

Direct Observation on Respectful Maternity Care in India: A Cross Sectional Study on Health Professionals of three different Health Facilities in New Delhi

Aastha Singh¹, Prof (Dr.) Manju Chhugani², Merlin Mary James³

Abstract: ***Background:** Poor quality of care at health facilities is a barrier to pregnant women and their families accessing skilled care. Increasing evidence of disrespect and abuse to women during institutional childbirth services is one of the deterrents to utilization of maternity care services in India. However little is known about how frequently women experience these behaviors. This study is one of the first to report the prevalence of respectful maternity care and disrespectful and abusive behavior at facilities by health professionals in selected Hospital of New Delhi. **Method:** A quantitative non experimental research, using descriptive survey research design was used. Data was collected from sixty three health professionals from three different health facilities of New Delhi from the month of October –November. Observational checklist was used based on RMC charter to collect the data clinical profile of postnatal mothers and the practices adopted by health professionals to the woman in labor and during delivery. **Result:** In the present study findings showed that the practices adopted by Health Professionals with regard to Respectful Maternity Care We find that mistreatment of patients during labor and delivery(98%) – particularly verbal abuse(93%) – is relatively common and that this abuse has the potential to reduce patient demand for services. My findings are largely consistent with those from recent international studies of patient mistreatment in maternity services both in terms of the extent of abuse they describe and the triggers for abuse they identify. There is an observed discordance between patients and providers in types of abuse most frequently mentioned. The present findings where (100%)no women was greeted by the health professionals, not encouraged to ask questions by health providers was (93%) and no privacy or support during labor scored (100%) and(76%) respectively. According to standards mentioned in my study Standard VI – Left without care ranked I in terms of not providing respectful maternity care or mistreatment, Standard II ranked II, in which right to information was not given, informed consent was not taken and preferred choice was not considered, then Standard VII – Detained or confined against will ranked III, Standard III – Confidentiality and Privacy ranked IV, Standard I – Physical harm or ill treatment ranked V, Standard IV – Dignity and Respect, ranked VI and Standard V Provision of Equitable Care, Free of discrimination ranked VII respectively. **Conclusion:** Efforts to use facility based maternity care for low socio-economic woman are unlikely to achieve the desired gains if there is no improvement in quality of care provided by health professionals especially for different elements of respectful maternity care. On the basis of the findings of the study*

Keywords: Respectful maternity care(RMC) , Health Professionals

1. Introduction

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability. The concept of “safe motherhood” is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care. 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. A woman’s relationship with maternity care providers and the maternity care system during pregnancy and childbirth is vitally important. Not only are these encounters the vehicle for essential and potentially lifesaving health services, women’s experiences with caregivers at this time have the impact to empower and comfort or to inflict lasting damage and emotional trauma, adding to or detracting from women’s confidence and self-esteem. Either way, women’s memories of their childbearing experiences stay with them for a

lifetime and are often shared with other women, contributing to a climate of confidence or doubt around childbearing.¹

Even when services are available, care may be compromised by social, ethnic and cultural barriers, an unwelcoming reception at the healthcare facility, lack of privacy and information for the client, and disrespect and abuse. Bowser and Hill’s landmark review of evidence for disrespect and abuse in facility-based childbirth identified numerous examples, including physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care, and detention in facilities.²

In recent years, a movement has been advancing to promote the implementation of more respectful maternity care. In recent years, many examples have been found globally of mistreatment of women at health facilities during childbirth, which likely discourages them from using health services. The WHO recently published quality of care standards, defining the needs of mothers and newborns in reproductive care, including both clinical and experiential factors.³

Mistreatment of women during labor and delivery is a global challenge, because it negatively influences women’s decisions to seek future obstetric care at health facilities and violates women’s rights despite nearly two decades of

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growing concern about poor provider attitudes and women experiencing mistreatment in health facilities few maternal health service interventions have a central objective focusing on these issues.⁴ In 2010, the United States Agency for International Development (USAID)-funded Traction Project commissioned a landscape analysis, on disrespect and abuse during facility based childbirth. This review by Bowser and Hill provided the platform for addressing disrespect and abuse globally. At around the same time, the White Ribbon Alliance (WRA)– also supported by USAID – convened an advocacy group of policy makers, advocates, programmers, and researchers (the Respectful Maternity Care Advisory Council) which developed the Universal Rights of Childbearing Women⁵. The Advisory Council designated the term ‘Respectful Maternity Care’ (RMC) to promote interventions that mitigate the factors and effects of disrespect and abuse⁵. The seven articles of the Charter are closely aligned to the seven domains of D&A (see ‘Seven rights’) While these approaches are similar, the Charter frames. the discussion in terms of Positive, desired behaviors.⁶ The concept of respectful maternity care (RMC) acknowledges that women’s experiences of childbirth are vital components of health care quality and that their “autonomy, dignity, feelings, choices, and preferences must be respected RMC has commonalities with other efforts to refocus medical care away from a disease-oriented model which privileges the physician as expert including patient-centered care and the humanization of childbirth].Seven rights of childbearing women from Respectful Maternity Care Charter

Article 1. Every woman has the right to be free from harm and ill treatment.

