglectful treatment during childbirth from health facilities. Although India has substantially increased the number of hospital deliveries, the quality of intrapartum and immediate postpartum care for delivering mothers has not given much importance. Therefore, assessing mistreatment and quality of care during childbirth is vital for promoting respectful maternity care (RMC). Aim and objectives were to assess the status of RMC in tertiary care centre and to assess and compare various domains of RMC.
Methods: The cross-sectional study was conducted in the division of obstetrics and gynaecology, with 170 patients were enrolled and standard set of validated questionnaires was given to assess the RMC and socio-demographic status with appropriate statistical evaluation
Results: Data was collected using a predesigned and pretested questionnaire based on seven major categories as per the RMC. Results showed that 100% experienced at least one form of disrespect during their labor, childbirth, or postnatal period at the hospital.
Conclusions: The study sheds important light on the current state of RMC wherein mothers are noticing and reporting positive changes in maternity care, RMC still has scope of optimization in certain domains.

Keywords: Respectful maternity care, Postnatal, Child birth

INTRODUCTION

Maternal health encompasses the physical and mental wellbeing of women during pregnancy, childbirth and the postnatal period. Each stage of women should have a positive experience that helps women and their babies to stay healthy and grow well. Every pregnancy and child birth journey is considered unique.

Tackling inequalities, especially those related to sexual and reproductive health rights and gender, is essential to ensure all women have access to respectful and high-quality maternity care.[1,2]

RMC implies provision of private, dignified, and confidential care to pregnant and birthing women, ensuring their right to live free from mistreatment and harm and enabling them to make their choices based on accurate information and also providing continuous support during labour and childbirth.[2-4] Although respectful care is a fundamental goal for health care providers, pregnant and birthing women -particularly in low and middle income countries often face disrespectful and abusive treatment during pregnancy and childbirth.[5,6] While some women may perceive such practices as' normal, while others find them devaluing and dehumanising, leading to a sense of helplessness and a lack of choice.[7,8]

Disrespect and abuse are driven by various sociocultural factors such as age, caste, parity, socioeconomic status, women's autonomy, empowerment and comorbidities as well as environmental challenges like poor infrastructure, overcrowding, under equipped health facilities, limited supplies, and barriers to healthcare access.[9,10] The primary goal of International guidelines recommendations is to ensure that pregnant women have a favourable experience with their healthcare providers, who will treat them with respect and take their cultural background into account.[11,13] The significance of RMC is becoming more acknowledged, especially in contexts with limited resources, but there is little proof that it is being put into practice. Existing studies, often based on in-person observations, reveal suboptimal application of RMC, with instances of inadequate information provision and instances of physical and verbal abuse during labour and delivery.[14,15]

There is a significant necessity of research on RMC and the study was carried out by providing strong evidence in many aspects of RMC for women who seek out healthcare services in hospitals and clinics.

METHODS

The cross-sectional study was carried out in obstetrics and gynecology department at tertiary care hospital at South-Eastern part after obtaining approval from institutional human ethics committee-IEC/2023/09/1980. The study was conducted for a period of two years and 170 patients were enrolled for analysis to ensure power of study. Women aged 18 to 49 years who had a Vaginal delivery at our tertiary care centre within 7 days of delivery were included in the study.

Exclusion criteria

Women with adverse obstetric outcomes such as stillbirth or early neonatal death and those who were mentally unstable were excluded from the study.

Data collection

The participants were informed about the objectives and methods of study and were asked to sign a written informed consent form if they agreed to participate. The study tool consisted of a two-part questionnaire. The first part of the questionnaire gathered information includes information on participants' sociodemographic characteristics including age, residence, religion, marital status, education, occupation, type of family, and socioeconomic status.

The second part consisted of questions based on seven major categories outlined in the RMC charter, which included-physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific attributes, abandonment or denial of care, and detention in a facility.[7]

Statistical analysis

The data was compiled in an excel sheet, and a master chart was prepared. The data were presented as percentages, means, and Standard deviations.

