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A Prospective Study of Patients' Perception Towards Respectful Maternity Care During Pregnancy in a Tertiary Care Hospital

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Keywords:

Compliance, disrespect, equity, maternity care, perception, privacy.

Abstract

Objectives: This study's objectives were to study prevalence of Respectful maternity care and to identify factors associated with provision of Respectful maternity care in a tertiary care setting.

Methods: A prospective study was conducted among 500 post- partum women aged in-between 18- 35 years, undergone normal vaginal delivery. The participants were interviewed by using study proforma regarding maternity services after taking consent.

Results: The maternity care percentage ranged from 45% to 100%. The mean and median percentages were 83.89±8.21 and 85.00%. Majority of the women (78%) received excellent care followed by good (21.60%) very few women reported fair care (0.40%). Socio cultural, economic, geographical, and infrastructural factors were found to have least or no significance in our current study.

Conclusion: This study provides valuable insight into the current perceptions and practices by health care personnel from rural health care facilities. Fair compliance with respect to engaging with effective communication was found to be followed fairly.

1. Introduction

The remarkable progress in the field of maternal health care services in recent decades has resulted in a decline in maternal and neonatal morbidity and mortality rates worldwide. However, many women across the world still experience disrespectful, abusive or neglectful treatment in health institutions during childbirth [1-3].

Respectful maternity care (RMC) refers to type of care that should be provided to all pregnant women in such a way that it should maintain her Dignity, Privacy, Confidentiality and ensures freedom from any type of harm and mistreatment and enables her participation in making decisions regarding her delivery and continuous support during labour and childbirth [1,4]. The emphasis on quality of care began in late 90's and underwent different modifications such as, 1) Quality care 2) Humanised care 3) Rights based care 4) Family centred care 5) Patient centred care 6) Women centred care 7) Respectful care [1,4]. Due to the importance of respectful maternal care as part of Quality maternity services it is important to study the prevalence of respectful maternal care and identify areas of improvement.

Due to the importance of respectful maternal care as part of Quality maternity services it is important to study the prevalence of respectful maternal care and identify areas of improvement. Increasing the proportion of women delivering in a health facility is challenging, as it requires comprehensive efforts to overcome sociocultural, economic, geographical, and infrastructural obstacles to reaching facility-based care [5,7]. Also, no such studies have been reported regarding the RMC in study area. Therefore, the present study was planned to determine the provision

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of Respectful maternity care in this hospital setting from rural area.

2. Materials and Methods

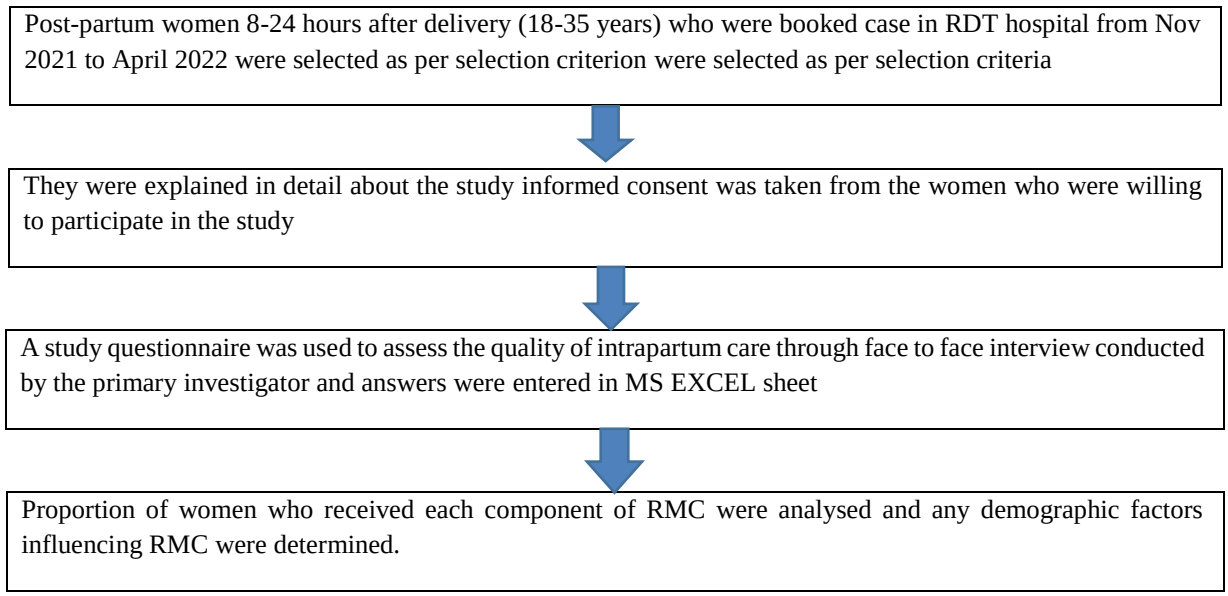
Study Design: This study is a prospective study conducted for the period of 6 months from November 2021 to April 2022, in the Department of Obstetrics and Gynecology, Rural Development Trust Hospital, Bathalapalli, Anantapuramu, Andhra Pradesh India. The Center has 322 beds with an average of 150 pregnant patients a day.

