

Implementation of RMC at Tertiary Care Centre in South India

Papa Dasari^{1*} and Mahalakshmy Thulasingam²

¹Department of Obstetrics and Gynaecology, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India

²Department of Preventive and Social Medicine, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India

Corresponding Author*

Papa Dasari,
Department of Obstetrics and Gynaecology,
Jawaharlal Institute of Postgraduate Medical Education and Research,
Puducherry, India
E-mail: dasaripapa@gmail.com

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Received: 03-Aug-2021, Manuscript No. JBTW-21-38929; **Editor assigned:** 06-Aug-2021, PreQC No. JBTW-21-38929(PQ); **Reviewed:** 20-Aug-2021, QC No. JBTW-21-38929; **Revised:** 25-Aug-2021, Manuscript No. JBTW-21-38929(R); **Published:** 03-Sep-2021, DOI:10.35248/2322-3308-11.1.004.

Abstract

Background: Disrespect and abuse experienced during child birth has been reported by women to various sections of health care workers. The objective was to abolish Disrespect and Abuse and to bring about a policy change in labour room practices and to implement Respectful Maternity Care (RMC) in a high volume tertiary care teaching hospital in South India.

Methods: A Workshop and Continuous Medical Education Programme involving RMC experts was conducted in Phase I with defined objectives. These targeted health care workers were nurses, resident doctors, consultants, medical nursing students involved in giving care during pregnancy and labour. In Phase II the Govt. of India Policy on Birth Companion was presented in meeting discussing on the National guidelines of "LaQshya". Consent forms for birth companion were introduced and a dedicated public health nurse was trained to train the birth companions regarding their role in maternal support. The change of policy was officially intimated to the hospital administration. A qualitative assessment was done whether the Residents and Nurses practiced RMC as demonstrated in the Workshop. The operationalization of the birth companion policy was followed on daily observations, enquiries and onsite surprise visits over one year period.

Results: The practice of RMC was followed only by few health care workers and certain cadre of women who laboured, received RMC and disrespect and abuse still prevailed. The bottle necks identified were low socioeconomic status of women, the in-charge consultants not insisting on presence of birth companions, the residents and nurses not promoting birth companion policy.

Conclusion: Implementation of Respectful Maternity Care needs change of attitudes of personnel who render care during child birth and it can only be successful unless it forms an integral part of Medical and Nursing curriculum.

Keywords: Disrespect and abuse • LaQshya • Birth companion • Training

Introduction

IRMC is treating a woman with dignity throughout her pregnancy, birth and the period following childbirth. It respects her rights and choices through supportive communication, actions and attitudes. Concept of "safe motherhood" only talks about physical safety, reducing morbidity and mortality. Quality care must include respectful maternity care in its core because memories of their childbearing always stay lifelong with women and they also often share it with other women. It has been the practice not to allow birth companion in Govt. hospitals across the country including Tertiary care teaching hospitals.

Disrespect and abuse of women in labour and delivery has been widely reported in the World across all cultures and India also [1]. Studies from India reported one or all 7 forms of abuse: Physical, verbal abuse non-consented care, non-confidential care, non-dignified care, discrimination based on specific attributes, abandonment or denial of care and detention in facilities. The prevalence of disrespect and abuse reported was as high as 57% [2-6]. The WHO Intrapartum guidelines of 2018 emphasises the realistic approach to a woman in labour and targets national and local public health policy-makers, implementers and managers of maternal and child health programmes, health care facility managers, Non-Governmental Organizations (NGOs), professional societies involved in the planning and management of maternal and child health services, health care professionals (including nurses, midwives, general medical practitioners and obstetricians) and academic staff involved [7].

The Government of India has recognized the need for RMC and given guidelines in provision of RMC (NHSRC) [8]. But in practice RMC is not provided at all hospitals or very poorly provided. Provision of Respectful maternity care is characterized by, caring, empathy, support, trust, confidence and empowerment as well as gentle, respectful and effective communication which will help women in making informed choices. It will build up climate of confidence between women and maternity care providers and maternity care system. There are many studies which proved the presence of birth companion results in decrease caesarean section rates, improved maternal satisfaction and promote mother and child bonding [9]. Disrespect and abuse has been reported by personal complaints to the unit heads, head of the departments and other administrators high in hierarchy by email or written complaints in our Institute. Hence this the objectives of the programme was 1) to clarify what exactly is RMC; 2) to enlighten regarding RMC and its incorporation as per the Govt. of India, Family Welfare, Ministry of Health Guidelines; 3) to promote RMC among various Health care workers practicing/caring for women during Pregnancy, Labour and Postpartum; 4) to create awareness regarding standards of measuring RMC; 5) to implement standards of RMC in the Department of Obstetrics and Gynaecology, WCH, JIPMER, Puducherry, India, a Tertiary care teaching hospital.

