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Women's Views and Experience of Respectful Maternity Care While Delivering in Three Regional Referral Hospitals of Bhutan

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Abstract

Background: Labor and childbirth represent one of the most vulnerable period in women's life and ensuring the quality of care with respectful during labour and childbirth still remains challenging. There are activities to promote respect for women's right, including respect for their autonomy, dignity; feelings, choices and preference however, little has been known about the elements of respectful care provided to women during labour and childbirth in health facilities. Respectful maternity care (RMC) is been neither reflected in pre-service curriculum nor mentioned in any policy document.

Objectives: The purpose of the study is to explore the attitudes, views, behaviors and emotional experience by women related to labour and childbirth and to describe women's satisfaction with RMC during the process in three regional hospitals of Bhutan.

Methods: The study is Cross-sectional study with the sample size of 426 from Jigme Dorji Wangchuk National Referral Hospital (JDWNRH) in Thimphu, Central Regional Referral Hospital (CRRH) in Gelephu and Eastern Regional Referral Hospital (ERRH) in Mongar. All women who delivered in November - December 2018 were included in the study until we got the required sample. The structured questionnaire used from survey (8 &10) and relevant literature sources were reviewed, finalized in our setting and was piloted in Bajo Hospital after approved by Research Ethics Board of Health (REBH). Descriptive analysis done and all the information gathered presented in the form of frequencies, percentages and number for categorical variables. Regression analysis shows the scientific significance in foul language (0.033) and scolding (0.020).

Results: Women had dreadful experiences. Overall satisfaction is excellent but views on the services still needs to improve on lack of communication, right for information and permission, dignity and privacy for the women because these are necessary for the service providers to provide to the women undergoing labour and childbirth.

Conclusion: There is need to improve on communication for information, permission, and policy for dignity and privacy for the women. Need to include in the pre-service curriculum for nurses and health workers and to provide in-service education on RMC to all health personnel providing maternity services.

Keywords: Childbirth; Women; Maternity care; Bhutan

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Abbreviations: RMC: Respectful Maternity Care; JDWNRH: Jigme Dorji Wangchuk National Referral Hospital; ERRH: Eastern Regional Referral Hospital; REBH: Research Ethics Board of Health; SPSS: Statistical Package for Social Sciences.

Introduction

Labor and childbirth represent one of the most vulnerable period in women's life and ensuring the quality of care with respectful during labour and child birth still remains challenging. There are activities to promote respect for women's right, including respect for their autonomy, dignity, feelings, choices and preference however, little is known about the elements of respectful care provided to women during labour and childbirth in health facilities. Respectful maternity cares are been neither reflected in pre-service curriculum nor mentioned in any policy document. This study will be timely to find out about respectful maternity care for women in Bhutan. The study intends to gain in-depth understanding of RMC from the perspective from women during labour and childbirth in referral hospitals. Generally, women were encouraged to choose to give birth in health care facilities to ensure proper skilled health care professionals but disrespectful and undignified care is prevalent in many facility settings particularly for under privileged, which will not guarantee good quality care and negative childbearing experiences remains with the woman throughout her life [1].

Statement of the problem

The purpose of the study is to find the views and experiences by women on aspect of respectful maternity care during their labour and childbirth in three regional hospitals of Bhutan, to explore the attitudes, views, behaviors and emotional experiences by women related to labour and childbirth and to describe women's satisfaction with RMC during their labour and childbirth. This study aims to find out the experiences of women about all these aspects while availing the maternity services during the time of labor and childbirth in the three regional namely JDWNRH at Thimphu, ERRH in Monger and CRRH of Gelephu. It also aims to explore about the delivery of the RMC based on the seven rights charter of white Ribbon Alliance [2,4,5] which unites citizens to demand the right to a safe labour and childbirth for every woman, everywhere. This study will be timely to find out about respectful maternity care in Bhutan from consumer perspective, help in informing decision and policy makers to come up with appropriate strategies and program related to RMC for both the care provider and for the consumers.

