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RESPECTFUL MATERNITY CARE AMONG WOMEN AVAILING DELIVERY SERVICES AT SELECTED HOSPITALS OF WEST BENGAL

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ABSTRACT

Respectful Maternity Care is a fundamental right of every childbearing woman. Skilled birth attendants play a crucial role in reducing maternal complications and mortality. This descriptive study assessed the level of RMC among postnatal women in three tertiary hospitals. A total of 135 postnatal women were selected through systematic random sampling. Data were collected using a structured interview schedule and record analysis proforma and analysed using descriptive and inferential statistics. The findings revealed that 56.3% of participants experienced an average level of respectful maternity care. Among the domains of RMC, preserving maternal dignity was the most consistently practised aspect. Significant associations were observed between the level of RMC and participants' educational qualification and socio-economic status at the 0.05 level of significance. The study highlights the need to improve awareness and training among healthcare providers to promote respectful and equitable maternity care.

Key words: *Respectful maternity care, women, delivery services.*

INTRODUCTION

Respectful Maternity Care ensures that every woman is respected by supporting women's autonomy, dignity, feelings, choices, and preferences wherever possible.[1] Pregnancy and childbirth are the two important events of a woman's life. In the safe motherhood practice, women experience different kinds of feelings at the same time. Mothers enter into the pregnancy with the expectation that their pregnancy and childbirth will involve happiness. As all pregnancies may cause some risk to the mother, a skilled birth attendant is mandatory for every birth. Provision of skilled birth attendants is the most effective way to reduce maternal mortality, as the majority of pregnancy-related complications cannot be predicted previously and require urgent attention.[2]

BACKGROUND OF THE STUDY

Globally, about 830 women die every day because of pregnancy and childbirth-related complications. The United Nations launched the Global Strategy for women's, children's, and adolescent health to reduce the global Maternal Mortality Ratio to fewer than 70 per 100000 by the year 2030. [3]

Globally, around 810 women die each day from preventable causes of pregnancy and childbirth; about 94% of deaths occur in low-resource settings (WHO 2019) [4].

In December 2017, the Ministry of Health and Family Welfare launched the Labour Room & Quality Improvement Initiative (LaQshya) guidelines, which aimed to reduce the maternal mortality ratio and improve the quality of care in labour rooms and enhance the positive childbirth experience by fostering RMC for all pregnant mothers while attending the health care facility. [5]

OBJECTIVES

1. To identify respectful maternity care received by women.
2. To determine the association of respectful maternity care received by women with selected demographic variables.

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RESEARCH METHODOLOGY

Research approach: A quantitative research approach was adopted to accomplish the objectives of the study.

Research design: Descriptive survey research design was adopted

Population: In the present study, the population comprised all the postnatal women with normal delivery.

Sample: The sample was postnatal women availing delivery services at selected hospitals of West Bengal.

Criteria for selection of sample

Inclusion criteria:

- Postnatal mother on day one of delivery.

Exclusion criteria:

- Women who are very sick and not able to talk.
- Mother's whose babies are at NICU (Neonatal Intensive Care Unit)

Sampling technique: Probability systematic random sampling technique was adopted.

Data collection tools and techniques:

Table 1: Data collection tools and techniques

Variables to be measured	Tools	Techniques
I. Background information		
A. Demographic variables	Structured interview schedule (Tool 1 A)	Interviewing
B. Obstetric profile	Record analysis proforma (Tool 1 B)	Record analysis
II. Respectful maternity care	Structured interview schedule (Tool II)	Interviewing

RESULTS

Table 2: Frequency and percentage distribution of postnatal women according to their age, habitat, educational qualification and occupation. n=135

Demographic variables		Frequency	Percentage (%)
Age (in years)	18 - 25	86	63.70
	26 - 33	42	31.11
	34 - 41	7	5.19
Habitat	Rural	109	80.74
	Urban	26	19.26
Educational qualification	No formal education	10	7.41
	Primary	11	8.15
	Secondary	88	65.19
	Higher secondary	23	17.03
	Graduate	3	2.22
Occupation	Homemaker	127	94.08
	Shopkeeper	3	2.22
	Housemaid	5	3.70

Data presented in Table 2 showed that the maximum 86 (63.70%) mothers belonged to the age group of 18 - 25 years. 42 (31.11%) mothers belonged to the age group 26 – 33 years, and only 7 (5.19%) mothers belonged to the age group 34 - 41 years. Regarding habitat, the majority 109 (80.74%) mothers were in rural areas, and 26 (19.26%) mothers were in urban areas. The majority of 88 (65.19%) mothers had Secondary level of education, 23 (17.03%) mothers had Higher Secondary level of education, 11(8.15%) mothers had primary education, 10 (7.41%) mothers had no formal education, and 3 (2.22%) mothers had completed graduation.