Methodology

Setting

Implementation of the respectful maternity care was conducted in JIPMER, a teaching medical college with a bed capacity of 2143 inpatient beds with 210 ICU beds. The institute is an autonomous institute and is designated as an institute of national importance and is situated in Puducherry a Union Territory, India. Maternity care services are provided in 'Women and Child Hospital (WCH) Block' by Department of Obstetrics and Gynecology. Around 15,000 deliveries are conducted in the institute per year. The hospital is a major referral center in Puducherry and adjoining areas of Tamil Nadu. The WCH block is equipped with state-of-the-art facilities for management of high-risk pregnancy and complications [10]. The efforts taken in the institute for implementation of respectful maternity care was done in phases in the institute as described below. The two day programme schedule was circulated to the participants a week in advance.

Phase I: Workshop and CME on respectful maternity care

To start with an orientation and training of the health care workers on RMC a Workshop was planned 6 months prior. Dr. Evita Fernandez, Managing Director of Fernandez Hospital and Senior Consultant Obstetrician at Stork Home [11]. RMC expert along with one of her mid-wives Ms. Inde Kaur were

2 of the National resource persons. The expert in the field had real-time experience in implementing RMC in their health facility for more than a decade. They have also conducted many nationwide workshops on RMC. The programme aimed to enhance knowledge and transform attitude on RMC of Health Care. The two day programme schedule (Annexure-I) was circulated to the participants a week in advance.

Day 1 (6-10-2018): In the department of Obstetrics and Gynecology, Onsite demonstration of use of various natural pain relief methods like deep breathing exercises, use of ball and maternal support and care which can be given by health care workers and birth companion were demonstrated by Ms. Indie Kaur. Various birthing positions that promote easy delivery were demonstrated by Dr. Fernandez. This was followed by a gathering of all nurses, residents and faculty of the department where the onsite demonstrations were reinforced by a talk. Nurses from the wards caring for pregnant women such as antenatal, postnatal wards, NICU, labour rooms, Casualty (Emergency Obstetric services) participated in the live session. To encourage the participants and to boost their involvement in RMC, all of them were honoured with a Memento received from the chief guests (Dr. Fernandez and Ms. Indie Kaur).

Day 2 (7-10-2018): The program was conducted in the institute in Collaboration with Nursing College, JIPMER Quality Council, and Service Nurses. Obstetrical Gynecological Society members of Puducherry along with department of Obstetrics and Gynaecology in the Institutes, Auditorium. The experts also included Deputy Director Family Welfare, Puducherry and two Nursing Co-ordinators of JIPMER Quality Council. The programme was attended by 255 participants and it was conducted as per the Schedule. To impart attitudinal change a role play was enacted by JIPMER Quality Nurses. Demonstration of various birthing positions by Ms. Indie Kaur and its advantages aimed to transform the traditional attitude of uniform supine position for labour. Additionally, to revamp the existing attitude, videos on birth companion and the narrative experiences of Dr. Fernandez on her journey to empower women in labour was projected. A printed handout regarding the UNICEF/USAID categorisation of Disrespect and abuse was given to each participant [12].

At the end of the session, the participants were asked to reflect on their attitude and behaviour in the past and were asked to write a 'pledge' regarding the changes they wish to make to provide respectful maternity care in their practice. Manual content analysis of the pledge was done. Each pledge was the unit of analysis. Similar pledges were grouped into codes. Similar codes were grouped together into categories. Categories were derived from the universal rights of childbearing women [13]. Additional category on training of students and staff was added. This category emerged as the intervention was done in a teaching institute. Also being a Government health facility without user charges the seventh right against the disrespect category 'detention in facility' did not emerge in the pledge. The themes, categories and codes are summarized in Table 1.

Table 1. Content analysis of the pledge taken by the participants during the workshop.

