Perceived experience of respectful maternity care among mothers attending a selected teaching hospital of Kaski district

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ABSTRACT

Introduction: Pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability. Because parenthood is a uniquely female experience, questions of gender justice and violence are at the heart of maternity care. The study aimed to find out the perceived experience of respectful maternity care and its associated factors among postnatal mothers. **Methods:** A descriptive cross-sectional research design was used. The study population consisted of mothers who had a normal vaginal delivery and were admitted to the Gandaki Medical College Teaching Hospital and Research Centre's postnatal ward from July 1 to August 1, 2021. A purposive sampling technique was used. Standard Respectful Maternity Care scale was used to collect the data. Collected data were entered, coded and edited into Statistical package for the social sciences version 16.0 and analyzed using both descriptive and inferential statistical methods. **Results:** Of total, 166 (83%) women did not receive respectful maternity care. Regarding the dimensions of RMC, more than half 106 (53%) of the mothers received abuse-free care. Only 40 (20%) of the mothers received friendly care. Parity with friendly care adjusted Odds ratio(AOR)=0.25, Confidence interval (CI) (0.10-0.64), education with abuse free care (AOR=3.66, CI 1.86-7.20), Parity with timely care (AOR=3.27, CI=1.45-7.38).Likewise, educational status of the respondent (AOR= 2.24,CI= 1.13-4.44), religion (AOR=2.88, CI=1.19-6.95) and parity are the factors influencing discrimination free care(AOR= 0.36, CI=0.18-0.73). **Conclusions:** The majority of women did not receive dignified and respectful care throughout labor.

Keywords: Mothers, perception, respectful maternity care.

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INTRODUCTION

The White Ribbon Alliance (WRA) has advocated for woman's right to the highest attainable quality of health, including the right to dignified, compassionate treatment during pregnancy and childbirth, as part of a global advocacy movement since 1999.[1] Safe Motherhood Network Federation Nepal works to protect women's rights, train health care providers, and develop and equip birthing centers in Nepal to improve maternal and newborn health.[2]

Pregnancy and childbirth are both priceless and unique experiences in a woman's life, and every mother wishes for a happy and successful childbirth experience.[3] Every woman has the right to give birth in a woman-centered environment free of violence and disrespect. However, women all over the world have been subjected to various forms of physical violence (beating, slapping, and pinching), undignified treatment (yelling, chiding, and humiliating comments), abandonment (leaving alone at various stages of delivery), and cultural prejudice.[4,5,6] This has hampered the use of maternal health care programs, resulting in a decline in their health and well-being.[7]

Women are vulnerable in any way during pregnancy, labor, or

childbirth, and if they do not receive compassionate maternity care, it may lead to negative experiences such as fear of childbirth, decreased vaginal childbirth, and a desire to have a cesarean section.[8] As a result, it is critical that healthcare providers pay greater attention to the physical and emotional aspects of pregnancy, as well as have compassionate and supportive caring actions during the pregnancy.[9]

Despite the fact that Respectful Maternity Care (RMC) emphasizes the removal of insensitive and oppressive environments from health facilities, research in different countries has shown that many women have not had access to RMC services in full essence. As a result, the health facility should concentrate on measures that ensure that every woman is treated with basic human dignity at one of her most vulnerable times in life.

In Nepal, there has yet to be a reliable estimation of the prevalence of respectful and non-abusive activity during childbirth in health facilities. As a result, it is an important subject to investigate in order to learn about the various types of disrespect and violence that exist in the nation. More research is required to recognize the obstacles to delivering dignified care and to put in place a standard procedure to promote respectful treatment in hospitals. It is important to decide how women view RMC to recognize the barriers. Hence, the researchers opted for this study.

METHODS

The study adopted a quantitative approach. A cross-sectional descriptive research design was used to address the research aims. The study lasted six months, from May to October 2021. It was conducted at the postnatal ward of Gandaki Medical College Teaching Hospital and Research Centre (GMCTH-RC), Pokhara, Nepal. GMC envisions a 750-bed teaching hospital with clinical and medical facilities providing exceptional healthcare services.

