https://doi.org/10.47811/bhj.50 **ORIGINAL ARTICLE**

Assess Knowledge, Attitude and Practices of Respectful Maternity Care among nurse midwives in Referral Hospitals of Bhutan

Sonam Deki[1], Jigme Choden[2]

[1]*Faculty of Nursing and Public Health, Khesar Gyalpo University of Medical Sciences of Bhutan, Thimphu, Bhutan*

[2]*Quality Assurance & Standardization Division, Jigme Dorji Wangchuck National Referral Hospital, Thimphu, Bhutan*

ABSTRACT

Introduction: Respectful Maternity Care (RMC) acknowledges that respects for woman's rights, choices and dignity during labor and childbirth is vital component of health care quality. This cross-sectional descriptive study intended to gain in-depth understanding on knowledge, attitude and practices of nurse midwives working in referral hospitals of Bhutan on RMC. The study also looked into determinants of RMC. **Methods:** The sample consisted of 83 nurse midwives who were working in birthing and maternity unit of three regional referral hospitals of Bhutan. The sites were chosen purposefully due to their high delivery volume. A survey instrument was piloted in Paro hospital prior to study. Data was collected from July to October 2017. Analysis was mainly descriptive, simple percentages were used to calculate frequency distribution of aspects and determinants of respectful maternity care. **Results**: Four in five of the respondents knew and practiced woman's right to information and communication during childbirth process. However, providers were found lacking on some aspects of the knowledge and practices related to respecting choices and rights of the women during childbirth and recounted their experiences of observing events which are described as abusive in maternal health literatures. Inadequate facilities, overworked staffs and limited trainings were found as detrimental factors. **Conclusions:** Aspects of RMC were not duly practiced. Providers must be made aware of the woman's right to respectful care which is crucial to improve maternal health services. Individual Health Facility must provide conducive environment to practice RMC. Future studies on RMC from receiver end are recommended.

Keywords: Care; Childbirth; Hospital; Labor; Maternity; Midwives; Respectful; Woman's right.

INTRODUCTION

The sustainable goal 3 brings attention towards improving the quality of maternity health services for the world's over 200 million childbearing women who deserve to be treated with respect and dignity during the labor and childbirth. For every woman worldwide, pregnancy and child birth are not only momentous events of their life but also a time of an intense vulnerability[1]. Growing evidence from both low and high resource countries suggest that the care women receive during labor and childbirth is sometimes rude, disrespectful, abusive and not responsive to their need[2]. Negative childbearing experiences remains with the woman throughout her life and deter from availing health facilities services for future birth[1]. Provider's attitude was the highest predictors in determining whether or not women deliver in facilities with skilled providers and it mattered more than the cost, distance, and lack of availability of free transport to the health facilities[3]. Disrespect and abuse of women seeking maternity care at the hands of care providers are becoming more urgent problems because they are violation of women's basic human rights[4].

Corresponding author:
Sonam Deki
sonamdeki@kgumsb.edu.bt

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. Although Bhutan has made significant progress in bringing down Maternal Mortality Ratio from 255 deaths per 100,000 live births in 2000 to 86 in 2012, the proportion of births attended by skilled health personnel in Bhutan still remain at 81% in the same year[5]. A broader focus on the part of care provider is required which encompasses not only death prevention but also inclusion of respectful maternal care and adherence to best practices with amiable attitude[4].

Nurse midwives play significant role in shaping the maternal health experiences of a woman in labor and child birth that would either empower and comfort the woman or inflict lasting damage and emotional trauma[6]. However, little is known about knowledge, attitude and practices (KAP) in relation to elements of respectful care. Respectful maternal care has neither been reflected in pre-service curriculum nor mentioned in any policy document. This study will be timely to find out about respectful maternity care in Bhutan. The study intends to gain in-depth understanding on KAP of nurse midwives working in referral hospitals on respectful maternity care based on seven rights charter of childbearing women developed by White Ribbon Alliance.