Theme: Pledge of doctors and nurses to provide respectful maternity care	Frequency
Category 1: Freedom from harm and ill treatment	
Refrain from physical abuse	4
Be kind in words and actions	15
Category 2: Right to information, informed consent and refusal and respect for choices and, including the right to companionship of choice wherever possible	
Permit and train birth companion	11
Guide and help the mother when needed	6
Give freedom to choose their preferred delivery position	8
Always get consent before doing a procedure	3
Respect patients' rights	9
Category 3: Confidentiality, Privacy	
Ensure privacy	8

Maintain confidentiality	8
Category 4: Dignity, Respect	
Render respectful and dignified care to the mother	40
Treat mother with love and compassion	23
Develop respectful positive attitude towards women in labour	17
Provide empathetic care	12
Emotionally support the women	7
Actively listen to the patient	3
Category 5: Equality, freedom from discrimination, equitable care	
Treat patient as her/ his own relative	6
Category 6: Right to timely healthcare and to the highest attainable level of health	
Provide holistic care including care for child	32
Educate pregnant women about labour	22
Provide pain relief	6
Category 7: Train students and others on respectful maternity care	
Train student and staff	9
Be a role model	6

Some of the verbatim pledges for each category are mentioned below.

Category 1: "Be polite with all patients and will not provide excuse with time and busy schedule."

Category 2: "Every woman is unique and distinctive; with different stressors and threshold to pain I will surely avoid comparing one patient with another and will respect her feelings and desires and help her in safe motherhood wholeheartedly."

"I will allow birth companion. Birth companion is the best support for relieving the mental stress."

"Remain sensitive to my patients' rights and respect for maternity care for all under my care throughout my life until I practice."

Category 3: "I will maintain confidentiality of patients, provide provided privacy where needed."

Category 4: "I never treat patient as a patient and I will treat them like human being. I will respect them regarding maternity care."

"I will welcome the patient and introduce myself."

Category 5: "I will treat her as my own relatives."

Category 6: "To provide holistic care i.e. mental, physical, social and spiritual care with smile."

Category 7: "I will train my staff and spend more time in labour room. I will spend more time in labour room and be a role model to show empathetic care and touch to my mother (women under his/her care)."

"Personally, I feel that the age, over burden or family tension changes our attitude. In young minds, the importance at respect for others to be seeded."

Phase II: Situational analysis of the existing RMC practices

To start with, a gap analysis done using the guidelines specified under the LaQshya. LaQshya is quality improvement initiative for the labour room practices in India. It presents quality assurance standards and checklist for assessment of RMC services at the health facility. These are classified into eight concern areas namely Service Provision, Patient Rights, Inputs, Support Services, Clinical Services, Infection Control, Quality Management and Outcome [8]. The gap analysis was done using this checklist by four members of Quality Council of the Institute (JQC). They also identified the strengths/good practices and also the areas to be improved in the labour room. The summary of the results given in Table 2. Seventy eight percent of the checklist items were scored well and the rest 22% items were identified as areas to be improved. The areas which had higher gaps were 'patients

rights' and 'inputs' followed by 'support services' and 'service provision'. The largest gaps noticed as per LaQshya were lack of birth companion (standard B-Patient rights), not advising on comfortable position during birthing, not ensuring promotion of early breastfeeding and mother child bonding.

Table 2. Gap analysis of the labor room using the LaQshya national quality assurance standards checklist for labour room.

Area of concern	Number of checklist items	Number of positive items	Number of items that need improvement
A. Service provision	5	4 (80)	1 (20)
B. Patient rights	14	5 (36)	9 (64)
C. Inputs	31	18 (58)	13 (42)
D. Support services	25	19 (76)	6 (24)
E. Clinical services	43	36 (84)	7 (16)
F. Infection control	16	14 (88)	2 (13)
G. Quality management	23	18 (78)	5 (22)
H. Outcome	4	3 (75)	1 (25)
Total	161	126 (78)	35 (22)

Corrective actions undertaken as per gap analysis

A meeting of doctors and nurses from department of Obstetrics and Gynaecology, Neonatology and Nursing was held in January 2019 for disseminating the results of gap analysis and decide on the corrective measures. The gap analysis was presented by a faculty of Obstetrics and Gynaecology in the meeting. One of the actions planned was a policy of permitting birth companion. The evidence regarding birth companion was presented by the organizer (First Author) along with the birth companion Policy of Govt. of India and few other countries [14]. The proposed birth companion policy based on Government of India guidelines for the department of Obstetrics and Gynaecology was also presented and discussed. More than 98% agreed upon allowing birth companion for women who request the same. The fears expressed by few were increased incidence of infection and interference of birth companion in management and gender differences. The final decision regarding the 'birth companion policy' was intimated to the Medical Superintendent and Nursing Superintendent officially.