Literature review

The sustainable goal 3 which is to ensure healthy lives and promote well-being for all woman at all ages brings attention towards improving the quality of maternity health services for the world's over 200 million childbearing women who want and deserve to be treated with respect and dignity during the time of labour and childbirth. It is also a time of an intense vulnerability apart from momentous events of their life. Women who receive mistreatment during childbirth are also less likely to return to health facilities for future birth [1,4,6].

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 needs. It also shows that quality of care received at the facility-based maternity services is not optimal and often lacking in the element of respectful maternity care. There are also seven categories of disrespect and abuse in childbirth identified: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes abandonment of care, and detention in facilities [3,4,7].

One of the important components of maternal health care quality is the women's experience of childbirth and that their feelings, dignity and preferences must be respected [4,5,9]. 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 [2,5,8]. While concerted efforts have been put in globally to remove barriers against accessing skilled birth attendance, studies have suggested that disrespect and abuse that woman often encountered in facility based maternity care are more potential deterrent to skilled birth care utilization than the usually recognized ones such as financial and geographical obstacles [7,10,11].

A recent population based study in Tanzania by Kruk and colleagues showed that provider's attitude was the highest predictors in determining whether or not women deliver in facilities with skilled providers [5,6,11]. Providers' attitude mattered more than the cost, distance, and lack of availability of free transport to the health facilities [4,7,12]. Disrespect and abuse of women seeking maternity care at the hands of care providers are becoming more problems that are urgent because they are the violation of women's basic human rights [3,5,9]. A broader focus on the part of care provider is required, which encompasses not only death prevention but also

inclusion of respectful maternity care and adherence to best practices with amiable attitude for women to have better experience during labour and childbirth [6,9].

This study intends to gain in-depth understanding on views and experience of women in receiving respectful maternity care based on seven rights charter of childbearing women developed by White Ribbon Alliance during labour and childbirth while delivering in health facilities of Bhutan, which unites citizens to demand the right to a safe birth for every woman, everywhere [5,7]. To promote RMC, White Ribbon alliance facilitated development of rights charter which includes seven rights of childbearing women which were drawn from the categories of disrespect and abuse that have been identified by researchers Bowser and Hill in 2010 [3,4,6]. While concerted efforts have been put in globally to remove barriers against accessing skilled birth attendance, studies have suggested that disrespect and abuse that woman often encountered in facility based maternity care are more potential deterrent to skilled birth care utilization than the usually recognized ones such as financial and geographical obstacles [2,5,9].

Although Bhutan has made significant progress in bringing down Maternal Mortality Ratio from 560 deaths per 100,000 live births in 1990 to 86 in 2012, the proportion of births attended by skilled health personnel in Bhutan has been only 74.6% in the same year 2016 [1,8]. The seven rights of all woman while in labour and during the time of delivery are; right to be free from ill-treatment and harm; right to information, informed consent, refusal and respect for choices and preferences including companionship during maternity care. It also includes the right to privacy and confidentiality; right to be treated with dignity and respect; right to equitable care; right to highest attainable level of healthcare and right to liberty autonomy, self-determination and freedom from coercion [2,4,5].

Amongst the care providers, nurse midwives play significant role in shaping the maternal health experiences of a woman from the ways in which maternity services to mothers and their babies are provided that would either empower and comfort the woman or inflict lasting damage and emotional trauma [8,11,12]. Nurse midwives play important role during the labour and childbirth process, however, little is known on the concept of respectful maternity care (RMC) among these professional group while delivering the care to women during labour and childbirth [4,9,11]. There are no studies done in Bhutan on RMC among the women undergoing labour and childbirth. Therefore this is a timely study to assess the RMC from the perspective of consumers' women and their family members as study had already been carried out on care providers especially among nurse midwives [8].

Methods

Study type, place and time

The study is Cross-sectional study with the sample size of 426 from JDWNRH in Thimphu, CRRH in Gelephu and ERRH in Mongar from November to December 2018.