METHODS

Study design & sample

The study was approved by Research Ethics Board of Bhutan vide Protocol No. REBH/Approval/2017/031. The study design applied was cross sectional descriptive study which interviewed 83 nurse midwives working in birthing unit and providing maternity services to women in labor and childbirth of three regional referral hospitals: Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) in Thimphu, Central Regional Referral Hospital (CRRH) in Glephu and Eastern Regional Referral Hospital (ERRH) in Mongar. The study sites were chosen purposefully due to high delivery volume taking place in these hospitals every year (Annual Health Bulletin, 2015). The consent forms were made available both in English and Dzongkhag. Participants were explained that their participation was voluntary and can withdraw anytime, only those participants who gave written consent were included in the study.

Instrument & data collection

A survey instrument which has been reviewed by the expert in the field was adopted from the published report[7] The tool was modified to suite the study purpose and it was piloted in Paro hospital to 27 staff prior to conducting the study; most did not have difficulty understanding the question except two respondents who commented on the mode of choices and accordingly the tool was modified slightly for the final study. The tool was self-administered structure questionnaire with both open and closed ended questions to allow the respondents to write down their opinions freely. 83 nurse midwife from three above mentioned sites participated in the study. Data was collected from July to October 2017.

Analysis

The 83 nurse midwife who worked in the birthing and maternity wards of three regional referral hospitals constituted the study population. Analysis was largely descriptive, simple percentages were used to calculate frequency distribution of aspects and determinants of respectful maternity care.

RESULTS

Demographic characteristics of Participants

A total of 83 nurse-widwives from Birthing and Maternity ward across three regional referral hospitals of Mongar, Gelephu and Thimphu participated in the study. Most were permanent staff (78%), others were recruited on contract and from direct employment scheme. The providers were on average 28 years old and had four years of experience in conducting deliveries. Most providers have studied till diploma level (69%) while only 1 in 5 were (17%) degree holder. Slightly more than half (54%) of the nurse-widwives have been trained from India while most of the remaining were trained in Bhutan. Four in five (80%) providers responded that they haven't had professional development opportunities related to midwifery.

Knowledge, attitude and practice of Provider on RMC

Providers were assessed with 14 questions (Table 1) on two major aspects of respectful maternity care which assessed how the provider would interact with client during the initial client assessment and how choices and rights of the women were respected during the labor and childbirth.

The study found that nearly 80% of the providers were aware and upheld women's right to information, informed consent, confidentiality and privacy and supported women and family members in a friendly way during labor and child birth (Table 1 & 2). However, some aspects of RMC are not practices: women were very less likely allowed to adopt preferred birth position during the labor and instead were made to adopt position that suite providers. Only 2 of 5 providers said they allowed women to consume food or fluid during labor (Table 1).

Aspects of RMC

The study included tool to assess the intensity with which providers promoted the aspects of respectful maternity care in the health facility. The respondents were asked to rate aspects of RMC on a scale with 4 indicating action taken with greater intensity and 1 to lesser; and 0 indicating that the particular aspect of RMC has not taken place.

Women's right to information, confidentiality and privacy were applied in the health facility at greater intensity. Good practices such as mother-infant skin-to-skin contact, promoting breastfeeding on demand and encouraging mother and baby to be together were appreciably practiced with 93% of the providers responding that breastfeeding was initiated soon after birth and within the first hour after birth. Other aspects of RMC on appropriate use of technology and effective lifesaving interventions, a care which did not include harmful procedure and practices and prevention of institutional violence against women and new-born were also implemented notably by more than half of the respondents (Table 2).

