A Study to Assess the Level of Adherence to Respectful Maternity Care (RMC) and Reasons of non-adherence among Health Personnel in the Maternity Department of Selected Hospitals, West Bengal

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Abstract
Evidence suggests that in countries with a high maternal mortality like India, the fear of disrespect and abuse that women often encounter in facility-based maternity care is a more powerful deterrent to use of skilled care. The purpose of the study is to assess the level of adherence of health care personnel to each component of Respectful Maternity Care and also to find out the factors influencing non-adherence. A descriptive survey with non-probability purposive sampling was used. An observation checklist and both structured and unstructured interview schedule were administered on 92 health personnel to assess the level of adherence to RMC and reasons of non-adherence. Findings of the study depicts, in physical harm area, adherence among doctors, nursing personnel and Gr-D was 81.9%, 91.6%, 79.2% respectively, in the informed consent area 41.2% (doctors) and 61.1% (nursing personnel). Adherence in the area of choice and preferences was nil and in the area of confidentiality & privacy was 48.7% (doctors), 66.7% (nursing personnel) and 39.6% (Gr-Ds). Non-adherence in the area of dignity & respect was 25.6% (doctors), 18.4% (nursing personnel), 8.3% (Gr-Ds) and in the area of abandonment or denial of care 3.5% (doctors), 4.5% (nursing personnel), 43.7% (Gr-Ds). Adherence in the area of non-discriminatory care was 100% for all and 100% adherence was found in the area of detention against will among doctors and nursing personnel except among Gr-Ds (45.8%). No significant association was found between age, experiences and level of adherence of health personnel [(χ²df (1)=3.841, 0.474 & 0.287, p>0.05] respectively). No significant differences were found between level of adherence score of doctors with nursing personnel [t (78)=2.00, p>0.05]. As observed, adherence to RMC is not at the same level in each area. Least adherent areas are informed consent, choice/ preferences, privacy and detention against will among other personnel.

Keywords: Abuse, Health Personnel, Respectful Maternity Care, West Bengal

Introduction
The concept of “Respectful Maternity Care” has evolved and expanded over the past few decades during the childbirth activism movement in Latin America in the
Respectful Maternity Care (RMC) by different health personnel.
To assess the level of adherence to Respectful Maternity Care (RMC) by different health personnel.
To identify the factors influencing non-adherence to Respectful Maternity Care.
To find out association between level of adherence to Respectful Maternity Care with selected demographic variables.

Materials and Methods
A non-experimental approach had been adopted for the present study to accomplish the objectives of assessing the level of adherence to each component of RMC and reasons of non-adherence and descriptive survey design was selected for the study. Population for the present study were comprised of all health personnel of West Bengal and sample for the present study were health personnel working at maternity department of two tertiary level hospital of Kolkata and who were available during the data collection period. In this study, total sample size was 92 because here samples were chosen from the two hospitals, who were willing to participate in the study and were fulfilled pre-determined criteria. Among them doctor was 40, nursing personnel was 40 and Gr-D was 12 and non-probability purposive sampling was adopted for study to select the study subject. Study used model based on Browser & Hill’s model of potential contributors and impact of disrespect and abuse in childbirth on skilled care utilization. Prior to final data collection, formal administrative permission was obtained from ‘Ethical Committee, MCH, Kolkata’; ‘Joint Director of Health Services (Nursing), Swasthya Bhavan, Salt Lake, Kolkata, West Bengal and other related authorities.

Demographic data was collected by interviewing the respondent by structured interview schedule consisting 4 items like age, sex, designation and experience. Data about level of adherence to RMC were collected by observing health personnel on 8 areas like physical harm or ill treatment, informed consent, choice/ preferences, confidentiality and privacy, equitable care, free of discrimination, abandonment or denial of care, detained or confined against her will while providing care to pregnant women and by interviewing pregnant women. 34 verification criteria under above mentioned eight areas were used for doctors, whereas 35 verification criteria for nursing personnel and 20 verification criteria for Gr-D were used respectively, based on their job responsibility. Pregnant women were also interviewed by using same verification criteria those were used to observe level of adherence of health personnel. Reasons of non-adherence were collected by using unstructured interview schedule. The content validity of tools was assessed and reviewed by seven content experts. Every day data was collected from approximately 5 samples from 9 am to 4 pm and data collection period was from 25 September 2017 to 4 November 2017. Total 92 sample were taken and out of which doctor were 40, nursing personnel were 40 and Gr-D (general duty attendant and cleaning staff) were 12. Beside that 92 postnatal mother who were receiving care at that time had been interviewed. Plan for data analysis was planned to analyse by using descriptive and inferential statistics. Data were analysed by using percentage descriptive and inferential statistics.