Description of study variables, study subjects and grouping

Study done on demographic profile, experiences on labor on childbirth, experiences on vaginal examination, scolding, episiotomy, physical abuse, verbal abuse, effects of attitude, views, behaviors, emotional experiences, and the satisfaction rate of RMC. The study sites are chosen purposefully as there is high delivery volume taking place in these hospitals every year. Moreover, there is separate birthing unit in these hospitals where nurse midwives are assigned in birthing unit to provide maternity care to the pregnant women in labour and childbirth.

Selection criteria

Inclusion criteria

- All eligible women who had delivered in these three regional referral hospitals to the study in between October to December 2018.
- Women of childbearing age, who had normal vaginal birth in these three regional referral Hospitals during the period of data collection.
- Women who are unwell and had severe postpartum hemorrhage and eclampsia.

(We had option for women who had PPH, eclampsia, and operative vaginal birth if they were in the state and willing to participate in the study).

Exclusion criteria: Women who had undergone caesarean section (either elective or emergency cesarean, who had not undergone complete process of labour and delivery. We can still include women who had PPH, eclampsia, an operative vaginal birth and caesarean section if they are willing to participate.

Instrument and data collection

The structured questionnaire used from survey and relevant literature sources were reviewed, finalized in our setting and was piloted in Bajo Hospital after approved by Research Ethics Board of Health (REBH). All women who delivered in November - December 2018 were included in

the study until we had the required sample were achieved from JDWNRH in Thimphu, CRRH in Gelephu and ERRH in Mongar. The tool was in depth interview questionnaire with both open and closed ended questions to allow the women to express freely of their opinions.

Ethical consideration

The study conducted after getting approval from REBH. The consent form was developing in both English and Dzongkha and explained to the participants for the purpose of the study. As participation for the study was on voluntary basis, women had the right to participate or not to participate. We obtained administrative clearance from Ministry of Health and from JDWNRH, ERRH and CRRH to conduct the study.

Sample size calculation

Margin of Error (Confidence Interval) - the confidence interval to determine how much higher or lower than the population mean we are willing to let our sample mean fall is **+/- 5%.**

Confidence Level - we will take 95% confidence that the actual mean falls within our confidence interval.
Standard of Deviation - we had taken the most for giving number in order to ensures that our sample will be large enough i.e 0.5.

Therefore the necessary sample size 'n' was:
n = *(Z-score) 2 * StdDev*(1-StdDev) / (margin of error) 2* ((1.96) 2x.5 (.5)) / (.05) 2 (3.8416 x .25) / .0025 .9604 / .0025 384.16 n = 385 respondents were needed and considering for non-respondent rate of 10% the actual sample size required was n = 424 women who delivered in the three regional hospitals of Bhutan.

Data collection Strategy

Using a structured questionnaire, women were interviewed in a private and quiet place. Structured questionnaire was adapted and used from Survey Report [8,10], and relevant sources which was pilot tested for its reliability. Interview were done for women who had delivered after 6 hours of delivery and during postnatal period (42 days) which was expected to take not more than 30 minutes. Most of the time women who had delivered were rested and recovered from pain and they were in the state to talk and give information after 6 hours. Interviewing was considered an appropriate method in collecting data for this study due to women's differing literacy levels.

Sample Selection

The total number of women who availed the delivery services in three regional hospitals JDWNRH, CRRH, ERRH for one year is as in the Table below

Delivery number for one year =4653	JDWNRH	Delivery number for one year = 710	Mongar	Delivery number for one year = 1300	Gelephu
Jan	300	Jan	38	Jan	72
Feb	281	Feb	25	Feb	50
March	308	March	27	March	51
April	254	April	34	April	52
May	270	May	35	May	70
June	265	June	34	June	70
July	300	July	42	July	66
August	225	August	41	August	98
September	279	September	33	September	92
October	284	October	41	October	76
November	276	November	37	November	94
December	238	December	47	December	102
	3280		**434**		**893**
		General Total			
		4607			
		424			
	71%		10%		19%
	301		**43**		**80**

Keeping in mind the delivery number, percentage for different hospital were calculated and from there, all the women fulfilling the inclusion criteria within that period of data collection were included. All women who deliver in November - December 2018 were included in the study until we got the required sample.