Table 1. Providers' knowledge attitude and practice of RMC

Variables	Always (%)	Sometimes (%)	No (%)	Missing data (%)
Greeted women and family members when they came in labor	38 (45.8)	43 (51.8)	1 (1.2)	1 (1.2)
Allowed women in labor to have support person	81 (97.6)	1 (1.2)	0	1 (1.2)
Taking informed consent from woman to carry out procedure	63 (75.9)	16 (19.3)	3 (3.6)	1 (1.2)
Explaining about the procedures before proceeding	75 (90.4)	7 (8.4)	0	1 (1.2)
Informing the woman about the findings of the labor	72 (86.8)	10 (12.1)	0	1 (1.2)
Encouraged woman to ask questions about labor & childbirth	55 (66.3)	25 (30.1)	1 (1.2)	2 (2.4)
Explained to woman &family members on labor & childbirth	54 (65.1)	27 (32.5)	0	2 (2.4)
Providing privacy to woman in labor	81 (97.6)	1 (1.2)	0	1 (1.2)
Maintaining all information of woman in confidential manner	67 (80.7)	15 (18.1)	0	1 (1.2)
Involving women and her family members in decision making	69 (83.1)	11 (13.3)	2 (2.4)	1 (1.2)
Allowed woman to consume food and fluids during labor	33 (39.8)	41 (49.4)	8 (9.6)	1 (1.2)
Assisted woman in labor to have liberty of movement	41 (49.4)	38 (45.8)	2 (2.4)	2 (2.4)
Allowed woman to adopt positions she like during childbirth	20 (24.1)	53 (63.9)	9 (10.8)	1 (1.2)
Provided support to woman in friendly way during childbirth	70 (84.3)	11 (13.3)	1 (1.2)	1 (1.2)

Table 2. Aspect of RMC implemented with greater intensity

Aspects of Respectful care implemented with greater intensity	4 Freq. (%)	3 Freq. (%)	2 Freq. (%)	1 Freq. (%)	0 Freq. (%)	Missing data Freq. (%)
The right to information, confidentiality, and privacy	64 (77.1)	16 (19.3)	0	2 (2.4)	0	1 (1.2)
Contact of the new-born skin-to-skin with the mother immediately after the delivery for at least the first hour	58 (70)	15 (18.1)	7 (8.4)	3 (3.6)	0	0
Early breastfeeding (within the first hour after birth)	77 (92.8)	6 (7.2)	0	0	0	0
Keeping mother and baby together 24 hours a day	69 (83.1)	12 (14.5)	2 (2.4)	0	0	0
Promoting breastfeed on demand	69 (83.1)	8 (9.6)	3 (3.6)	1 (1.2)	0	2 (2.4)
Appropriate use of technology and effective lifesaving interventions	46 (55.4)	31 (37.4)	4 (4.8)	1 (1.2)	1 (1.2)	0
Provision of care that seeks to avoid potentially harmful procedures and practices	43 (51.8)	36 (43.4)	2 (2.4)	1 (1.2)	1 (1.2)	0
Prevention of institutional violence against women and new-born, including disrespectful care	52 (62.7)	22 (26.5)	5 (6)	1 (1.2)	2 (2.4)	1 (1.2)

Table 3. Aspect of RMC implemented with lower intensity

Aspects of Respectful care implemented with lower intensity	4 Freq. (%)	3 Freq. (%)	2 Freq. (%)	1 Freq. (%)	0 Freq. (%)	Missing data Freq. (%)
Evidence based care that enhances and optimizes the normal processes of pregnancy, birth and postpartum	39 (47)	34 (41)	7 (8.4)	1 (1.2)	0	2 (2.4)
Provision of drug-free comfort and pain relief methods during labor	27 (32.5)	25 (30.1)	23 (27.7)	4 (4.8)	3 (3.6)	1 (1.2)
Provision of continuous support during labor (i.e., lack of abandonment)	40 (48.2)	31 (37.4)	8 (9.6)	2 (2.4)	1 (1.2)	1 (1.2)
Choice of position for delivery	21 (25.3)	35 (42.2)	15 (18.1)	9 (10.8)	3 (3.6)	0
Appropriate use of technology and effective lifesaving interventions	46 (55.4)	31 (37.4)	4 (4.8)	1 (1.2)	1 (1.2)	0
Mutually respectful and collaborative relationship among all types of care providers	35 (42.2)	41 (49.4)	4 (4.8)	3 (3.6)	0	0
Avoidance of the overuse of drugs and technology(oxytocin augmentation, episiotomy, cesarean section, new-born blood gases, incubation, sonograms)	40 (48.2)	32 (38.6)	8 (9.6)	2 (2.4)	1 (1.2)	0

The other aspects of RMC which were practices poorly in the facility based childbirth were evidence based care that normalized process of pregnancy, birth and postpartum, providing drug free comfort and pain relief method during labour, lack of abandonment during labour, mutually respectful and collaborative relationship among all types of care providers and the least practiced was on the choices of preferred position for delivery by women (Table 3).