The postnatal mothers admitted to the postnatal ward of GMCTH-RC comprised the study population. Sample size was calculated using Cochran's equation. A similar study among postnatal mothers attending Nepal Medical College Teaching Hospital concluded that 84.7% of the mother's had experienced overall RMC services.[10] Hence estimating a prevalence of 84.7% and using the Cochran's equation, the precise sample size was 200. The participants were selected by purposive sampling technique. Based on the study's goals, we utilized this sampling technique to choose individuals intentionally who can give a depth of information sufficient for thorough analysis. -Postnatal mothers irrespective of the parity, and admitted to the postnatal ward were included in the study as samples. However, postnatal mothers with critically ill babies having the APGAR score 3-5/10 (mild to moderate asphyxia), who had IUFD, and still birth were excluded from the study

Data were collected using a semi-structured interview schedule. Hence, a semi-structured standardized interviews were the primary form of data collection. PartI of the interview schedule included the socio-demographic characteristics of the respondents, and was developed after an adequate literature review and consultation with subject expertise. Furthermore, part II of the interview schedule is Respectful Maternity Care scale which is a standard open access tool and is valid with high average factor loading of the four components ranging from 0.76 to 0.82 and low correlation between the components and reliable with $\alpha = 0.845$.[11] Before the data collection, pretesting was done among two postnatal mothers from the same setting, but no changes were made to the interview schedule or data collection techniques. Also, the pre-tested samples were not combined with the subsequent interviews for further analysis.

Those postnatal mothers meeting the inclusion criteria, mothers irrespective of the parity, and admitted to the postnatal wardwho were willing to participate in the study, and who could articulate their experiences were identified first. The researcher clarified the study's goal and research questions for each participant. After explaining the study objectives and acquiring the informed written consent, the researchers themselves collected the data. The duration of the data collection varied. However, on average, the interviews lasted between 25 and 40 minutes. The ethical approval for this study was taken from the Institutional Review Committee of GMCTH-RC before the initiation of the study (Ref. No: 11/2078/2079). Written informed consent was also obtained from the research participants.

After the completion of the data collection, data were checked for its completeness and accuracy. The obtained data was edited, coded and entered on the same day by the researcher herself. Data was entered into the computer using the software Epi-data version 3.1 and transferred into statistical package for social science (SPSS) version 16.0 for further analysis. Data was analyzed and interpreted according to the objectives of the study and research questions, and both descriptive and inferential statistics were used. Descriptive statistics were used to describe the socio-demographic characteristics of the participants. Inferential statistics was applied at 5% level of significance. Chi- square test was used to find out the association between RMC experience and socio-demographic characteristics

of the participants and logistic regression was used to identify the factors affecting RMC.

RESULTS

Among the 200 women interviewed, 105 (52.5%) of mothers belong to the age group of more than 25 years and majority 167 (83.7%) follow Hinduism. More than half 106 (53.0%) of the mothers had educational status above Secondary level. A total of 146 (73%) of the respondents had medium income status. Just more than half of the mothers 103 (51.5%) reside in urban area and 113 (56.5%) were multigravida. A total of 100 (50%) of the mothers had done at least four ANC visits (Table 1).

Table 1: Characteristics of the study population (N=200)

Characteristics	Number	Percentage
Age (in year)		
≤25	105	52.5
>25	95	47.5
Mean ± SD =25± 5.03		
Religion		
Hinduism	167	83.5
Buddhism	33	16.5
Education		
Upto Secondary	94	47
Secondary and above	106	53
Family income status		
<10000 (low income)	32	16
10000-36000 (medium income)	146	73
36000-111000 (upper medium income)	22	11
Residence		
Rural	97	48.5
Urban	103	51.5
Parity		
Primigravida	87	43.5
Multigravida	113	56.5
No. of ANC Visit		
Less than 4 visit	32	16
Up to 4 visit	100	50
More than 4 visit	68	34

Table 2 reveals the mean score and SD of each dimension as well as the overall dimension of RMC. A total of 166 (83%) of mothers stated that they had not perceived overall all dimensions of RMC with the mean score being 44.99 with SD of 7.89. Likewise, among four dimension of RMC, 106 (53%) percent of the women received abuse free care.

Table 2: Level of perception on four dimensions of RMC

Variables	Experienced RMC n (%)	Not experienced RMC n (%)	Mean ± SD
Friendly Care	40 (20)	160 (80)	(22.11 ± 5.6)
Timely Care	45 (22.5)	155 (77.5)	(9.23 ± 2.10)
Abuse-free Care	106 (53)	94 (47)	(7.76 ± 2.42)
Discrimination free care	84 (42)	116 (58)	(5.89 ± 1.71)
Overall RMC	34 (17)	166 (83)	(4.99 ± 7.89)

Table 3 reveals the association between friendly and abuse care experience and socio-demographic characteristics of the respondents. Friendly care experience was found to be significantly associated with parity (p=0.004). Women with a single child had 74.5% higher odds of experiencing friendly care than women with more than one child. Likewise, Abuse free care experience of respondents were found to be significantly associated with education (p<0.001). Respondents who had completed at least their secondary education were 3.7 times more likely to experience abuse free care than other respondents.