Instrument

The structured questionnaire used from survey and relevant literature sources were reviewed, finalized in our setting and was piloted in Bajo Hospital after approved by REBH.

Statistical Methods

Four hundred twenty six women who visited the three regional referral hospitals within the time framed in November – December to avail the services were included for the study. The analysis part is in line with the objectives of the study by using SPSS 20 and the information gathered from the study that are presented in the form of frequencies, percentages. Regression analyses are done to extract the factors associated with delivery of respectful maternity care and of statistical significance.

All the statistical analysis was performed using statistical package for social sciences (SPSS) software version 22. Descriptive analysis was undertaken and the information from this are presented in the form of frequencies, percentages and number for categorical variables. The most applicable regressions analyses is done to examine factors associated with delivery of respectful maternity care and a two sided p-value of <0.05 will be regarded as indicating statistical significance.

7.1. Informed consent forms

Only those participants who had agreed to participate and signed the informed consent were included and interviewed for the study. Every questionnaire, different codes are use before interviewing the women to ensure participant's confidentiality. The researchers will securely store the consent forms and the questionnaires that had details of the participants for five years. The study also includes informed consent forms duly signed by women to participate in the study.

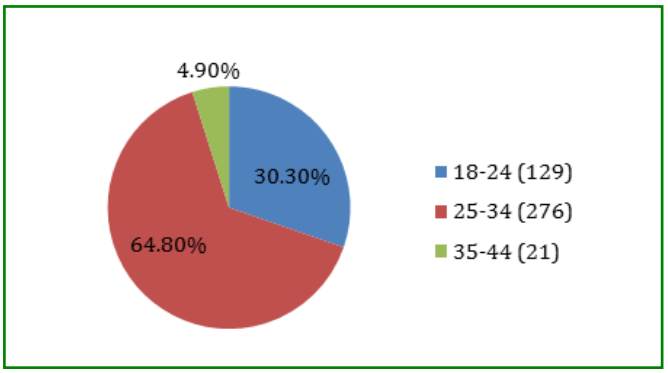
Analysis

Sample size of 426 from JDWNRH in Thimphu, CRRH in Gelephu and ERRH in Mongar were collected and a descriptive analysis were undertaken and the information are presented in the form of frequencies, percentages and number for categorical variables.