Methods for implementing birth companionship

One Public health nurse of department of Obstetrics and Gynaecology who attended the workshops, CME on RMC and departmental meeting regarding LaQshaya guidelines was trained in training the birth companion. The consent form for the birth companion was introduced and made available in the Antenatal OPD, Wards and Labour rooms. The following videos were selected and shown to the pregnant women (who were given the option of having the birth companion) and the chosen birth companion and a visit was undertaken to the labour room to familiarise the birth companion.

1. <https://www.ndtv.com/video/features/news/the-birth-companion-205700>
2. <https://www.youtube.com/watch?v=jw94EyVz3Rw>
3. <https://www.youtube.com/watch?v=YvBRXH7gxP8>

Onsite demonstration and Hands on training was carried out in the initial 3 months of implementation by the Public Health Nurse. Posters on RMC and the Policy of Birth companionship were displayed in a prominent

Area of Labour room and Emergency Obstetric service areas.

Results

Observations were done monthly over one year by supervisory visits and informal/formal verbal feedback from the staff in-charge of labour room and from the Resident Doctors. A qualitative assessment was done by the organizer/First author whether the Residents and Nurses practiced RMC as demonstrated in the Workshop.

The operationalization of the birth companion policy was followed on daily observations, enquiries and onsite surprise visits over one year period. The practice was followed only by few health care workers and certain cadre of women who labored, received RMC and disrespect and abuse still prevails. The bottle necks identified were low socioeconomic status of women, the in-charge consultants not insisting on presence of birth companions, the residents and nurses not promoting birth companion policy.

Discussion

Implications for policy-makers

Work shop on respectful maternity care improves the knowledge of the participants.

Pledge taken by the participants shows their commitment to provide RMC.

The gap analysis as per "LaQshya" guidelines shows the areas need to be improved mainly are protection of patient rights and provision of birth companions.

Qualitative analysis following Implementation of RMC assesses change in attitude of health care workers including doctors, Nurses and ancillary staff.

Implications for public

Child birth is a long lasting experience and women remember it lifelong. Pain and discomfort is unavoidable in large hospitals catering free services to pregnant women. But disrespect and abuse if prevails makes the woman suffer psychologically and they carry unpleasant memories lifelong. To abolish this Govt. of India gave guidelines for implementation of Respectful Maternity Care the main component of which includes the presence of birth companion. This policy is not implemented and the Public are not aware of it.

Research has shown that maternal support during labour improves pregnancy outcomes like successful vaginal deliveries, mother-child bonding, less number of operative deliveries and positive childbirth experience leading to happy mother hood. The role of birth companion during labour is essential and the public should be aware of the actions they are expected to do when caring for women during labour and immediate postpartum [15].

Conclusion

Implementation of the respectful maternity care was below average, even though the training was well appreciated. We planned to quantify the disrespect and abuse experienced by women undergoing delivery in the institute. A qualitative study on the perspectives of health care staff in the labour room regarding the drivers for disrespectful behaviour toward women in labour was also planned. Such a mixed method research would give a complete picture of the practices in the labour room from the perspective multiple stakeholders. The Government of India, LaQshya guidelines and the results of the survey and interview can be used as an advocacy tool for putting system in place for improving respectful maternity care. Being a teaching institute, the workforce would be changing frequently. We need to periodically train and retrain doctors and nurse on RMC. Development

and pretesting of a training material will improve the skill set of students. It should be participatory, and involve multiple teaching learning methods so as to improve on knowledge, attitude and skills. Real time case studies of how different organizational units such as Government, Private, and Non-Governmental Organization have implemented RMC needs to be included. Their success stories on its impact of these on the quality of care and satisfaction of the patient will motivate health care workers for a change.

Continuous feedback from the patients will help to improve the services and also help in monitoring the changes in the system with the implementation of the guidelines. Simple mobile applications such as "Mera Aspataal" to collect anonymous feedback specific to respectful maternity care could be developed and used. Multi-pronged approach with situation analysis, training, supervision and monitoring, feedback and system changes are essential to bring about a sustainable change for RMC. Implementation of Respectful Maternity Care needs change of attitudes of personnel who render care during child birth and it can only be successful unless it forms an integral part of Medical and Nursing curriculum.

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