Determinants of RMC

The study analyzed determinants of RMC from provider's perspectives. It has been categorized into three groups: facility, providers and standards. 53% of the respondents said in their workplace, the infrastructure and equipment were not adequate for providing quality care to woman in labor and childbirth. The proportion was more (33%) from Mongar and Gelephu compared to Thimphu (20%).

In terms of adequacy of the staff, 74% of the respondents said they did not have adequate staff to provide maternity care to woman in labor and child birth: most wrote that the shifts are usually manned by only 3 staff and the nurse to patient ratio are 1:6 in the morning and 1:12 in the evening & night shift. The workload is huge and in some of the interviewed site, there is no separate birthing and maternity unit with having to multi-task and also take care of the new-born is too tasking for an individual. Many (89%) did not know if there were any policies or protocols in place for providing RMC. Nearly all the respondents (96%) said they need to have training on RMC. Some of the reasons are mentioned below:

Need training on RMC

- To gain knowledge and improve RMC practice
- RMC is new topic for us, we need to learn more about it.
- It will help in improving interpersonal communication between provider & women
- It will facilitate in developing polices and protocols for uniform practice of RMC
- It will deter provides from practicing disrespect and abuse

Table 4. Determinants of RMC

Variables	**Yes** Freq. (%)	**No** Freq. (%)	**Missing data** Freq. (%)
In your place of work, is the facility in terms of infrastructure and equipment adequate for providing quality care to woman in labour and childbirth?	32 (38.6)	44 (53)	7 (8.4)
In your place of work, do you think there is adequate staff to provide maternity care to woman in labour and childbirth?	22 (26.5)	61 (73.5)	0
Do you feel that you have support from doctors and seniors staff in provision of care to women in labour and childbirth?	82 (98.8)	1 (1.2)	0
Do you know if there are any policies or protocol in place for provision of respectful maternity care?	8 (9.6)	74 (89.2)	1 (1.2)
Do you feel that you need to have training on Respectful Maternity Care?	80 (96.4)	3 (3.6)	0

Polices and National Protocols

As described in table 4, 89% of the providers did not know if there are any policies or national protocols in place which require them to provide respectful maternity care. Providers were not aware about RMC. One respondent said:

"RMC is a new concept, I need to know more about it"

Physical and Verbal abuse

Providers were asked if they heard personally of staff being abusive to women during labor and childbirth. Among 83 respondents, 24% responded that they have heard of staff being abusive to women (Figure 1). Staff tend to get abusive in the situations when women is uncooperative and refuse to follow instructions which may cause risk to baby or when women complain of pain repeatedly and ask for frequent per-vaginal examination.

Providers described the abuse:

- In the past midwives shout and pinch mothers who were already exhausted. Instead of encouraging mother, they got annoyed and irritated.
- Staff make women adopt position that suite the staff and were rigid on fluid intake.
- While I was trainee, a nurse slapped woman on her thigh as she was not pushing and another staff on duty hit on patient's head and made woman lie on the bed.
- Being rude and hitting on woman's thigh is frequent experience for women in labor but after a child is born, women are happy and do not complain.
- Heard from women that they were spanked and talked rudely about their sex life.
- In the past we have seen right in front of us, staff using abusive words and disrespecting women in labor but now this has reduced by far.

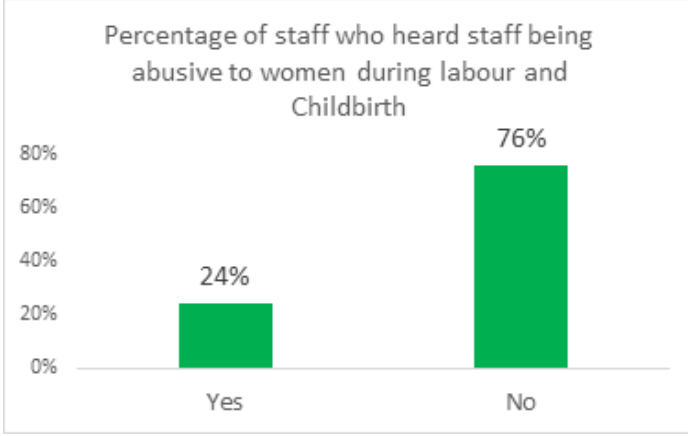

Figure 1. Providers heard of staff being abusive to women, 2017(*n*=83)