RESULTS

Socio-demographic details

A total number of 170 participants were enrolled in the study. Age distribution of surveyed individuals were 73 (42.9%) in the 18-25 range, 56 (32.9%) in the 26-29 range, and 41 (24.1%) aged over 30.Individuals across religious affiliations, with 8 (4.7%) as Christian, 145 (85.3%) as Hindu, and 17 (10.0%) as Muslim.The frequencies of individuals according to their occupational status, indicating that 161 (94.7%) are housewives, 4 (2.4%) are semiskilled workers, and 5 (2.9%) are skilled workers.The distribution of individuals based on their educational status, revealing that 29 (17.1%) have a diploma, 111 (65.3%) are graduates, and 30 (17.6%) have completed high school. Information on the frequencies of different types of families, with 75 (44.1%) belonging to 3-generation families, 65 (38.2%) to joint families, and 30 (17.6%) to nuclear families. The frequencies of individuals categorized by socioeconomic status, indicated that 1 (0.6%) fall under class 2, 163 (95.9%) fall under class 3, and 6 (3.5%) under class 4. Table 1 presents the detailed sociodemographic profile of the study participants.

Physical abuse

Physical abuse domain, sheds light on various aspects of maternity care experiences. Among the surveyed individuals, 169 (99%) reported receiving physical comfort measures such as elevation of the head-end of the table and provision of pillows. Regarding the denial of fluids during delivery, 116 (68%) experienced no denial, while 54 (32%) females reported denial of fluids. Pain relief medication provision exhibited a stark contrast, with 158 (93%) receiving care and only 12(7%) not receiving it. Physical force or abusive behavior were rarely reported by 4 (2%) of respondents. Importantly, 170 (100%) women reported that health care providers consistently refrained from any inappropriate touching or examination or their babies (Table 2).

Non consented care

Comprehensive overview of experiences within the non-consented care domain during maternity care are (Table 3). When it comes to the introduction of service providers, 105 (62%) reported that providers did introduce themselves. The 86 (51%) females were permitted to have a birth companion of their choice in wards, 152 (89%) females were not allowed to have a birth companion in labor rooms. Regarding the allowance of asking questions, 149 (88%) indicated positive experience. The 165 (97%) reported that questions being answered clearly, politely,

and truthfully. Verbal consent before major procedures was obtained in 168 (99%) of cases. Delivering in a position of their choice was allowed for 163 (96%) participants. The 165 (97%) gave positive feedback that health-care providers explained how to push during contractions as (Table 3).

Non confidential care

In this domain in terms of privacy during examination and delivery, a substantial 94% reported positive experiences, with a mean score of 1.91 (SD 0.4) was noted (Figure 1).

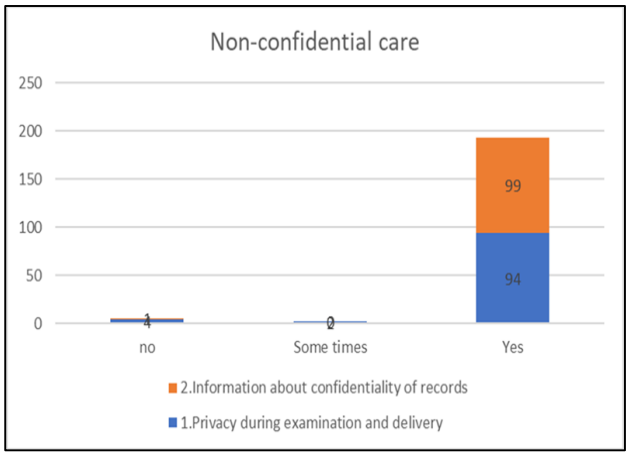

Figure 1: Non-confidential care.

This indicates a prevalent perception of adequate privacy measures during critical stages of maternity care. Furthermore, when it comes to being informed about the confidentiality of records, an overwhelming 99% affirmed receiving such information, resulting in a high mean score of 2.0 (SD 0).

Non dignified care

With respect to non-dignified care domain within maternity services, the majority of respondents, 155 (91%) females, reported being greeted by the staff as shown in Table-4. Instances of staff screaming or shouting were reported by only 7 (4%). Impressively, the labor tables were consistently reported to be cleaned before delivery by 169 (99%) females. Overcrowding in labor rooms and postnatal wards was perceived as low, with 149 (88%) indicating no overcrowding. Concerns about cleanliness in the wards and general environment were reported by 16 (9%), sometimes by 48 (28%), and positively by 106 (62%). With respect to toilet facilities, 61% of the participants reported cleanliness with 1.44 as a mean score (SD 0.77).