Study Subjects: A total of 500 pregnant women aged between18 to 35 years, who have undergone normal vaginal delivery Department of Obstetrics and Gynecology, Rural Development Trust Hospital, Bathalapalli, Anantapuramu, Andhra Pradesh India.

Exclusion criteria were women with serious intrapartum or postpartum complications or who have given birth to babies with congenital anomalies in the current pregnancy or have been admitted for intensive care, any serious medical conditions including cancer and women on medication or treatment for any type of psychiatric illness.

Intervention: Primary investigator of the study interviewed the women using the study proforma, translated into the local language, in a face -to- face interview regarding RMC.

Data collection: The selected women, who had given their consent, were interviewed and general information including age, pregnancy details, was obtained. Further, all the women were interview by primary investigator so as to obtain the response on RMC based on WHO recommendations during intrapartum period for a positive childbirth experience [4], the PCMC (Patient centered maternity care) questionnaire and the observation tool and community survey tool of the STAHA project [8]. Data was collected by the primary investigator using the study proforma, translated into the local language, in a face -to- face interview. All the responses were noted on a predesigned proforma.



Sample size: The sample size was calculated according to proportion of women who reported proper consent for procedures including PV examination and episiotomy that is, 66%, in hospital-based studies from India according to a systematic review[6] and using the following formula;

$n=Z^2*P*Q/d^2$

Where, n= sample size, Z^2 =Constant at 95% Confidence interval that is, 1.96, P=Proportion of women who reported proper consent for procedures including PV examination and episiotomy that is, 66%, as reported in a hospital-based study from India by

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Shakibazadeh E. et al.[9] (2018), d^2=Standard error or absolute precision that is 5% at 95% CI,

Q= constant that is, 100-p = 100-66 = 44

Therefore, n= 1.96^2*66*44/5^2= 227.67 ≈ 228

Considering the above values, the minimum sample required to determine the desired objective was 228. However, based on a constant flow of around 400 deliveries per month and the exclusion criterion, the sample size was increased to 500 cases.

Outcome parameters: For the modified questionnaire on RMC, 11 questions from the PCMC questionnaire, five questions from the dignity and respect subscale, four from the communication and autonomy subscale and two from supportive care subscale were chosen. Apart from these, one question on non-discrimination and equitable care and nine questions on Quality of care based on WHO recommendations for positive pregnancy experience and Staha questionnaire were included as below.

Domains involved in the modified RMC questionnaire:

1. Being free from harm and mistreatment
2. Maintaining privacy and confidentiality
3. Preserving women's dignity and respect
4. Prospective provision of information and seeking informed consent
5. Ensuring continuous access to family and community support
6. Providing equitable maternity care
7. Engaging with effective communication
8. Provision of efficient and effective care

Data evaluation: The data obtained was coded and entered into Microsoft Excel spread sheet and master chart was prepared. The data was analyzed using SPSS statistical software version 20.0. Categorical data was expressed in terms of rates, ratios and percentages. Continuous data was expressed as mean ± standard deviation (SD). The comparison of categorical data was done using chi-square test or Fisher's exact test. All tests were two-tailed and at 95% confidence interval (CI), a probability value ('p' value) of less than or equal to 0.050 was considered to be statistically significant.

Ethical clearance

Prior to the commencement, the study was approved by the Ethical and Research Committee, Rural Development Trust Hospital, Bathalapalli, Anantapuramu, Andhra Pradesh India. Patients' privacy and confidentiality was preserved in compliance with data protection laws.

3. Results

The present hospital based prospective study included a total of 500 pregnant women aged between 18 to 35 years delivered vaginally during the study period who fulfilled the selection criteria were enrolled.

Table 1 provides the information about distribution of women according to maternity care services received in the setting. About 78% of the sample population received excellent services in the setting.