DISCUSSION

Only 1 in 4 providers allowed woman to adopt the preferred position of women during labor. Food and fluids are not allowed liberally and liberty of movements were restricted during labor. This deprives women rights to respect for their choices and preferences as per the White Ribbons Alliance's Respectful Maternity Care Charter which outlines seven universal rights of childbearing women. However, it is worth noting that nearly all providers allow women to have choice of companion during the labor. Providers also showed good knowledge of explaining procedure before proceeding, getting informed consent, maintaining privacy and confidentiality on the principle of respectful care.

Government initiatives and policies and procedures in place played a significant role in shaping provider's abilities to promote RMC in their work. For example, there are certain aspects of RMC which are implemented with greater intensity

such as mother-infant skin-to-skin contact, promoting breastfeeding on demand and encouraging mother and baby to be together were significantly practiced and almost all providers initiated breastfeeding soon after birth. This has been possible as a result of Ministry of Health's initiated programs like baby friendly health facility initiative, early essential newborn care and kangaroo mother care all of which highly promote the above practices. On the other hand nearly 90% of the providers did not know if there were any national policies and protocols in place that required the nurse midwives to provide RMC. It is fact that as of now there are neither polices and guidelines developed to support RMC practice nor rules and regulations that discourages disrespectful care. Hence, other components of RMC such as evidence based care that normalized process of pregnancy, birth and postpartum, providing drug free comfort and pain relief method during labor and lack of abandonment during labor are poorly practiced with the least being on the choices of preferred position for delivery.

Similarly, infrastructure and manpower support determined providers ability to practice RMC. Over half of the providers responded that they did not have adequate infrastructure and equipment in their work place to provide quality maternal care. It was concerning for all the providers that they were not provided with adequate staff to care the mother and newborn. The huge workload with multitasking compromised their time and effort for quality care. 96% of the providers said they require training on RMC. It is not because the provider do not want to care with respect but due to their lack of knowledge and skills on RMC and other quality aspects of structural and process limitation[8].

It is globally gaining recognition that disrespect and abuse of women during labor and childbirth is not only a violation of women's right but will also deter women from availing life-saving facility based maternity services[9]. Open ended questions that allowed providers to write in details were rich sources of information on abuse experiences faced by women in facility based childbirth. Considering the sensitivity of the question and less possibilities of the provider to admit that they have abused the women during labor and childbirth, instead they were asked if they personally observed or heard other staff abusing women. Our findings are consistent to other international study of patient's mistreatment in maternity services. Women during the labor are sometimes spanked, slapped and often shouted at mostly for their non-cooperation and when it posed risk to life of mother and baby are often reason cited for the unintended abuse[2].

STUDY LIMITATION

A limitation of our study is our data collection tool did not segregate three components of knowledge, attitude and practice. The questions were mixed but it contained all three aspects and this type of study is good way to measure health care delivery such as on RMC. Since the study sites included only referral hospitals, it may not be generalizable to all the health facility of Bhutan, however, with nearly 60% i.e. 6263 out of total 10718 facilities based delivery happening in the districts of 3 interviewed sites[5], the study is first of its kind and can give general perception of RMC across facility based delivery services.

CONCLUSIONS

Our findings suggest that RMC is relatively new for most of the providers and require urgent attention and promotion among the providers working in the facility based child birth to improve quality of maternal health services. A collaboration and dialogue is required among all the stakeholders to provide conducive environment to practice RMC. A curriculum on RMC is suggested in midwifery course. Health facilities should develop standards and protocols supporting RMC. Future studies from receiver end is also recommended for wider understanding of RMC practices across health centers which provide emergency obstetrics care in all 20 districts of Bhutan.

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AUTHORS CONTRIBUTION

Following authors have made substantial contributions to the manuscript as under:

SD: Concept, design, data collection and analysis, manuscript writing and review.

JC: Concept, design, data collection and analysis, manuscript review.

Author agree to be accountable for all respects of the work in ensuring that questions related to the accuracy and integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST

None

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