Only 14% of participants reported experiencing threats of disastrous consequences for their mother and babies, indicating such incidents were rare. Instances of healthcare providers making fun of patients in their regional languages were minimal, reported by 3% only (Table 4).

Discrimination based on specific attributes domain

Discrimination based on specific attributes domain within maternity care, presents frequencies and mean scores with standard deviations across various attributes. Notably, respondents overwhelmingly reported no discrimination based on religion, caste, socioeconomic status, HIV/HBsAg status, or any form of disability, with 100% indicating "No" for caste and religion, and 99% for socioeconomic class, HIV/HBsAg status, and any form of disability as shown in Figure 2. The mean scores across all attributes were close to zero, emphasizing the absence of perceived discrimination.

Abandonment or denial of care

Abandonment or denial of care domain within maternity services, provides a detailed breakdown of frequencies and mean scores with standard deviations for distinct dimensions. The majority of respondents, 124 (73%), reported being encouraged to call for help if needed, yielding a mean score of 1.59 (SD 0.73). Additionally, 90% indicated that staff promptly responded to their needs when help was required. Notably, 169 (99%) reported receiving periodic updates on the status and progress of their care, reflected in a high mean score of 1.99 (SD 0.08). Instances of being left alone and unattended were reported by only 7 (4%) females.

A high percentage 167 (98%) reported being allowed to remain with their baby at all times. Regarding support for early skin-to-skin contact, 96% reported positive experiences. Explaining treatment after discharge and newborn immunization received positive feedback from 98%, with mean scores of 1.98 (SD 0.19) and 1.99 (SD 0.11), respectively (Table 5).

Detention in the facility

In the context of domain of detention in the facility, all 170 (100%) females responded that they were never unjustly detained in the hospital. However, approximately 9 (5%) women reported instances of demands for informal payments or bribes, making this the lower scoring item in the domain with a mean score of 0.14 (SD 0.47).

Every woman in the study reported encountering at least one instance of disrespect during labor, childbirth, or postnatal period in the hospital. The bar diagram in the below Figure 3 illustrates the mean scores for each domain of RMC. Discrimination based on specific attributes emerged as the lowest scoring domain (0.014), followed by detention in the facility (0.035), physical abuse (0.75) and non-dignified care (1.13). The highest scoring domain was non-confidential care with the highest possible score of 1.95. The domain of abandonment or denial of care and non-consented care required focused improvement efforts, for which the mean score was 1.67 and 1.52 respectively (Table 6).

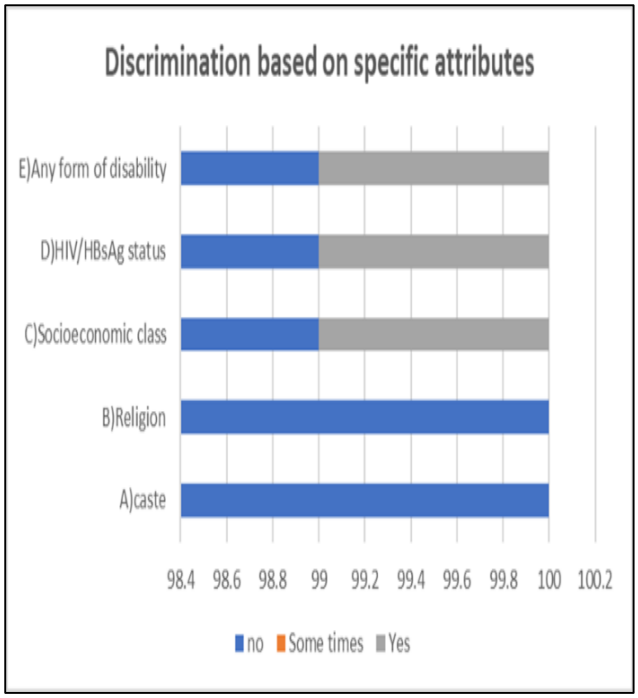

Figure 2: Discrimination based on specific attributes.