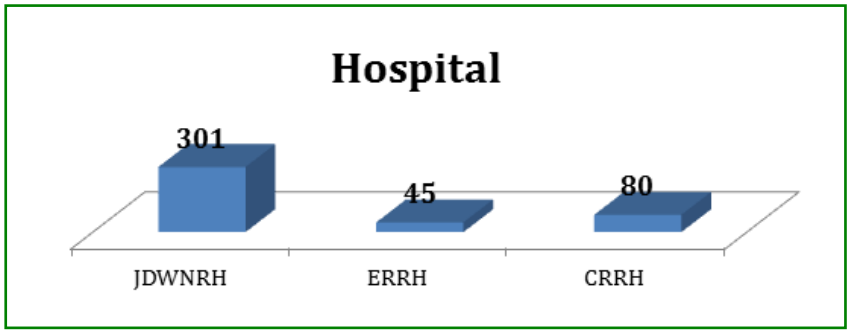
Results

Demographic profile of the participants

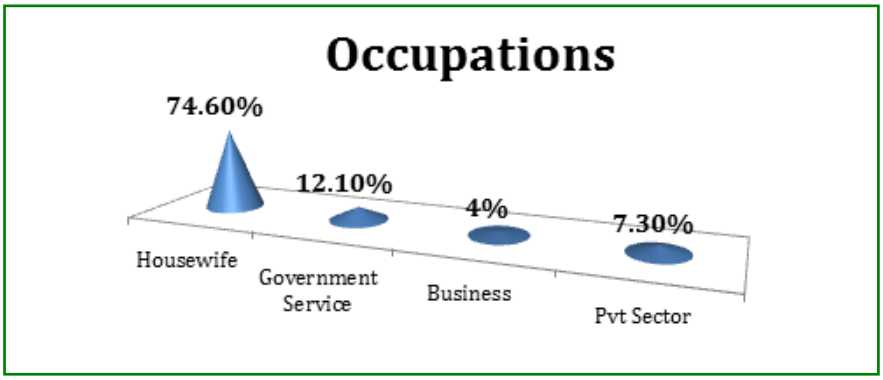
Question on age of the woman participating in the study was included to find out the minimum, maximum and mean age of women participating in the study. Minimum age was 18 years, maximum age was 44 years and mean age was 27.37. Separating the age group into three groups, following were the findings of different age groups, age in between 25 - 34 years was (64.80%), 18 - 24 years was (30.30%) and 35 - 44 years was (4.90%) respectively.

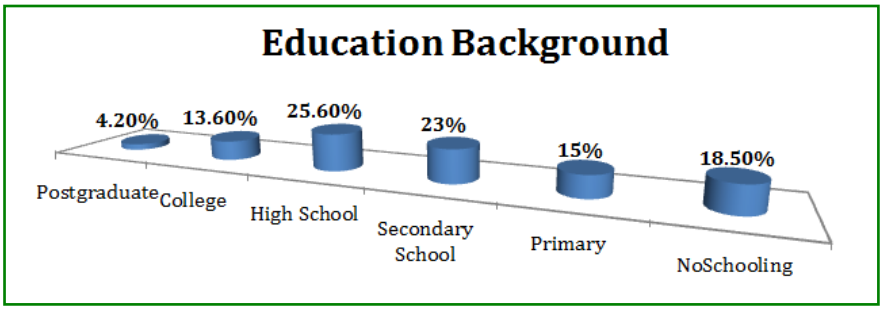


According to the number of women receiving the services in these three hospitals, we obtain the sample to be collected from each regional hospital were, from JDWNRH (70.7%), from ERRH (10.6%) and from CRRH (18.8%). The highest was from JDWNRH, followed by CRRH and the least was from ERRH.



Occupation wise, majority of the women in the study was house-wives 74.60%, government service were 12.10%, private sectors were 7.30% and business was 4%.





Experiences of labour and childbirth

Expression on women's experiences on labour and childbirth, dreadful experience was the highest 41.8% and only 4% had wonderful experience from 426 women. We had women who had unpleasant experience 18.10%, pleasant experience 10.10% and okey 26.80% with labour and childbirth experiences (Figure 1).