Table 2 depicts that in this study 100% correct response was noted for the question *"did you feel you were treated unequally by the health care provider because of poverty or your religion or age or marital status"* and maximum negative responses (40.40%) were noted for question *"did you feel like the doctors, nurses or other staff at the facility asked about your decision about your care".*

Table 3 shows that 47.80% of the women were aged from 21 to 25 years followed by 26 to 30 (29%), 18 to 20 (17.80%) and 31 to 35 years (5.40%). However, no association was found between RMC with age of the women (p=0.721).

Table 4 shows that 50.20% of the women had multi para followed by 48.40% with primi para and 1.40% with grand multi para. However, no association was found between RMC with parity of the women (p=0.521).

Table 5 gives overall view of distribution of women according to episiotomy and its association with RMC services provided in hospital setting and was found independent of that factor.

Table 6 depicts that in this study 76.80% of the women had episiotomy. Among them, 78.39% women responded excellent RMC and 23.28% with good RMC. However, no association was found between RMC with episiotomy (p=0.823).

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In table 7, it was observed that the duration for initiation of breast feeding was less than or equal to one hour in 65.60%. Among them, 80.18% women responded excellent RMC, 19.51% with good RMC and 0.30% with fair RMC. However, no association was found between duration for initiation of breast feeding and RMC (p=0.227).

Table 1. Distribution of women according to RMC*

RMC score	Distribution (n=500)	
	Number	Percentage
Excellent (>75)	390	78.00
Good (50 to 74)	108	21.60
Fair (<50)	2	0.40
Total	**500**	**100.00**

***indicates Respectful maternity care

Table 2. Distribution of women according to the domain wise responses

Domain	Question No.	Response (n-500)			
		Fair		Poor	
		No.	%	No.	%
Being free from harm and mistreatment	10	486	97.20	14	2.80
	11	476	95.20	24	4.80
	15	468	93.60	32	6.40
	18	376	75.20	124	24.80
	16	464	92.80	36	7.20
Maintaining privacy and confidentiality	1	496	99.20	4	0.80
	2	463	92.60	37	7.40
Preserving women's dignity and respect	9	481	96.20	19	3.80
Prospective provision of information and seeking informed consent	5	379	75.80	121	24.20
	6	376	75.20	124	24.80
	7	433	86.60	67	13.40
Ensuring continuous access to family and community support	13	398	79.60	102	20.40
	14	461	92.20	39	7.80

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Providing equitable maternity care	8	500	100.00	0	0.00
Engaging with effective communication	3	435	87.00	65	13.00
	4	299	59.80	202	40.40
Provision of efficient and effective care	12	418	83.60	82	16.40
	17	491	98.20	9	1.80
	19	460	92.00	40	8.00
	20	421	84.20	79	15.80

Table 3. Distribution of women according to age and its association with RMC*

Age group (Years)	**RMC***						**Total**		**p value**
	Excellent		**Good**		**Fair**				
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
18 to 20	69	77.53	20	22.47	0	0.00	89	17.80	
21 to 25	192	80.33	46	19.25	1	0.42	239	47.80	
26 to 30	107	73.79	37	25.52	1	0.69	145	29.00	**0.721**
31 to 35	22	81.48	5	18.52	0	0.00	27	5.40	
Total	**390**	**78.00**	**108**	**21.60**	**2**	**0.40**	**500**	**100.00**	

***indicates Respectful maternity care**

Table 4. Distribution of women according to parity and its association with RMC

Parity	**RMC***						**Total**		**p value**
	Excellent		**Good**		**Fair**				
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Primi	191	78.93	1	0.41	50	20.66	242	48.40	
Multi	195	77.69	1	0.40	55	21.91	251	50.20	
Grand Multi	4	57.14	0	0.00	3	42.86	7	1.40	**0.521**
Total	**390**	**78.00**	**2**	**0.40**	**108**	**21.60**	**500**	**100.00**	

***indicates Respectful maternity care**

Table 5. Distribution of women according to episiotomy and its association with RMC*

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Episiotomy	RMC*						Total		p value
	Excellent		Good		Fair				
	No.	%	No.	%	No.	%	No.	%	
Yes	301	78.39	81	21.09	2	0.52	384	76.80	
No	89	76.72	27	23.28	0	0.00	116	23.20	**0.823**
Total	**390**	**78.00**	**108**	**21.60**	**2**	**0.40**	**500**	**100.00**	

Table 6. Distribution of women according to the initiation of breast feeding and its association with RMC*

Initiation of breast feeding	RMC*						Total		p value
	Excellent		Good		Fair				
	No.	%	No.	%	No.	%	No.	%	
>1	127	73.84	44	25.58	1	0.58	172	34.40	
≤1	263	80.18	64	19.51	1	0.30	328	65.60	**0.227**
Total	**390**	**78.00**	**108**	**21.60**	**2**	**0.40**	**500**	**100.00**	

***indicates Respectful maternity care

4. Discussion:

Pregnancy and childbirth are momentous events in the lives of women and families which represent a time of intense vulnerability. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care [12]. However, limited studies are reported on the extent of respectful maternity care during labor and delivery in India and rural set ups in particular. Hence in this study was made to determine the provision of RMC in the study area.