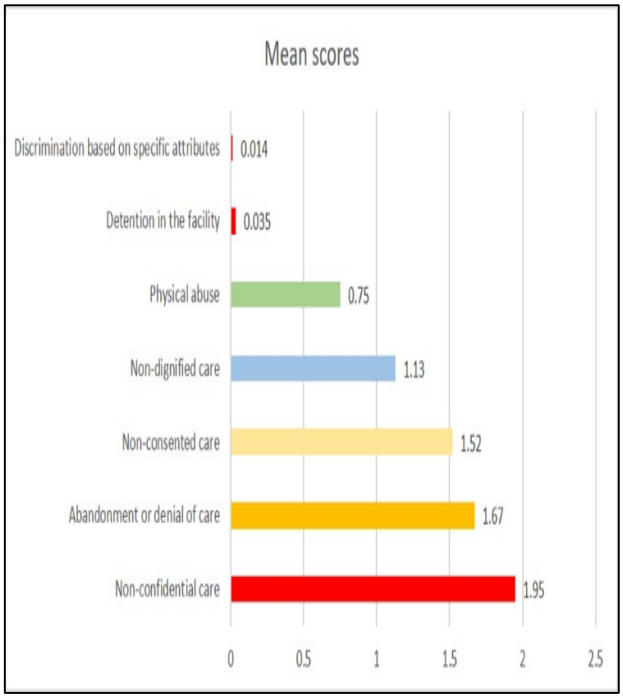

Figure 3: Mean scores of all domains in RMC.

Table 1: Distribution of sociodemographic characteristics.

Variables	Categories	N
Age (in years)	18-25	73 (43%)
	26-29	56 (32.9%)
	>30	41 (24.1%)
Educational status	Graduate/postgraduate	111 (65.3%)
	Diploma	29 (17.1%)
	High-school or below	30 (17.6%)
Occupational status	Skilled	5 (2.9%)
	Semi-skilled	4 (2.4%)
	Homemaker	161 (94.7%)
Type of family	Nuclear	30 (17.6%)
	Joint	65 (38.2%)
	Three generation	75 (44.1%)
Socio economic status	Class I (upper class)	0
	Class II (upper middle class)	1 (0.6%)
	Class III (middle class)	163 (95.9%)
	Class IV (lower middle class)	6 (3.5%)
	Class V (lower class)	0

Table 1: Physical abuse.

Physical abuse	No, N (%)	Yes, N (%)	Mean, (SD)
Was physical comfort (e.g. Raising the head-end of the table giving pillows etc.?) given?	1 (1)	169 (99)	1.99 (0.08)
Was fluid denied to you during delivery?	116 (68)	54 (32)	0.64 (0.93)
Did the care providers give pain relief medication?	12 (7)	158 (93)	1.86 (0.51)
Did they use any physical force or abusive behaviour with you (during the examination delivery stitches)?	166 (98)	4 (2)	0.05 (0.30)
Did the care providers touch /examine you inappropriately or with a lack of care?	170 (100)	0	0
Did the care providers touch /examine your baby inappropriately or with a lack of care?	170 (100)	0	0

Table 3: Non-consented care.

Non-consented care	No, N (%)	Sometimes, N (%)	Yes, N (%)	Mean (SD)
Did the service providers introduce themselves to you?	4 (2)	61 (36)	105 (62)	1.59 (0.54)
Did they allow the birth companion of your choice to accompany you?				
In ward?	78 (46)	6 (4)	86 (51)	1.05 (0.98)
In labor room?	152 (89)	5 (3)	13 (8)	0.18 (0.55)
Did they allow you and your birth companion to ask questions	11 (6)	10 (6)	149 (88)	1.81 (0.53)
Were your questions answered in a clear polite and truthful manner?	1 (1)	4 (2)	165 (97)	1.96 (0.21)
Did the staff take verbal consent before any action or practice like major procedures sampling inserting an IV-line etc?	2 (1)	0	168 (99)	1.98 (0.22)
Did they allow you to deliver in your position of choice?	4 (2)	3 (2)	163 (96)	1.94 (0.33)
Did the health providers explain how to push during a contraction and relax when the contraction disappears?	1 (1)	4 (2)	165 (97)	1.96 (0.21)
Did they separate you from your baby without your consent?	166 (98)	1 (1)	3 (2)	0.04 (0.27)
Did they support you in breastfeeding your baby within the first hour of delivery?	3 (2)	0	167 (98)	1.96 (0.26)
Did they provide you with information about breastfeeding?	0	3 (2)	167 (98)	1.98 (0.13)
Did they provide you with information regarding contraception?	9 (5)	2 (1)	159 (94)	1.88 (0.46)

Table 4: Non-dignified care.