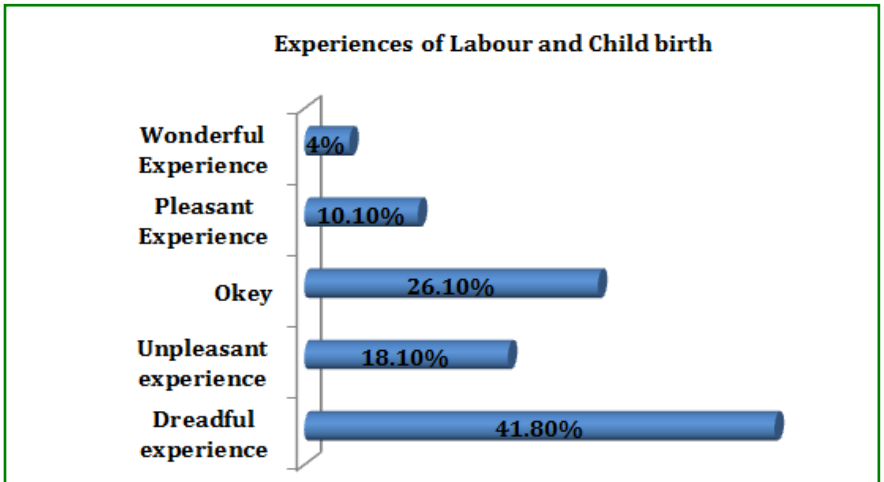


Figure 1: Overall experiences of labour and childbirth

Women's experience on vaginal examination

The study included the question on seeking permission to perform vaginal examination, 88.7% women was asked permission but there were 0.6% who were not asked permission and 0.7% did not response to the question (Table 1).

Variables	Number (%)		
	Yes	No	No Response
Seek Permission during vaginal examination	378(88.7%)	45 (10.6%)	3 (0.7%)
Preferred not to have them	69	16.2%	
I did not mind	92	21.6%	
Found helpful (information about progress of labour)	264	62%	
No Response	1	(0.6%)	

Table 1: Women's Experience on Vaginal examination (n = 426).

Women's experience on scolding and episiotomy

Two hundred seventy seven women answered that they made noise and shouted during labour and childbirth and hundred sixty-six women had pushed before time. Women got scolding for making noise and pushing before time. Though the number is not significantly high, we do have women who experienced scolding during the time of labor and childbirth (Table 2).

Variables	Number (%)			
	Yes	No	No Response	n
Scolded for making noise and shouting	22 (7.9%)	255 (92.1%)	-	277
Scolded for pushing before time	16 (9.6%)	150(90.4%)	-	166
Explained about episiotomy	68(63.6%)	36(33.6%)	3 (2.8%)	107

Table 2: Women's Experience on scolding and episiotomy

One hundred seven women in the study had received episiotomy during delivery time. It was found out that some women in the study received explanation about the episiotomy procedure and some women did not received any explanation about the episiotomy procedure. This clearly shows there is lack of communication, the right to information, right for consent for episiotomy procedures around the time of childbirth for women in labour and childbirth. It also indicates that the practice of episiotomy without woman's notification or consent is taking place.

Physical and verbal abuse

Regression analysis shows the scientific significance in use of foul language 0.033 and scolding 0.020%. Some women in the study experienced physical and verbal abuse during the time of their labour and childbirth.

Regression analysis - Use of Foul language during labour and childbirth.

Foul language ANOVA[b]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.305	1	1.305	4.560	.033[a]
	Residual	121.315	424	.286		
	Total	122.620	425			
Scold ANOVA[b]						
Model		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
1	Regression	4.193	1	4.193	5.480	.020[a]
	Residual	324.438	424	.765		
	Total	328.631	425			
a. Predictors: (Constant), Age Range						
b. Dependent Variable: Q15b						

Attitude

Greet in respectful manner. Yes = 368 (86%) had been greeted, but No = 58 (13.6%) were not greeted, Communication

Views

Respect for beliefs, tradition and culture. Yes 372 (87.3%), No 10 (2.3%) and No response 44 (10.3%), Discrimination.

Right to information about confidentiality and privacy. Yes 425 (99.8%) and No1 (0.2%), Communication

Behaviors

Explained about procedure before proceeding. Yes 402 (94.4%), No 21 (4.9%) and No response 3 (0.7%). **Communication:** Informed women the findings. Yes 422 (99.1%), No 3 (0.7%) and No response 1 (0.2%). **Communication:** Privacy during labour and childbirth. Yes 422 (99.1%), No 1 (0.1%) and No response 3 (0.7%).

Dignity: Explained about what will happen during labour. Yes 378 (88.7%), No 45 (10.6%) and No response 3 (0.7%).

Communication: Support women in friendly way during labour. Yes 419 (98.4%), No 5 (1.2%) and No response 2 (0.5%).

Dignity: Provide drapes before delivery. Yes 414 (97.2%), No 7 (1.6%) and No response 5 (1.2%).