Article 2. Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care.

Article 3. Every woman has the right to privacy and confidentiality.

Article 4. Every woman has the right to be treated with dignity and respect.

Article 5. Every woman has the right to equality, freedom from discrimination, and equitable care.

Article 6. Every woman has the right to healthcare and to the highest attainable level of health.

Article 7. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion⁶.

2. Materials and Methods

The research design selected for this study is Descriptive Survey Research Design to accomplish the objectives of the

study. The setting for the present study was labor rooms of selected hospitals of New Delhi. After prior permission from the concerned authority. The samples for the present study was comprising of Health Professionals working in labor room of selected Hospitals of New Delhi, during providing care to the woman in labor or during delivery . The sample size was 63 Health Professionals in 3 different Settings.63 Health Professionals were selected by using Purposive sampling technique out of the total population and then was allocated. Since the study aim is to observe the practices adopted by health professionals in regard to Respectful Maternity Care. So an observational checklist based on RMC charter was used to collect the data for the study. The observational checklist based on the Respectful Maternity Charter contains 7 performance Standards and each Performance standard comprises of certain sub items to observe during the care provided to the woman in labor room and during delivery.

Table 1: Blueprint of RMC Charter

7 performance standards of Respectful Maternity Care	Sub Items in each performance standard
1) Physical harm and ill treatment	11
2) Right to information, informed consent and preferred choice	11
3) Confidentiality and privacy	7
4) Dignity and respect	9
5) Provision of equitable care, free of discrimination	5
6) Left without care	5
7) Detained or confined against will	4
	Total= 52

Trained assessor were clinician (bachelor and master degree level midwives and health officers) . Data were collected in October and November 2017. Assessor observed midwives, nursing officers and doctors who were providing labor and delivery services during day and night. The observation of women started in the second stage of labor and was continued to two hours post-delivery. To ensure data quality, the study coordinator oversaw the data collection process, eachday; supervisors checked the completeness of observational data collected.

3. Results

The unit of analysis was an observation which represents the practices adopted by the health professionals in care of women during labor. Frequency and percentage of occurrence of each items and checklist was expressed. The highest and lowest percentage of 7 determinants was presented.

Table 2: Frequency and Percentage Distribution of Respectful Maternity Care Performance Standards of Health Professionals working in 3 Hospitals, N=3

<i>Performance Standards</i>	<i>Frequency of yes score</i>	<i>Frequency of no score</i>	<i>Percentage</i>
STANDARD I: Physical harm and ill treatment			
1) Used any physical force or abrasive behaviour with women, including slapping or hitting or any gesture towards slapping or hitting	59	4	93
2) Touched /examined inappropriately or with lack of caring	56	7	88
3) Women restricted to lying down (lithotomy or dorsal) position during delivery	63	0	100
4) Fluid denied to the women during delivery	49	14	77
5) Physical comfort not provided (e.g. Raising head end of table, giving pillow, mattress, back	53	10	84

