

Autonomy and respect among the postnatal mothers during maternity care in a tertiary level hospital in Nepal

Shila Adhikari,¹ Kiran Bajracharya²

¹Bir Hospital Nursing Campus, Kathmandu, Nepal

²Maharajgunj Nursing Campus, Kathmandu, Nepal

Corresponding author: Shila Adhikari, Email: shilaadkh@gmail.com

Academic Editor: Lok Raj Joshi, MD

ABSTRACT

Background: Ensuring high level of respectful maternity care encourages the women to utilize facility-based care, which is essential for improving maternal and neonatal health. Thus, the objective of the study was to find out the level of autonomy and respect during maternity care among the postnatal mothers in a tertiary level hospital in Nepal.

Methods: A descriptive cross-sectional study was conducted among postnatal mothers receiving child birth services from the Tribhuvan University Teaching Hospital, Kathmandu. Two hundred and fourteen participants were selected using convenient sampling technique and interviewed using structured questionnaire in September 2018.

Results: The study results indicated that 74.8% of the respondents scored above 50% in the self-reported scale of autonomy and 71% of the respondents scored above 50% in the self-reported scale of respect. A significant association was present between autonomy of postnatal mothers with caste (lower level of autonomy in those belonging to the Dalit and Disadvantaged Janajati group, $p=0.005$) and parity (lower level of autonomy in multipara, $p=0.001$). A significant association was also present between level of respect of postnatal mothers with type of delivery (lower level of respect to women having vaginal delivery, $p=0.027$).

Conclusion: The findings revealed that one fourth of the participants had scores of less than fifty percent regarding overall autonomy and respect during maternity care. Therefore, it is recommended that doctors, nurses and supporting staff in the hospital should be provided with continuous professional development programs facilitating respectful and autonomous care.

Keywords: autonomy, hospital-patient relations, obstetric delivery, postnatal mothers, respect

INTRODUCTION

Lack of respectful maternity care (RMC) is considered as a violation of fundamental human rights [1–3]. Generally the concept of safe motherhood is restricted to the physical safety. However, it should be expanded beyond the prevention of morbidity and mortality [4]. According to WHO, respect and autonomy during maternity care are essential for positive maternity experiences [5,6]. In 2010, a landscape report by Brower and Hill described seven categories of disrespect and abuse during childbirth [1]. The White Ribbon Alliance led a multi-sectorial collaboration which produces a consensus document the Respectful Maternity Care Charter: The Universal Rights of Childbearing Women [2].

Every childbearing woman has the universal human right to respectful maternity care (RMC), which should

be provided in all health systems worldwide. Women are mistreated and have their rights infringed during childbirth all over the world [3]. The report mentions physical and verbal abuse, non-consensual procedures, privacy violations, denied admission, pain relief refusal, neglect leading to complications, and detention in facilities due to inability to pay, as forms of disrespectful treatment during childbirth. Because they don't know whom or how to tell about these experiences, they remain silent and carry the scars with them for the rest of their lives. .

Women's autonomy and respect in the maternity care encourage the women to utilize the service in future also. High utilization of maternal health care services makes it possible to reduce maternal and neonatal morbidity and mortality.[5] A study on respectful maternal care and newborn care in a hospital in Nepal

Article information

Received: 09 April 2023

Accepted: 23 May 2024

Published online: 30 May 2024

Copyright © 2024 by the author(s), wherein the author(s) are the only owners of the copyright of the published content
Licensing: This published content is distributed under the terms of the [Creative Commons Attribution International License \(CC BY 4.0\)](https://creativecommons.org/licenses/by/4.0/) license, and is free to access on the Journal's website. The author(s) retain ownership of the copyrights and publishing rights without limitations for their content, and they grant others permission to copy, use, print, share, modify, and distribute the article's content even for commercial purposes.

Disclaimer: This publication's claims, opinions, and information are the sole creations of the specific author(s) and contributor(s). Errors in the contents and any repercussions resulting from the use of the information included within are not the responsibility of the publisher, editor, or reviewers. Regarding any jurisdictional assertions in any published articles, their contents, and the author's institutional affiliations, the Journal and its publisher maintain their objectivity.

shows that out of the 4296 women surveyed, thirteen percent said their birth experience did not fulfill their cultural and religious expectations, while fifteen percent expressed dissatisfaction with privacy [7]. We aimed to study the level of women's autonomy and the respect in the maternity care in Tribhuvan University Teaching Hospital, Kathmandu.

METHODS

A descriptive cross-sectional study design based on quantitative approach was used to find out women's autonomy and respect during maternity care. The setting of the study was the postnatal ward of the Tribhuvan University Teaching Hospital (TUTH) Kathmandu and the duration of the study was four weeks (from September 02 to September 30, 2018).