Table 3: Association between friendly and abuse free care with socio-demographic characteristics of the respondents

Factors	Friendly Care			Abuse Free Care		
	Experiencing RMC n (%)	Not Experiencing RMC n (%)	Adjusted OR(95% CI)	Not Experiencing RMC n (%)	Experiencing RMC n (%)	Adjusted OR(95% CI)
Age						
≤25	20 (19)	85 (81)	1	60 (57.1)	45 (42.9)	1
>25	20 (21.1)	75 (78.9)	1.14 (0.51-2.56)	46 (48.4)	49 (51.6)	0.90 (0.461.78)
Residence						
Rural	23 (23.7)	74 (76.3)	1	50 (51.5)	47 (48.5)	1
Urban	17 (16.5)	86 (83.5)	1.35 (0.58-3.10)	56 (54.4)	47 (45.6)	1.54 (0.773.10)
Religion						
Hindu	28 (16.8)	139 (83.2)	1	84 (50.3)	83 (49.7)	1
Others	12 (36.4)	21 (63.6)	0.45 (0.18-1.12)	22 (66.7)	11 (33.3)	0.71 (0.30-1.68)
Education						
Up to Secondary	23 (57.5)	71 (44.4)	1	64 (68.1)	30 (31.9)	1
Secondary and above	17 (16)	89 (84)	1.72 (0.76-3.88)	42 (39.6)	64 (49.8)	3.66 (1.86-7.20) *
Parity						
One	8 (9.2)	79 (90.8)	1	51 (58.6)	36 (41.4)	1
More Than one	32 (28.3)	81 (71.7)	0.25 (0.10-0.64) *	55 (48.7)	58 (51.3)	

*p value significant at < 0.05; OR= odds ratio CI= confidence interval; 1= reference value

Table 4 reveals the association between timely and discrimination free care experiences with socio demographic characteristics of the respondents. Timely care experience of respondents were found to be significantly associated with parity (p=0.004). Respondents having more than one child were 3.3 times more likely to experience timely care than other respondents. Discrimination free care experience of respondents were found to be significantly associated with religion (p=0.019), education (p=0.020) and parity (p=0.005). Respondents other than Hindus were 2.9 times more likely to experience discrimination free care than other respondents. Similarly respondents who had completed at least their secondary education were 2.24 times more likely to experience discrimination free care. However, respondents with more than 1 child had 36.5 times less odds of experiencing discrimination free care than other respondents.

Table 4: Association between timely care and discrimination free care with socio-demographic characteristics of the respondents

Factors	Timely Care			Discrimination Free Care		
	Experiencing RMC n (%)	Not Experiencing RMC n (%)	Adjusted OR(95% CI)	Not Experiencing RMC n (%)	Experiencing RMC n (%)	Adjusted OR(95% CI)
Age						
≤25	30 (28.6)	75 (71.4)	1	44 (41.9)	61 (52.6)	1
>25	15 (15.8)	80 (84.2)	1.38 (0.60-3.18)	40 (42.1)	55 (57.9)	1.37 (0.68-2.74)
Residence						
Rural	27 (27.8)	70 (72.2)	1	42 (43.3)	55 (56.7)	1
Urban	18 (17.5)	85 (82.5)	2.10 (0.90-4.89)	42 (40.8)	61 (59.2)	1.26 (0.64-2.53)
Religion						
Hindu	40 (24)	127 (76)	1	74 (44.3)	93 (55.7)	1
Others	5 (15.2)	28 (84.8)	1.61 (0.54-4.80)	10 (30.3)	23 (69.7)	2.88 (1.19-6.95)
Education						
Upto Secondary	16 (17)	78 (83)	1	46 (48.9)	48 (51.1)	1
Secondary and above	29 (27.4)	77 (72.6)	0.66 (0.29-1.52)	38 (35.8)	68 (64.2)	2.24 (1.13-4.44)
Parity						
One	29 (33.3)	58 (66.7)	1	46 (48.9)	48 (51.1)	1
More than one	16 (14.2)	97 (85.8)	3.27 (1.45-7.38)	38 (35.8)	68 (64.2)	0.36 (0.18-0.73)

*p value significant at < 0.05 OR= odds ratio CI= confidence interval; 1 = reference value

Table 5 reveals the association between RMC experience and socio-demographic characteristics of the respondents. A statistically significant association was found between RMC experience with religion (p=0.010) and parity (p=0.001). Women with a single child had 66% higher odds of experiencing RMC than women with more than 1 child. Likewise, women following hinduism had had 61.5% of experiencing RMC than with women following other religion.