massage or verbal comfort			
6) Verbal information given by health professional while performing episiotomy to the women	0	0	0
7) Pain- relief medication (e.g. local anaesthesia during episiotomy and while suturing the episiotomy) not given	31.5	31.5	50
8) Use of unsterile /unclean drapes/mackintosh/linen on labour table during delivery or shifting	6	57	9
9) Improper hand washing by health professionals during care or delivery or touching the unsterile field after wearing sterile gloves	27	36	42
10) Using unsterile or rusted articles in patient care	15	48	23
11) Nursing officers refuses to remove drip because a women is complaining too much.	0	0	0
Standard II: Right to information, informed consent and preferred choice			
1) Provider does not introduce self to the women or to her birth companion	63	0	100
2) Birth companion not allowed to remain with women during labor	63	0	100
3) Women and her birth companions were not allowed to ask questions	63	0	100
4) Questions were not responded in clear polite and truthful manner (e.g. after checking fetal heart or NST	59	4	93
5) Woman is not allowed to walk around during her labor nor allowed to deliver in position of choice	54	8	85
6) Explanation not provided to the women in labor on how to push during contraction and relax when contraction disappears.	48	15	76
7) Information not given in the sex of the baby and delayed till the expulsion of placenta (scolded when asked about sex of the baby	19	44	3
8) No information or verbal consent taken while performing following interventions (episiotomy, forceps, ventouse etc.)	60	3	95
9) Adequate counseling not given regarding PPIUCD insertion	62	1	98
10) No information given regarding money expenditure if any complication occurs	63	0	100
11) No information given regarding New born Vaccination to the mother or family member	63	0	100
Standard III: Confidentiality and privacy			
1) Students allowed observing delivery and examining /assisting without informing women or taking her verbal consent.	45	18	71
2) While doing examination no privacy is provided (sending out the male companion, no female provider along the side of women if male doctor is examining the patient	63	0	100
3) No screens or curtains provided during examination	62	1	98
4) Inappropriate exposure of unwanted parts during examination	0	0	0
5) Clients records are left over in an area where they can be read by others not involved in care	12	51	19
6) Discussing about the patient with compromised condition (HIV, HbsAG, or any psychiatric disorders) with the person not involved in patient care	0	0	0
7) Any other specific.	0	0	0
Standard IV: Dignity and respect			
1) Greet the patient	0	0	63
2) Staff speaks impolitely to woman and companion	57	90	6
3) Woman or her companion not permitted to do any cultural practices or superstitious belief which are not harmful for mother or baby(e.g. prayer)	63	100	0
4) Unclean linen provided or staff asked the women to lie down on the floor (e.g. mackintosh, pillow, drawsheet, gown)	9	14	54
5) Provider threatens or presents disastrous consequences for women or her baby if their instructions are not followed (e.g. if she does not bear down her baby's head will stuck baby will be a still born)	48	76	15
6) Toilets are unhygienic, or there is mechanical failure of taps, flushes and disposal system	21	33	42
7) Woman labour table are not cleaned after every delivery or not even giving then fresh gown after delivery	31.5	50	31.5
8) Unpredictable and Unwanted financial demands (e.g. being forced to wait longer while those with more money are seen first	0	0	63
9) Talking in their regional language and making fun of the patient unwanted condition.	2	3	61
Standard V: Provision of equitable care, free of discrimination			
1) Unequal treatment -verbal and physical disrespect of woman based on any specific attributes(e.g. disability, caste, religion, presence of too many relatives , grand multipara, unwed mother, wearing dirty clothes, uneducated, unhooked case, referred case, does not have any money for medicine, forced to make out pocket expenditure	8	12	55
2) Provides refusal to wake up for night delivery or care for woman	0	0	0
3) Provider demonstrated favoritism (towards those who are not connected or known)	0	0	0
4) Neglects the care for the patient who were not present on their bed according to providers convenience	11	17	52
5) Any Other Specific	0	0	0
Standard VI: Left without care			
1) Essential care (periodic examination of vitals, etc) not provided to the women	63	100	0
2) Women discouraged to call if needed	60	95	03
3) Left alone and unattended	13	2	50

4) Provider had no time to explain concern or treatment after discharge	63	100	0
5) Woman felt ignored post-delivery (no counseling for breast feeding , perianal care and postures to be maintained).	63	100	0
Standard VII: Detained or confined against will			
1) Women detained against their will	0	0	63
2) The facility has a policy of not providing care, medicine or investigations for women who do not pay	0	0	63
3) Demands made for informal payments /bakshish /bribe	63	100	0
4) Any other specific	0	0	0

The data presented in Table 2, depicts the frequency and percentage distribution of Respectful Maternity Care Performance Standards.

Table 3: Respectful Maternity Care Performance Standards of Health Professionals working in 3 Hospitals by the Number of Times Observed, N=3

Performance Standards	Hospital A	Hospital B	Hospital C	TOTAL
I. Physical harm or ill treatment	424	247	134	805
II. Right to information, informed consent and preferred choice	180	192	151	523
III. Confidentiality and privacy	211	103	18	332
IV. Dignity and respect	195	138	81	414
V. Provision of equitable care, free of discrimination	14	08	0	22
VI. Left without care	140	159	98	397
VII. Detained or confined against will	53	48	34	135

The data presented in Table 3, shows the RMC performance standards of health professionals during labor and delivery in 3 hospitals by the number times it was observed. Standard I – Physical Harm or ill treatment was observed the maximum times, followed by Standard II and Standard V was observed the least number of times.

Section I: Findings related to background data of hospitals

The data presented highlights the background data of the 3 hospitals. With respect to hospital A, the total number of labor tables were 4, the total number of deliveries observed during the period of data collection were 40, the total number of health professionals were 21 and the number of days observed were 8. In hospital B, the total number of labor tables were 4, the total number of deliveries observed during the period of data collection were 56, the total number of health professionals were 24 and the number of days observed were 8. And, in hospital C, the total number of labor tables were 2, the total number of deliveries observed during the period of data collection were 33, the total number of health professionals were 18 and the number of days observed were 8.