Non-dignified care	No, N (%)	Sometimes, N (%)	Yes, N (%)	Mean (SD)
Did the staff greet you?				1.88 (0.42)
Did the staff scream or shout at you?				1.56 (0.58)
Was the labour table cleaned before your delivery?	6 (4)	9 (5)	155 (91)	1.99 (0.08)
Did you feel the health facility's labour rooms and postnatal wards were overcrowded?	149 (88)	11 (6)	10 (6)	0.18 (0.52)
Did you feel the wards and the general environment of the health facility were clean?	16 (9)	48 (28)	106 (62)	1.53 (0.66)
Were the toilets clean and hygienic with working taps flushes and disposal systems?	29 (17)	37 (22)	104 (61)	1.44 (0.77)
Were you threatened of disastrous consequences for you and your baby if the instructions of the health care providers were not followed?	118 (69)	28 (16)	24 (14)	0.45 (0.73)
Did you ever feel the health care providers were talking in their regional languages and making fun of you?	164 (96)	1 (1)	5 (3)	0.06 (0.35)

Table 5: Abandonment or denial of care.

Abandonment or denial of care	No, N (%)	Sometimes, N (%)	Yes, N (%)	Mean (SD)
Did they encourage you to call for help if you were in need?	24 (14)	22 (13)	124 (73)	1.59 (0.73)
Did the staff quickly respond to your need in case any help was required?	2 (1)	15 (9)	153 (90)	1.89 (0.35)
Did they provide periodic updates on the status and progress	0	1 (1)	169 (99)	1.99 (0.08)
Were you left alone and unattended?	161 (95)	2 (1)	7 (4)	0.09 (0.41)
Did they allow you and your baby to remain together at all time?	2 (1)	1 (1)	167 (98)	1.97 (0.23)
Were you supported in giving early skin-to-skin contact to your baby?	6 (4)	1 (1)	163 (96)	1.92 (0.38)
Was the treatment after discharge explained to you properly?	1 (1)	2 (1)	167 (98)	1.98 (0.19)
Was the immunization of new-born explained to you properly?	0	2 (1)	168 (99)	1.99 (0.11)

Table 6: Detention in the facility

Detention in the facility	No, N (%)	Sometimes, N (%)	Yes, N (%)	Mean (SD)
Detention in the facility	156 (92)	5 (3)	9 (5)	0.14 (0.47)

DISCUSSION

RMC ensures that all individuals received dignified and respectful treatment during childbirth. It emphasizes autonomy, informed choice, non-discrimination, and the provision of a safe, supportive environment.[1] This approach is essential for fostering trust between healthcare providers and patients, enabling individuals to make informed decisions about their healthcare, and advocating for equitable and compassionate maternity services worldwide.[2,3] This study examined the prevalence and the factors influencing compassionate and RMC during facility-based childbirth at the study hospital.

Multiple studies have documented women's feelings of being disrespected by healthcare providers during child birth due to various health care system cadres like town centres vs. rural centres, and health facilities (hospitals vs. health centres) all have varied RMC category predominance.[4-6]

In the present study, women reporting physical abuse has an overall mean of 0.75 which is lower than that observations of Sharma et al.[6] In certain situations, health care workers may feel the need to physically prompt women to bear down believing it is necessary to safeguard the health of both the mother and child.[6,7] Others studies have resorted higher instances of physical or verbal abuse, possibly due to lack of awareness or the perceived normalization of such behavior.[7]

Among the participants, 105 women stated that the healthcare providers introduced themselves, 89 percent said that most women were not permitted to bring birthing companions inside the delivery rooms. The goal was to keep patients safe from needless congestion and infections, which may compromise their treatment. Similar results were reported by Singh et al.[8] Positive delivery outcomes and satisfaction are enhanced when women have birth companions who provide continuous labor assistance.[9,10] Thus an essential aspect of RMC during labor and delivery includes the recommended practice of having a birth companion.