Results
Findings Related to the Demographic Characteristics of Health Personnel
Table 1 revealed that 48.9% health personnel were in the age group of 25-35 years, 32.6% of health personnel were in the age group of 36-45 years and other categories of respondents are listed in Table 1. Reasons of non-adherence were divided into seven categories: role of person adverse to woman, family and community, policy and logistic issues, physical harm or ill treatment, lack of training, lack of concern and psychological support, and other categories (Table 2). The reasons of non-adherence were found to be highest in physical harm or ill treatment (25.3%) and lack of concern and psychological support (20.2%).
are in the age group of <25 years where as only 18.5% of health personnel are in the age group of >35 years. 91.3% health personnel were female whereas only 8.7% of health personnel are male. 43.5% health personnel were doctors and nursing personnel's each whereas only 13% of health personnel were Gr-D. 64.2% health personnel having 1-5 years of experience followed by 15.2% having 5-10 years and >10 years each and only 5.4% of health personnel having <1 years of experience.

Table 1.Demographic characteristics of the health personnel

| Variables       | Percentage (%) |
|-----------------|----------------|
| Age (years)     |                |
| <25 years       | 32.6           |
| 25-35 years     | 48.9           |
| >35 years       | 18.5           |
| Sex             |                |
| Male            | 8.7            |
| Female          | 91.3           |
| Designation     |                |
| Nurse           | 43.5           |
| Doctor          | 43.5           |
| Gr- D           | 13             |
| <1 year         | 5.4            |
| 1-5 years       | 64.2           |
| 5-10 years      | 15.2           |
| >10 years       | 15.2           |

Table 2.Demographic characteristics of the pregnant women

| Variables       | Percentage (%) |
|-----------------|----------------|
| Age (years)     |                |
| <19 years       | 4.3            |
| 19-30 years     | 95.7           |
| >30 years       | 0              |
| Education       |                |
| Illiterate      | 5.4            |
| Primary         | 34.6           |
| Secondary       | 50             |
| Higher secondary and above | 9.8 |
| Number of children |                |
| No children     | 58.7           |
| One child       | 35.9           |
| Two child and more | 5.4 |

Table 2 revealed that 4.3% pregnant women were in the age group of <19 years, 95.7% of pregnant women are in the age group of 19-30 years. 5.4% pregnant women were illiterate whereas 34.6% had primary, 50% had secondary and 9.8% had higher secondary and above level of education. 58.7% of pregnant women had no children, 35.9% had one and 5.4% had two or more child.

Table 3. Level of adherence to RMC among health personnel

| Area                                           | Doctor | Nursing personnel | Gr-D |
|------------------------------------------------|--------|-------------------|------|
| Physical harm or ill treatment                 | 81.4%  | 91.6%             | 79.2%|
| Informed consent                               | 40.5%  | 61.3%             | -    |
| Choice/ Preferences                            | 0%     | 0%                | NA   |
| Confidentiality and privacy                    | 48.7%  | 68.7%             | 39.6%|
| Dignity and respect                            | 73.9%  | 81.6%             | 91.7%|
| Equitable care, free of discrimination         | 100%   | 100%              | 100% |
| Abandonment or denial of care                  | 96.5%  | 95.9%             | 56.3%|
| Detained or confined against her will          | 100%   | 100%              | 45.8%|