Table 2 also showed that the majority of 127 (94.08%) mothers were homemakers, 3 (2.22%) mothers were shopkeepers, and 5 (3.70%) mothers were housemaids.

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Table 3: Frequency and percentage distribution of postnatal women according to their number of family members and socio-economic status. n=135

Demographic variables		Frequency	Percentage
No. of family members	3 - 5	79	58.52
	6 - 8	52	38.52
	9 - 10	4	2.96
Socio-economic status	Upper class (≥ Rs.9098)	Nil	Nil
	Upper middle class (Rs.4500 - 9097)	8	5.93
	Middle class (Rs.2729 - 4549)	18	13.33
	Lower middle class (Rs.1365 - 2728)	63	46.67
	Lower class (< Rs.1365)	46	34.07

(B.G. Prasad modified scale 2024)

Table 3 showed that the majority of 79 (58.52%) mothers had 3 - 5 family members, 52 (38.52%) mothers had 6-8 family members, and 4 (2.96%) mothers had 9 - 10 family members. It also showed that regarding Socio-economic status of the mother, the majority of 63 (46.67%) mothers were lower middle class (Rs.1365 – Rs.2728), 46 (34.07%) mothers were lower class (<Rs.1365), 18 (13.33%) mothers were middle class (Rs.2729 – Rs.4550), and only 8 (5.93%) mothers were upper middle class (Rs.4549 – Rs.9097).

Table 4: Frequency and percentage distribution of postnatal women according to their parity and gestational age during delivery. n=135

Parity	Gestational Age			
	Preterm (≤37 weeks)		Full Term (>37 weeks)	
	Frequency	Percentage	Frequency	Percentage
Primipara	6	4.44	61	45.19
Multipara	4	2.96	64	47.41

Table 4 showed that 6 (4.44%) primipara mothers delivered at preterm (≤37 completed weeks) and 61 (45.19%) primipara mothers delivered at full-term (>37 completed weeks). This table also showed that 4 (2.96%) multipara mothers delivered at preterm (≤37 completed weeks) and 64 (47.41%) multipara mothers delivered at full-term (>37 completed weeks).

Table 5: Range of maximum possible score, Range of obtained score, Mean, Median and Standard deviation of respectful maternity care received by women availing delivery services. n=135

Variable	Range of maximum possible score	Range of obtained score	Mean	Median	Standard deviation
Respectful maternity care	39 - 117	60 - 92	74.49	75	5.26

Table 5 depicts that the range of maximum possible score was 39-117, the range of obtained score was 60-92, the mean was 74.49, the median was 75, and the standard deviation was 5.26. The mean and median are very close, indicating a symmetric distribution of data. The standard deviation shows moderate variability around the mean.

Table 6: Grading, Range, Frequency and Percentage distribution of respectful maternity care received by women availing delivery services. n=135

Respectful maternity care received	Range of obtained score	Frequency	Percentage
High	79 - 92	28	20.74
Average	72 - 78	76	56.30
Poor	60 - 71	31	22.96

Maximum obtained score – 92

Minimum obtained score – 60

Data presented in Table 6 predict that the majority 76 (56.30%) mothers received average respectful maternity care, 31 (22.96%) mothers received poor respectful maternity care, and only 28 (20.74%) mothers received high respectful maternity care.

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Table 7: Domain-wise range of score, mean, mean % and rank regarding respectful maternity care received by women availing delivery services. n=135

Domain-wise respectful maternity care	Range of score	Mean	Mean%	Rank
Preserving mother's dignity	6 - 18	13.88	77.11	1
Effective and continuity of care	4 - 12	8.31	69.25	2
Informed consent and effective communication	6 - 18	11.92	66.22	3
Maintaining privacy and confidentiality	5 - 15	9.48	63.20	4
Free from harm and mistreatment	6 - 18	11.26	62.56	5
Physical environment and resources	5 - 15	8.90	59.33	6
Availability of competent and motivated human resources	2 - 06	3.24	54.00	7
Respecting women's choice that strengthens their capabilities	5 - 15	7.49	49.93	8

Table 7 showed that regarding domain wise respectful maternity care, preserving mother's dignity was first (77.11%), followed by Effective and continuity of care (69.25%), Informed consent and effective communication (66.22%), Maintaining privacy and confidentiality (63.20%), Free from harm and mistreatment (62.56%), Physical environment and resources (59.33%), Availability of competent and motivated human resources (54%) and Respecting women's choice that strengthens their capabilities (49.93%).