Studies conducted in India have identified non-consented care as one of the most common forms of disrespect experienced during childbirth.[10,11] The vast majority of individuals (99%) in our survey gave their verbal permission. In the study by Sharma et al and other studies, percentage for obtaining verbal consent was comparatively low due to various attritions like overcrowded wards, which made it challenging to obtain consent for minor non-invasive procedures.[6,11]

In the study, many women reported positive interactions with health care providers and felt well informed about their care. This was reported low in Raval et al and other studies. It was clear that there were problems with providers' communication skills and a lack of continuity of care throughout the intrapartum period.[9] When it comes to healthcare facilities, the standard of care for mothers and newborns depends on how well staff communicate with one another.[10-12] Components of excellent care that were highlighted in the World Health Organization's criteria include treating patients with respect and dignity, having competent and motivated personnel, and providing an adequate physical environment.[9,12]

In terms of privacy during examination and delivery, 94% reported positive experiences. Furthermore, when it comes to being informed about the confidentiality of records, an overwhelming 99% affirmed receiving such information Figure 1. Similar findings were reported in Yadav et al study.[7] While the observations of prior studies in DH found low levels of non-confidential care, misconceptions about women, healthcare providers' failure to effectively communicate with patients, excessive workloads, cramped labor rooms and a general lack of medical professionals might all have been contributed to this disparity.[6,9]

In non-dignified care domain, majority of respondents, 155(91%) females, reported being greeted by the staff. Overall, the non-dignified care is found similar to observations by Adugna et al differing with Bluto et al Raval et al reported reduced care compared to this stud with possible factors being large number of patients, insufficient facilities, a lack of qualified workers, or excessive stress at work.[5,9,10] Medical staff's adherence to proper hygiene protocols was also impaired. Just one-fifth of the hospitals really cleaned the labor tables just before giving birth. Threats of disastrous consequences for the mother and baby were rare, reported by 24 (14%). Instances of healthcare providers making fun of patients in their regional languages were minimal, reported by 5 (3%) females.

The majority of respondents in the Discrimination based on Specific Attributes category said that they had never experienced prejudice because of their handicap, socioeconomic background, religion, caste, or HIV/HBsAg status as in Figure 2. This was similar to Sharma et al and Raval et al.[6,9] A few global studies have reported instances of discrimination based on race, ethnicity, and socio-economic class. Mistreatment of women based on ethnicity, place of residence, language or economic status represents a significant barrier in providing RMC.

The majority of respondents, 124 (73%), reported being encouraged to call for help if needed, 90% indicated that staff promptly responded to their needs when help was required and 169 (99%) women reported receiving regular updates on the status and progress of their care. A high percentage 167 (98%) reported being allowed to remain with their baby at all times. Regarding support for early skin-to-skin contact, 96% reported positive experiences. A mean score of 1.67 was recorded for abandonment/denial of care overall. This figure was significantly higher when compared to findings from other studies. Yadav et al, Sharma et al and Raval et al reported poor care and increased prevalence of abandonment/denial of care.[6,7,9] Since it is difficult to maintain the necessary staff-to-patient ratio in a public setting, this might be because the nursing staff is overworked.[13,14] Figure 3 depicts the mean scores of all domains in RMC.

And lastly, in the facility detention domain, one hundred and seventy-five percent of the women said that they had never been unjustifiably held at the hospital. Approximately 5% of the women who participated in our survey said that cleaning personnel had asked for informal payments. A greater percentage of unreasonable requests was found in other research, such as those of Sharma et al and Devi et al.[6,15] Families offer sweets and informal payments of their own will in view celebrating childbirth which is universal in Indian culture.

Critical appraisal

The study being first of its kind conducted in tertiary care centre in the Eastern part, as a benchmark by providing robust evidence across various domains of RMC as experienced by women accessing maternity services in healthcare facilities.

A key strength of the study was that responses were collected within the first seven days of postpartum, which helped minimize recall bias during data collection.

A main limitation of this study was that the hospitalized state of women may have influenced their willingness to provide honest responses regarding mistreatment in the health care setting potentially leading to courtesy bias. The generalizability of the findings may be limited, as the study was hospital-based, conducted in a single institution, and employed a non-random sampling method.

CONCLUSION

The study concludes by providing valuable insights into the current state of RMC wherein the proportion of discrimination-based attributes and detention in the facility were the lowest scoring ones. Mothers are recognizing and reporting positive changes in maternity care practices, the full realization of RMC remains a work in progress.

Greater emphasis must be placed on providing woman-centered care in compassionate and a respectful manner to encourage more women to utilize health facilities and ensure that services are more responsive to their needs and thus the study serves.

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