Findings Related to Level of Adherence to RMC by Health Personnel

Table 3, reveals that in physical harm area, adherence among doctors, nursing personnel and Gr-D was 81.9%, 91.6%, 79.2% respectively, in the informed consent area 41.2% (doctors) and 61.1% (nursing personnel). No adherence was found in the area of choice and preferences. Adherence in the area of confidentiality & privacy was 48.7% (doctors), 66.7% (nursing personnel) and 39.6% (Gr-Ds). in the area of dignity & respect was 25.6% (doctors), 18.4% (nursing personnel), 8.3% (Gr-Ds) and in the area of abandonment or denial of care 3.5% (doctors), 4.5% (nursing personnel), 43.7% (Gr-Ds). Adherence in the area of non-discriminatory care was 100% for all and 100% adherence was found in the area of detention against will among doctors and nursing personnel except among Gr-Ds (45.8%). Adherence was assessed by using observation checklist in presence of assessment criteria in checklist. Figure 1, depicts level of adherence to RMC in some common area among health personnel as observed.

All these data are supported by data presented feelings of pregnant women regarding services rendered (Figure 2).
Findings Related to Description of Reasons of

Reasons of non-adherence was analysed by using unstructured interview schedule if the non-adherence presenting particular area as listed in the observation checklist. Findings of the study was that majority of study subjects were not maintaining proper aseptic technique in the area of physical harm, ill treatment and reason was cited by all (51, 63.8%) is ‘sometimes not possible in emergency’ followed by parting the thigh forcefully, and stated reason is ‘not following the instruction (20, 25%)’. Maximum study subjects had provided reason for giving fundal pressure during is that ‘she (pregnant woman) is not giving bearing down effort properly (15, 18.8%)’ delivery and ‘using gloves (12, 100%)’ for cleaning the patient without washing hand. Stated reasons are ‘women is not cooperative (2, 2.5%)’, ‘lignocaine not given as tear is very small (2, 3.7%)’, ‘already crowning had occurred (1, 1.7%)’, ‘women are not cooperative & not following the instruction (1, 2.5%)’, ‘women is not cooperative (1, 1.25%)’, and ‘not following the instruction (1, 11.1%)’ behind slapping in the thigh, always suturing of episiotomy/ tear with local anaesthesia, giving episiotomy without local anaesthesia, hitting with hand, pushing roughly, and slapping for noncompliance to instruction respectively. Observed non-adherent behaviours in the area of informed consent were performing per vaginal examination without informing women, informs client regarding findings, performing any procedure without explanation/ taking consent and performing per abdominal examination without informing women. Stated reasons are ‘taking permission is not possible (53, 76.8%)’, ‘they (pregnant women) will not understand (40, 100%)’, ‘not possible to explain every time as workload is heavy (31, 46.3%)’ and ‘taking permission is not possible (14, 43.8%)’ respectively.

Health personnel did not perform both verification criteria under the area of choice/ preferences. These two were, ‘asks women for preferable delivery position’, ‘encourages to walk & change position in 1st stage of labour’ and reasons were ‘position other than lithotomy is not possible
in current setting (80, 100%)’ and ‘not possible in current setup (40, 100%)’ respectively.

Reasons given in the area of confidentiality and privacy was it ‘is not possible to use screen every time’ (92, 100%). Most common non-adherent behaviour in the area of dignity and respect was against verification criteria of greets the pregnant women courteously and reason stated by health personnel was heavy workload (80, 100%). Other two non-adherent behaviours were against verification criteria of speaks to pregnant women with due respect, shouting at pregnant women for making noise due to pain and reasons stated against first one was ‘workload is heavy, so not possible always (21, 26.3%)’ and for second one was two. These two reasons were ‘not listening to instruction and uncooperative (16, 17.4%) and ‘sometimes irritation occurs due to workload (1, 1.1%). Stated reasons were ‘not following instruction & not cooperative also (1, 1.1%)’, ‘not following instruction and not cooperative (1, 1.3%)’ and ‘not following instruction (1, 8.3%)’ behind using slang language, blaming pregnant women in labour if she can’t tolerate pain, scolding if they did not comply with instructions and respectively.

Non-adherence in the area of abandonment or denial of care was present against verification criteria of responding to pregnant women’s call, responding to pregnant women’s questions, never left women unattended, delay in cleaning after delivery. Reason cited for first three was ‘workload’ and findings were (3, 4.5%), (2, 5%), (6, 15%) respectively and last one is ‘busy in other work as workload is heavy (6, 75%)’.