Section II: Findings related Practices adopted by Health Professionals with regard to Respectful Maternity Care (RMC)

Part1: Findings related to the Respectful Maternity Care (RMC) Performance Standards of health professionals during labor and delivery in 3 hospitals.

The data presented, shows the mean, modified mean and rank order of respectful maternity care performance standards of health professionals in 3 hospitals during labor and delivery. The modified mean was ranked in descending order, which means higher the mean, lesser is the care given with respect by health professionals.

Standard VI – Left without care ranked I in terms of not providing respectful maternity care or mistreatment, Standard II ranked II, in which right to information was not

given, informed consent was not taken and preferred choice was not considered, then Standard VII – Detained or confined against will ranked III, Standard III – Confidentiality and Privacy ranked IV, Standard I – Physical harm or ill treatment ranked V, Standard IV – Dignity and Respect, ranked VI and Standard V – Provision of Equitable Care, Free of discrimination ranked VII. The data presented in, shows the RMC performance standards of health professionals during labor and delivery in 3 hospitals by the number times it was observed. Standard I – Physical Harm or ill treatment was observed the maximum times, followed by Standard II and Standard V was observed the least number of times.

Part 2: Findings related to the Respectful Maternity Care in 3 Hospitals.

The data presented in, shows the range of obtained scores, mean and standard deviation of the scores of 3 hospitals with regard to respectful maternity care. Hospital A had a mean score of 29.62, followed by Hospital B with a mean score of 27.13 and Hospital C with a mean score of 24.55.

Section III: Findings related to the relationship between the scores of Respectful Maternity Care and number of health professionals in 3 hospitals.

The data presented in table 7 shows that by using fisher’s exact test, the calculated p value was 0.000001 was lower than 0.05. Hence we reject the null hypothesis (H_{01} : There is no significant relationship between the scores of respectful maternity care and the number of health professional) and accept the research hypothesis. This indicates that there was a significant relationship score of Respectful Maternity Care with the number of health professionals.

Ethics

The study protocol was reviewed and approved by the Review Board of JamiaHamdard, New Delhi to conduct the research study. Permission was sought from the concerned authorities of selected Hospitals, New Delhi to conduct the research study. Anonymity and confidentiality of the subjects were maintained while carrying out the study.

4. Discussion

This study examines the experiences of disrespect and abuse in maternal care from the perspective of providers and patients. We find that mistreatment of patients during labor and delivery – particularly verbal abuse – is relatively common and that this abuse has the potential to reduce patient demand for services. My findings are largely consistent with those from recent international studies of patient mistreatment in maternity services both in terms of the extent of abuse they describe and the triggers for abuse they identify.

A study was conducted in East and South Africa by Heather E. Rosen¹*, Pamela F. Lynam², Catherine Carr The findings revealed a total of 2164 labor and delivery observations were conducted at hospitals and health centers. Encouragingly, women overall were treated with dignity and in a supportive manner by providers, but many women experienced poor interactions with providers and were not well-informed about their care. The findings of this study also align to the present study where there was a significant physical and verbal abuse observed during the study.⁶

The findings of the present study were also conformed to the study conducted This research drew on in-depth interviews with 112 respondents including women who delivered in the preceding 14 months, their male partners, public opinion leaders and community health workers to understand experiences with and responses to abuse during childbirth. All interviews were recorded, transcribed, translated and coded using Atlas.ti. Analysis drew on the principles of Grounded Theory. When initially describing birth experiences, women portrayed encounters with providers recounted events or circumstances that are described as abusive in maternal health literature: feeling ignored or neglected; monetary demands or discriminatory treatment; verbal abuse; and in rare instances physical abuse. The result of this study is somewhat similar and supportive by present study findings.⁷

A direct observational study for the prevalence of disrespect and abuse during facility-based maternity care was conducted by Lolade Oseni³, Angella Mtimuni⁴, Tambudzai Rashidi⁵ and Fannie Kachale⁶ in Malawi A total of 2109 observations were made across 40 facilities (12 health centers and 28 hospitals) in Malawi. The results showed that while women were frequently greeted respectfully (13.9% were not), they were often not encouraged to ask the health provider questions (73.1%), were not given privacy (58.2%) and were not encouraged to have a support person present with them (83.2%). It is somewhat similar to the present findings where (100%) no women was greeted by the health professionals, not encouraged to ask questions by health providers was (93%) and no privacy or support during labor scored (100%) and (76%) respectively.⁸

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