Dignity: Through interview, it shows that physical and verbal abuse occurred with the women, even though the number is not high, but women had experienced scolding (75.8%) which is higher than beat with hand or instrument (2.3%), Pinch on their thigh (1.6%), Use of Foul language (0.9%). Physical and verbal abuse Scolding **(0.02)** and Foul language (verbal abuse) **(0.033)** which is significant (Table 3).

Variables	Yes	No	No Response
Greet in respectful manner	368(86%)	58 (13.6%)	-
Respect for beliefs, tradition and culture	372 (87.3%)	10 (2.3%)	44 (10.3%)
Encourage women to have support person during labour	410 (96.2%)	11 (2.6%)	5 (1.2%)
Provision of continuous support during labour	410(96.2%)	12(2.8%)	4 (0.9%)
Encourage women to have support person during delivery	420(98.6%)	4 (0.9%)	2 (0.5%)
Explained procedure before proceeding	402 (94.4%)	21 (4.9%)	3 (0.7%)
Informed women the findings	422 (99.1%)	3 (0.7%)	1 (0.2%)
Encourage the women to ask questions about her labour and childbirth	313 (73.5%)	11 (26.1%)	2 (0.5%)
Privacy during labour and child birth	422(99.1%)	1 (0.1%)	3 (0.7%)
Right to information about confidentiality and privacy	425 (99.8%)	1 (0.2%)	-
Explained about what will happen during labour	378 (88.7%)	45 (10.6%)	3 (0.7%)
Support women in friendly way during labour	419 (98.4%)	5 (1.2%)	2 (0.5%)
Provide drapes before delivery	414 (97.2%)	7 (1.6%)	5 (1.2%)
Institutional violence against women-Scolding	323 (75.8%)	102 (23.9%)	1 (0.2%)
Beat with hand or instrument	10 (2.3%)	413 (96.9%)	3 (0.7%)
Pinch on their thigh	7 (1.6%)	416 (97.7%)	3 (0.7%)
Use Foul language	4 (0.9%)	419 (98.4%)	903 (0.7%)
Encourage or advice to drink during labour	275(64.6%)	151 (35.4%)	-
Encourage or advice to eat during labour	113 (26.5%)	313 (73.5%)	-

Table 3: Affects of attitude, views, behaviors and emotional experiences of women related to labour and childbirth. (n=426)

Emotional

Encourage women to have support person during labour and childbirth. Yes 410 (96.2%), No 11 (2.6%) and No response 5 (1.2%). Dignity

Provision of continuous support during labour and childbirth. Yes 410 (96.2%), No 12 (2.8%) and No response 4 (0.9%). Dignity

Encourage women to have support person during delivery and childbirth. Yes 420 (98.6%), No 4 (0.9%) and No response 2 (0.5%). Dignity

Encourage the women to ask questions about her labour and childbirth. Yes 313 (73.5%), No 11 (26.1%) and No response 2 (0.5%). Communication

Women's view to have nurse midwife to be present during labor (n = 426)

Women should be encouraged to express their views freely, even when they differ from service providers' views. They prefer to have health professional present during labor during entire process or as much as possible (37.1%). We do have women who also responded to have only when necessary (25.8%) but preferable it is better to have the midwife nurses to be near the patient during the labour and childbirth.

The Satisfaction rate of RMC during their labour and childbirth

Generally, overall Satisfaction among women is excellent (37.1%), although few had mixed feeling (9.2%), rather unsatisfactory (1.9%) and unsatisfactory (0.5%) (Figure 2).