Table 8 Chi-square value showing association between respectful maternity care scores of mothers and selected demographic variables according to their age, habitat and educational qualification. n=135

Demographic variables		Respectful maternity care scores			Chi-square value	p-value
		<Median	³Median	Total		
Age (in years)	**≤ 25**	40	46	86	0.002	0.96
	> 25	23	26	49		
Habitat	**Rural**	54	55	109	1.87	0.17
	Urban	9	17	26		
Educational qualification	**≤ Secondary level**	56	53	109	**5.04***	0.02
	> Secondary level	7	19	26		

χ^2 (df1) 3.84, p ≤ 0.05

Chi-square value given in Table 8 also showed that the chi-square value computed at df(1) between RMC and educational status *(5.04) is significant at the 0.05 level because the computed chi-square value (5.04) is greater than the table value (3.84) at the 0.05 level. Thus, it can be interpreted that there is a significant association between RMC and the educational qualification of the mothers.

Table 9: Chi-square value showing association between respectful maternity care scores of mothers and selected demographic variables according to their occupation, number of family members and Socio-economic status. n=135

Demographic variables		Respectful maternity care scores			Chi-square value	p-value
		<Median	³Median	Total		
Occupation	**Homemaker**	60	67	127	0.02	0.86
	Other than homemakers	3 #	5	8		
Number of family members	**≤ 4**	18	23	41	0.18	0.67
	≥ 4	45	49	94		
Socio-economic status	**Above lower middle class (More than Rs.2728)**	17	9	26	**4.53***	0.03
	Lower middle class (≤ Rs.2728)	46	63	109		

χ^2 (df1) 3.84, p≤0.05

 # Yates's correction applied

Chi-square value given in Table 9 showed that the chi-square value computed at df(1) between RMC and Socio-economic status of the mother *(4.53) is significant at the 0.05 level of significance because the computed chi-

square value (4.53) is greater than the table value (3.84) at the 0.05 level of significance. Thus, it can be interpreted that there is significant association between RMC and Socio-economic status of the mother.

Table 10: Chi-value showing association between respectful maternity scores of mothers and obstetric profile. n=135

Obstetrics profile		Respectful maternity care scores			Chi-square value	p-value
		< Median	³ Median	Total		
Parity	Primipara	31	36	67	0.008	0.92
	Multipara	32	36	68		
Gestational age during delivery	Full term (> 37 weeks)	59	66	125	0.01	0.91
	Preterm (≤ 37 weeks)	4 #	6	10		

χ^2 (df1) 3.84, p≤0.05

 # Yates's correction applied

The chi-square value given in Table 10 showed the association between RMC and selected Obstetrics profile. Data show that the chi-square value computed at df (1) between RMC and parity (0.008) is not significant at the 0.05 level because the computed chi-square value (0.008) is less than the table value (3.84). Thus, it can be interpreted that there is no significant association between RMC and Parity.

The chi-square value given in Table 10 showed the association between respectful maternity care received by the mothers and Gestational age during delivery. Data show that the chi-square value computed at df(1) between RMC and Gestational age during delivery (0.01) is not significant at the 0.05 level because the computed chi-square value (0.01) was less than the table value (3.84) at df(1).

DISCUSSION

Findings indicate moderate levels of respectful maternity care, consistent with similar studies.

The majority of mothers say that a birth companion is not allowed in the labour room. The health care provider does not take verbal consent and maintain privacy before any examination and procedure. But it is noted that the health care provider never separated babies without their consent, and they help the mother to breastfeed their babies within the first hours of life. Education and socio-economic status influence awareness and quality of care. Respectful maternity care needs strengthening through provider training and policy implementation to ensure respectful, dignified and equitable care during childbirth.

RECOMMENDATIONS

- A similar study can be conducted using a large population to generalise the findings.
- A similar study can be conducted in another setting and by using different assessment tools.
- A similar study can be undertaken by using different teaching methods regarding Respectful Maternity Care.
- Health care facilities must offer women privacy through use of curtains or partitions and allow her to choose her own support person/ birth attendant.
- Maternity staff nurses need to be valued and respected, and provided with adequate support, mentorship and training, which will enable them to provide respectful maternity care successfully.

CONCLUSION

Nurses and midwives need to learn how to respect women autonomy, dignity, empathy, and confidentiality, enable informed choice, and continue support during labour and childbirth. In-service training should be included in both pre and post registration education programmes. The findings suggest that the presence of caring attributes cannot be offered as a possible reason for care of mothers by nurses. It is crucial that nurses too develop skills so that they can provide safe and effective care for mothers and be able to maintain respect for mothers. This indicates partial adherence to the core principles of RMC, with significant gaps still existing in other components such as communication, informed consent, emotional support, and privacy. Mothers feel more comfortable and develop their satisfaction levels towards the health care provider and also towards the government.

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