Convenient sampling technique was used for the selection of 214 postnatal mothers meeting the inclusion criteria. All postnatal mothers who had given live birth of their babies irrespective of the mode of delivery were included in the study. A structured interview schedule was developed by the researchers based on the objectives of the study. The reference was taken from extensive literature review and consultation with advisor [7-11]. Around 25-30 minutes was taken to collect data from each respondent.

In this study, level of autonomy was measured by using dichotomous questions. The score of one was given for responding 'Yes' and zero for 'No'. Reverse coding was used for negative statements. The maximum possible score was 10 with a higher score indicating higher level of autonomy. The total score above 50% would mean the score of six or above. Similarly, the level of respect was measured by using dichotomous questions. The score of one was assigned for responding 'Yes' and zero for 'No'. Reverse coding was used for negative statements. The maximum possible score was 16 and a higher score would indicate a higher level of respect. The total score above 50% would mean the score of nine or above.

Pretesting was done in the final Nepali version among 10% (21 mothers) of the estimated study sample who met the inclusion criteria in similar setting to check for appropriateness and feasibility. Reliability of the translated Nepali tool in terms of internal consistency was computed (Cronbach's alpha coefficient = 0.72).

The collected data was checked for completeness, was edited, classified, coded and entered in Statistical Package for Social Sciences (SPSS) software version 16 for further analysis. Analysis was done by using descriptive and inferential statistics. Descriptive statistics i.e., number, percentage, mean, standard deviation was used to describe the demographic and obstetric variables. A non-parametric test namely chi-square was used to assess the association between autonomy and respect of postnatal mothers and selected variables.

RESULTS

Among the 214 postnatal mothers, two-thirds (61.68%) were in the age group of 25 years or older. The mean age (SD) of respondents was 26.59 years (4.69 years). Regarding the place of residence, more than half (54.7%) resided in rural areas. Regarding caste, more than half

(56.1%) of the participants were Brahmin/Chhetri. Most respondents (83.2%) followed the Hindu religion. Regarding educational status, almost all (96.7%) were literate. More than half of the respondents had a vaginal delivery (55.64% of postnatal mothers), and the rest had a cesarean section (44.4%). Regarding parity, almost half of the respondents were primipara (50.9%). [Table 1]

The study result indicated that 74.8% of the respondents

Characteristics	Frequency (%)
Age group (in completed years)	
Up to 24 years	82 (38.3)
25 years and more	132 (61.7)
Mean \pm SD = 26.59 \pm 4.69	
Range = 19- 40	
Place of residence	
Urban	97 (45.3)
Rural	117 (54.7)
Ethnicity	
Dalit, disadvantaged groups, religious minority	43 (20.1)
Relatively advantaged janjati	51 (23.8)
Brahmin/Chhetri	120 (56.1)
Religion	
Hinduism	178 (83.2)
Others ^a	36 (16.80)
Educational status	
Cannot read and write	7 (3.3)
Able to read and write	207 (96.7)
Type of delivery	
Cesarean Section	95 (44.4)
Vaginal Delivery	119 (55.6)
Parity	
Multi	105 (49.1)
Primi	109 (50.9)
<i>Others ^a: Islam, Buddhism, Christianity</i>	

scored above 50% in the scale of autonomy and 71% of the respondents scored above 50% in the scale of respect.

Most of the respondents (95.3%) reported that they were allowed to see their newborn immediately after birth. Only one-third (38.6%) of the respondents were allowed to choose a birth companion during vaginal delivery. Almost of all respondents (96.7%) reported that they were allowed to eat and drink light food during labor. Regarding cesarean birth most of them (95.78%) were informed about the indication. Almost half (49.5%) were not provided adequate information about the progress during caesarean section. [Table 2]

Very few respondents (10.7%) reported to have been greeted respectfully and very few service providers (7.5%) introduced themselves on first contact. Almost

Table 2: Descriptions related to autonomy during maternity care	
Statements	Yes [N (%)]
Information, Involvement and Consent (N = 214)	
Explained rational of giving medicine	121 (56.5)
Involvement in decision making	155 (72.4)
Permission before doing any procedure	158 (73.8)
Provided the information on care option and that have been chosen	172 (80.4)
Allowed to see newborn	204 (95.30)
Autonomy during Active Phase of Labor (N=119)	
Allowed to choose birth companion	46 (38.6)
Allowed to walk freely during labor pain	55 (46.2)
Allowed to change the position of choice	68 (57.1)
Informed about the progress of labor	93 (78.2)
Allowed to eat light food and drink in between	115 (96.6)
Autonomy in Caesarean Section Birth (N=95)	
Provided adequate information about progress	48 (50.5)
Obtained verbal consent while shaving for part preparation	63 (66.3)
Obtained verbal consent while catheterization	66 (69.5)
Provided adequate recovery instruction	69 (72.6)
Provided adequate information about the indication	91 (95.8)

all respondents (92.5%) said the provider helped them breastfeed within an hour (92.5%) and most (93%) reported that their cultural preferences were respected. Nearly a third of respondents reported having been verbally abused (30.8%) and (0.4%) reported having experienced physical abuse. The majority of respondents (92.1%) said that service providers were interested in frequent visits. [Table 3]