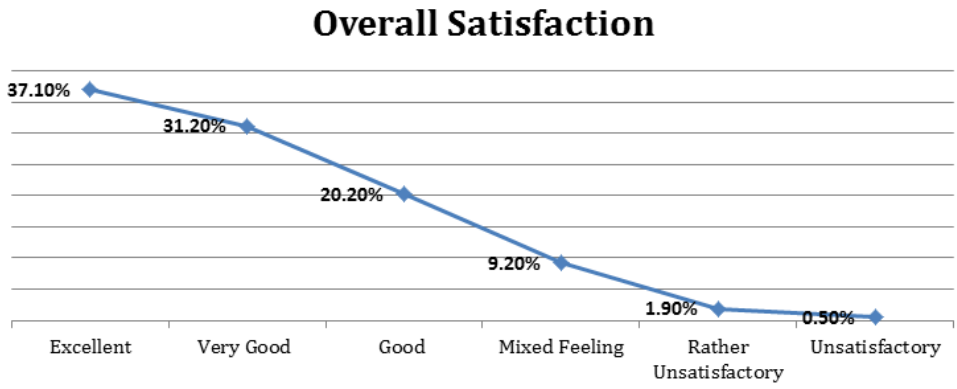


Figure 2: The Satisfaction rate of RMC during their labour and child birth. (n=426).

Discussion

From the diagram though many women who availed the service are educated, majority of them are housewife (74.60%), 12.10% are government service, 7.30% are in private sector and 4% got business to run. The study included the permission for vaginal examination, 88.7% women were asked permission but there are 10.6% who were not asked permission and 0.7% did not response for the permission which indicates that it is another lack of communication, the right for information, privacy, dignity and respect for the women [4,5,7]. Two hundred seventy seven women in the study made noise and shouted during labour and childbirth and one hundred sixty six women had pushed before the time. These women got scolded for making noise and pushing before time. Though the number is not significantly high, we do have women who experienced scolding (0.02) during the labour and childbirth [8,9,12]. One hundred seven women received episiotomy during delivery time. Within those women, some women were explained about the episiotomy procedure and for some women were not explained about the procedure.

There are lack of communication, the right for information, right for consent for common procedures around the time of labour and childbirth, which indicates the practice of episiotomy without patient notification or consent [3,5,6]. Through interview it was found that physical and verbal abuse occurred with the women though the number is not significally high, but women had experienced. Scolding (75.8%) which is higher than beat with hand or instrument (2.3%), Pinch on their thigh (1.6%), Use of Foul language (0.9%). Women should be encouraged to express their views freely, even when they differ from service providers' views [4,6,10]. They prefer to have health professional present during labor during entire process or as much as possible (37.1%). We do have women who also responded to have only when necessary (25.8%) but preferable to have at all times will be better to have the midwife nurses to be near the patient during the labour and childbirth [5,11,12]. Given the choice of experiences, dreadful experience is the highest (41.8%) and only 4% had wonderful experience among 426 women. We do have women who had unpleasant experience with labour and childbirth and there are women who were okey with the experiences [3,4,6].

Generally, overall satisfaction among women is excellent (37.1%), few had mixed feeling (9.2%), rather unsatisfactory (1.9%) and unsatisfactory (0.5%). Women

view on health professional to be present during the labour and childbirth; they preferred to have them during entire process or as much as possible, which indicates the value of presence of midwife during the entire process [5,11,12].

Conclusion

In the findings, women had dreadful experiences, overall satisfaction is excellent but views on the services still needs to improve on lack of communication, right for information and permission, dignity and privacy for the women because these are necessary for the services provider to provide to the women who are in labour and childbirth.

Recommendations

There is need to improve the communication skills by the health care provider for information, permission, and policy for dignity and privacy for the women.
To include RMC topic in the preservice curriculum for nurses and health workers.
To provide in-service education on RMC to create awareness among health care providers to enhance RMC for women receiving maternity care during labour and childbirth.

Acknowledgment

We would like to thank all the women, who agreed to participate in the study, the staff from the three regional referral hospital in collecting the data, the funding agency UNFPA and REBH for approving the study to conduct.

Limitation of the study

Owing to the limited time and resources, the researchers administered survey questions only to the woman which is expected not to take more than 30 minutes. There were some women who were reluctant to respond to the questions.

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