In our current study, socio cultural, economic, geographical, and infrastructural factors were found to have least or no significance. Based on the responses to the questionnaire majority of the women (78%) received excellent RMC followed by good (21.60%) very few women reported fair RMC (0.40%). Further, 100% RMC compliance was noted with respect to the question *"did you feel you were treated unequally by the health care provider because of poverty or your religion or age or marital status"* which is the sole criterion for providing equitable maternity care.

In the present study maximum negative responses (40.40%) were noted for question *"did you feel like the doctors, nurses or other staff at the facility asked about your decision about your care"* according to the questionnaire in proforma which is the component of engaging with effective communication. this component needs to be strengthened in the study setting through stepping up the quality of health care facilities through adequate staff, advanced diagnostic and prognostic approach and strengthening by eliminating the inappropriate practices through improving IEC activities.

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In the present study 47.80% of the women were aged from 21 to 25 years followed by 26 to 30 (29%), 18 to 20 (17.80%) and 31 to 35 years (5.40%). However, no association was found between RMC with age of the women (p=0.721). The mean age noted in the present study sharply corroborates with the results of a recent study by Raval H. et al. [10] in 2021, who reported mean age of the women as 25.41±1.87 years.

In this study slightly more than half of the women (50.20%) reported multi parity followed by 48.40% with primi para and very few women (1.40%) belonged to grand multi para. Further, parity of the women was not associated with RMC (p=0.521). These observations hypothesize that majority of the women in the present study already childbearing experience and RMC was independent of parity. A similar study by Rajkumari R. et al. [11] in 2021, reported maximum women with multipara (51.1%) which sharply corroborates with the present study.

More recently a study by Sharma SK et al. [1] in 2022, found that, more than half of the respondents reported that privacy was never maintained during medical examination and delivery and attributed this to infrastructural constraints and scarcity of resources in a public health setup make it difficult to maintain adequate privacy. Manu A et al. [13] in 2021 and Sethi R et al. [14] in 2017 reported that privacy was not ensured for women during delivery.

In this study majority of the women (76.80%) underwent episiotomy. The rate of RMC compliance among the majority of the women who underwent episiotomy was excellent (78.39%) followed by good compliance (23.28%) and only a few women (0.52%) had fair compliance of RMC. These observations suggest that, the rate of episiotomy was high in the study area but episiotomy a procedure associated with pain and complications has no influence on RMC.

In the present study an important part of the motherhood and newborn health that is, the duration for initiation of breast feeding was less than or equal to one hour in majority of the women (65.60%). These observations suggest that the initiation of breast feeding within one hour after delivery is practiced adequately in the hospital setting.

In the present study an important part of the motherhood and newborn health that is, the duration for initiation of breast feeding was less than or equal to one hour in majority of the women (65.60%). These observations suggest that the initiation of breast feeding within one hour after delivery an important part of promoting mother and child health is practiced adequately in the hospital setting and RMC was not influenced by this practice.

5. Conclusion

Overall, the findings of this study provide valuable insight into the current perceptions and practices by health care personnel from rural health care facilities. The present study showed excellent RMC practices in rural hospital set up among the women who underwent normal vaginal delivery. These RMC practice parameters adopted in the hospital settings were independent of age, parity, sex of the newborn, episiotomy and initiation of breast feeding. An essential strength of this study is that the postpartum mothers were interviewed within the first three to five days post-delivery. This time frame significantly reduces the recall bias.

This study had several limitations also. The findings in this study were based on the data having a relatively smaller sample size from a single center of rural area. Another important limitation of the study was sociodemographic determinant like religion, socioeconomic status, and educational status, type of family and family members was not taken into account which was beyond the scope of this study.

Further, multicentric studies involving a large sample size including caesarean section deliveries and other sociodemographic determinant like religion, socioeconomic status, and educational status, type of family and family members may help the policy makers in implementing and promoting RMC concept.

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