There was statistically significant association between level of autonomy and caste with a lower level of autonomy in Dalit and disadvantaged *Janajati* groups ($p=0.005$). Also, There was significant association between level of autonomy and parity with lower level of autonomy in multiparous women ($p=0.001$). [Table 4]

There was a significant association between type of delivery and level of respect with lower level of respect received by women who delivered vaginally ($p=0.027$). [Table 5]

DISCUSSION

This study aimed to assess the level of autonomy and respect during maternity care among the postnatal mothers in a tertiary level hospital in Nepal.

In this study, about three-fourth (73.8%) respondents reported that care provider asked permission before doing any procedure. In contrast, a study from Ethiopia, 52% of women were asked for their consent or permission prior to any procedure [12]. It might be because of

Table 3: Descriptions related to respect during maternity care	
Statements	Yes [N (%)]
Respect in Care (N=214)	
Introduced by health personnel	16 (7.5)
Greeted respectfully	23 (10.7)
Treated in a friendly manner	150 (70.1)
Treated politely	165 (77.1)
Called by name	171 (79.9)
Supported for anxiety and fear	173 (80.8)
Shown concern by visiting frequently	197 (92.1)
Helped in breast feeding within one hour	198 (92.5)
Cultural preference respected	199 (93.0)
Respect in Privacy (N=214)	
Conversation not heard by other	65 (30.4)
Health information kept confidential	118 (55.1)
Minimal exposure during birth	131 (61.2)
Respect and Abuses (N=214)	
Physical Abuse	1 (0.4)
Verbal abuse	66 (30.8)
Respect during Normal Birth (N=119)	
Provided adequate non-pharmacological pain relief measures	54 (45.4)
Provided close attention during labor	10 (8.6)
Respect during Cesarean Birth (N=95)	
Provided close attention in recovery area	82 (86.3)
Provided adequate pain relief medication after cesarean birth	87 (91.6)

different settings. Our study findings showed that 95.3% of the respondents were allowed to see their newborn immediately after birth. Similarly, study of Uttar Pradesh, India showed that 95.7% respondents are allowed to see the newborn as soon as possible after birth [13].

Regarding autonomy during vaginal birth, less than half of the respondents who had vaginal birth reported that they were allowed to walk freely during labor. In contrast, study of Ethiopia showed more than two third (69%) of the women were encouraged to walk [14]. Our study findings showed that more than half of the respondents were allowed to choose a birth companion. In contrast, a study in India, Uttar Pradesh showed that only 19.6% respondents are not allowed a companion during childbirth [13]. Our study findings showed that majority of respondents reported that they were allowed to eat and drink light food during labor who had a vaginal delivery. Similarly, study of Ethiopia (2015) showed that most of the respondents (83%) reported that they were allowed to take light food [14]

Regarding respect while receiving care, 10.7% were greeted respectfully and 7.5% reported that service providers introduced themselves upon first meeting. This showed very low levels of respect. In contrast, in a study of patient and provider determinants for receipt of

Table 4: Association between autonomy and socio-demographic characteristics (N=214)

Variables	Level of autonomy score		χ^2	p value
	> 50% [n(%)]	≤ 50% [n(%)]		
Age group				
Up to 24 years	59 (72.0)	23 (28.0)	0.055	0.814
25 years and more	93 (70.4)	39 (29.6)		
Place of residence				
Rural	79 (67.5)	38 (32.5)	1.542	0.214
Urban	73 (75.3)	24 (24.7)		
Religion				
Hindu	134(75.3)	44 (24.7)	0.400	0.527
Others	26 (72.2)	10 (27.8)		
Caste				
Dalit and disadvantaged group	22 (51.2)	21 (48.8)	10.746	0.005*
Advantaged janajati	37 (72.5)	14 (27.5)		
Brahmin/Chhetri	93 (77.5)	27 (22.5)		
Type of delivery				
Vaginal Delivery	81 (68.1)	38 (31.9)	1.142	0.285
Cesarean Section	71 (74.7)	24 (25.3)		
Parity				
Primi	81 (74.3)	28 (25.7)	1.164	0.001*
Multi	71 (67.6)	34 (32.4)		