Table 5: Association between RMC experience and socio-demographic characteristics of the respondents

Factors	Experienced RMC		Chi-square	p-value	AOR	95% CI
	Yes n (%)	No n (%)				
Age						
≤25	21 (19)	84 (81)	1.25	0.66	1	
>25	19 (21.1)	76 (78.9)			1.52	0.65-3.57
Residence						
Rural	23 (23.7)	74 (76.3)	1.62	0.20	1	
Urban	17 (16.5)	86 (83.5)			0.82	0.344-1.97
Religion						
Hindu	28 (16.8)	139 (83.2)	6.61	0.01*	1	
Others	12 (36.4)	21 (63.6)			0.38	0.15-.96
Education						
Up to Secondary	23 (24.5)	71 (75.5)	2.21	0.13	1	
Secondary and above	17 (16)	89 (84)			1.43	0.61-3.34
Parity						
One	8 (9.2)	79 (90.8)	11.23	0.00*	1	
More than one	32 (28.3)	81 (71.7)			0.34	0.13-0.85
ANC visit #						
Yes	33 (17.6)	155 (82.4)		0.39	1	
No	1 (8.3)	11 (91.7)			2.46	0.30-19.8
Income status						
Low income	8 (25)	24 (75)	1.72	0.21	1	
Medium to high income	26 (15.5)	142 (84.5)			1.57	0.76-3.20

Fischer's exact test, P value significant at <0.05, OR= odds ratio CI= confidence interval; 1= reference value

DISCUSSION

The study aimed to find out the perception of RMC among the women undergoing normal delivery. Majority of the respondent did not experience Respectful Maternity Care .The study finding is similar with the study done in Asmara Public Hospital, Eritrea[12] & Tanzania [13] and Addis Ababa, Ethopia.[14] Also, the finding is supported by a systematic review done using 22 article which concluded that disrespectful and abusive care was practiced in Ethopia[14] And the same finding contradict with the finding of the study done in Nepal Medical college[10] and the study in Kenya.[15] The perception was measured in four dimension; experiencing abuse free care 53%, which contradict with the study in Tanzania.[13] Likewise, findings in discrimination free care (42%), timely care (22.5%) and friendly care (20%) contradict with the finding of the study in Nepal Medical College.[10]

This study reveals that women with one child had higher odds of experiencing friendly care than women with one child (AOR=0.255; 95% CI=0.101-0.643). In addition to this, women who had completed at least secondary level education were more likely to experience abuse free care (AOR=3.664; 95% CI=1.863-7.208). This finding is similar to a study conducted in Bheri hospital, Nepal in which parity was significantly associated with friendly care[15] whereas this finding is in contrast with another study conducted in Nepal where parity was significantly associated with abuse free care and length of hospital stay was significantly associated with friendly care.[10]

This study also reveals that women having more than one child were three times more likelyto experience timely care than other women (AOR=3.273; 95% CI=1.451-7.383) but similar other studies showed timely care were associated with time of delivery[10] and age, ethnicity, occupation, monthly income, gravida, type of delivery, and complications.[16] This study found statistically significant association between RMC experience with religion (p=0.006) and parity (p=0.028). This finding is different form a study conducted in Ethiopia where RMC experience was significantly associated with increased number of visits, previous history of facility delivery and time of delivery.[14]

This study addresses not only the physical but also the emotional and psychological aspects of women's life which helps to avoid the negative experience of the care provided to them. Thus, in order to achieve target SDG, Nepal for

achieving 90% of institutional deliveries, the care provided by the health workers matters. So the study can be used to find out the areas that need more emphasis on improving the health of women and child which is the strongest part of the study. As the study is interview schedule, there might be selection bias.

CONCLUSIONS

Majority of the women were not experiencing RMC throughout the labor.More than half of the mothers received abuse-free care. Parity and religion were the factors influencing the perception of Respectful maternity care. Parity was the factor influencingfriendly and timely care, education for abuse free care. Likewise, educational status of the respondent religion and parity were the factors influencing discrimination free care. So, there is a need to advocate at all level of health care facility so that health care professional pays greater attention to the physical and emotional aspects of pregnancy, as well as have compassionate and supportive caring actions during the pregnancy.

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