Non-adherence in the area of detained or confined against her will were present against verification criteria of delay in taking to ward after delivery and demanding money for shifting to the ward. Reasons stated by them were ‘busy in other work as workload is heavy (1, 8.3%)’and ‘pregnant women’s relative give them (12, 100%) happily.

**Association between Level of Adherence to RMC and Selected Demographic Variables**

Table 4 reveals that no significant association was found between age and experiences and level of adherence of health personnel (doctor and nursing personnel) (χ²df (1)=3.841, 0.474 & 0.287 respectively). No significant differences were found between level of adherence score of doctors with nursing personnel [t (78)=2.00, p<0.05].

**Table 5.Mean, mean difference, SEMD & ‘t’ value of RMC score of doctors and nursing personnel**

Table 4.Association between RMC score and selected demographic variables

| S. No. | Variables       | RMC score | χ² value | df |
|--------|----------------|-----------|----------|----|
| 1.     | Age            | >Median (>53.5) | 14       | 0.474 |
|        |                | ≤Median (≤53.5) | 17       |       |
| 2.     | Experience     | >Median (>53.5) | 26       |       |
|        |                | ≤Median (≤53.5) | 23       |       |
|        | >5 years       | 32         |          | 0.287 |
|        | ≤5 years       | 30         |          |       |

χ²df (1) =3.841, *p<0.05.

**Discussion**

Present study findings reveal that least adherent area is not maintaining choice and preferences (100%) followed by not maintaining privacy and confidentiality (66.7% to 39.6%) among three category of health personnel. This is in some extent consistent with study conducted by Azhar Z et al.11 In their study titled “Disrespect and abuse during childbirth in district Gujrat, Pakistan: A quest for respectful maternity care”, the most common objective Disrespect and abuse was violation of women’s right to be informed and make her own choices (97.5%), followed by abandonment of care (72.5%) and non-confidential care (58.6%).

Present study findings reveal that least practiced item is not asking women’s preference of birth position, not examining with screen/ curtain, not greets the pregnant women courteously, observed in all of the observations (100%). Shouting to pregnant women for making noise due to pain was present in 18.5% of observation. Women were examined and cleaned without curtain and demanding money for shifting to the ward in 100% observations. In 100% cases light food was offered after delivery. This is in some extent, consistent with study conducted by Sheferaw ED et al.12 To observe Respectful maternity care in Ethiopian public health facilities. The most frequently practiced RMC element was ensuring that women take light food, occurring in 83% (n=193) observations. In this study least practiced item was asking women’s preference of birth position, observed in only 29% (n=68) of the observations. At least one form of mistreatment of women was committed in 36% of the observations (38% in health centers and 32% in hospitals). Of the total 240 observations, in 36% (n=87) at least one form of mistreatment of women was observed.
The element with the highest prevalence was abandonment or being left alone, 19% (n=43). Verbal abuse occurred in 8% (n=18) of the observations. Present study findings reveal that mostly stated reasons are workload, non-compliance to instruction, non-cooperative patient and set up of labour room. No specific study was found in this respect but Bowser D, Hill K in their report on landscape analysis “Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth” stated some provider’s contributing factor. One of which is shortages of human resources which is similar with findings.

Chi square value is computed between experiences and the RMC score of two categories of health personnel i.e. doctor, nursing personnel. Result shows that there is no significant association between experiences and RMC score of doctors, nursing personnel, as the obtained values is 0.287, which is lower than table value (3.841) at df 1 at the 0.05 level of significance. Exactly similar study is not available. However, this is in some extent consistent with study conducted by Banks KP et al. Their study revealed that the cadre of birth attendant at the time of delivery was not significantly associated with reporting of D&A.

Limitation
Study did not use uniform tool to observe the adherence to components of RMC among health personnel as job responsibility of them are different.

Conclusion
Based on observation of health personnel, researcher had come to conclusion that, adherence to respectful maternity care is not at the same level in each area. Least adherent areas are informed consent, choice/preferences, privacy and detention against will among other personnel, which needs to be addressed pertinently.

Conflict of Interest: None

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