*p-value significant at ≤ 0.05

Table 5: Association between respect and obstetric characteristics (N=214)

Variables	Level of Respect score		χ^2	p value
	> 50%, n(%)	≤ 50%, n(%)		
Type of delivery				
Vaginal Delivery	82 (68.9)	37 (31.1)	4.877	0.027*
Cesarean Section	78 (82.1)	17 (17.9)		
Parity				
Primi	83 (76.1)	26 (23.9)	0.224	0.636
Multi	77 (73.3)	28 (26.7)		

*p value significant at ≤ 0.05

three dimensions of respectful maternity care in Kigoma Region, Tanzania (2016), nearly all clients (96.3%) reported that they were greeted respectfully upon admission, and 45.6% reported that the provider introduced themselves [15].

Regarding respect and abuses, the study findings showed that 30.8% of the respondents reported verbal abuse and 0.5% reported physical abuse. In a study in Tanzania (2017), physical and emotional abuse was reported by 1.3% and 2.7% respectively [15].

The study findings showed that less than half of the respondents reported they were provided adequate non pharmacological pain relief methods. This indicated priority is not given to the comfort of the respondents. A study in Tanzania showed 88.7% respondents reported that their care provider advised them about comfort

measures [15].

Limitations: The self-constructed quantitative tool was used to perform the study, which examines the autonomy and respect postpartum mothers receive during their whole maternity care experience. A thorough investigation into perception was not possible. Additionally, since only one context was considered and convenience sampling was used, it is impossible to determine whether the findings have the potential to be generalized.

CONCLUSION

The findings show that one fourth of participant had overall score of less than fifty percent regarding autonomy and respect during maternity care. Therefore, it is recommended that hospital managers and decision-makers organize continuous professional development

programs that facilitate respectful and independent care to improve the birth experience and prevent the adverse effects of negative birth experiences.

Author contributions: SA: Concept and design of research, literature search, data collection, analysis and interpretation, drafting the manuscript; KB Tool development, drafting manuscript. Both authors reviewed the manuscript and approved the final version of the manuscript. Both authors agreed to be accountable for all aspects of the research work. (Note: SA and KB are abbreviated names of the authors.)

Ethics approval: This research was approved by Institutional Review Committee of Institution of Medicine, Tribhuvan University with the reference number of 91(6-11-E)/075/076 on 24 August 2018.

Consent and/or assent: Written informed consent was obtained from all the participants.

Data availability: Related data will be available on request.

Conflicts of interest: The authors declare that there is no competing interest.

Source of funding: The author(s) received no external fund for this research.

REFERENCES

1. Bowser D, Hill K. Exploring Evidence for disrespect and abuse in facility-based childbirth report of a landscape analysis. Harvard Sch Public Heal Univ Res Co, LLC. 2010;1-57. Available from: https://www.hsph.harvard.edu/wp-content/uploads/sites/2413/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf
2. Respectful maternity care: The universal rights of childbearing women. White Ribbon Alliance Safe Mother; 2011. 6 p. Available from: https://whiteribbonalliance.org/wp-content/uploads/2022/05/WRA_RMC_Charter_FINAL.pdf
3. The prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva: World Health Organization; 2015. Available from: http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1
4. Reis V, Deller B, Carr CC, Smith J. Respectful maternity care: Country experiences. Survey Report; November 2012. 42 p. Available from: <https://bit.ly/48owrhE>
5. Standards for improving quality of maternal and newborn care in health facilities. Geneva: World Health Organization; 2016. 73 p. Available from: <http://www.who.int/iris/handle/10665/249155>
6. World Health Statistics 2017: Monitoring health for the SDGs, Sustainable Development Goals. Geneva: World Health Organization; 2017. 103 p. Available from: <http://apps.who.int/iris/bitstream/10665/255336/1/9789241565486-eng.pdf?ua=1>
7. Gurung R, Ruysen H, Sunny AK, Day LT, Penn-Kekana L, Målqvist M, et al. Respectful maternal and newborn care: measurement in one EN-BIRTH study hospital in Nepal. BMC Pregnancy Childbirth. 2021;21(Suppl 1):1-13. Available from: <http://dx.doi.org/10.1186/s12884-020-03516-4>
8. Hall J, Collins B, Ireland J, Hundley V. The human rights and dignity experience of disabled women during pregnancy, childbirth and early parenting. Bournemouth: Center for Midwifery Maternal and Perinatal Health, Bournemouth University; 2016. 37 p. Available from: <https://birthrights.org.uk/wp-content/uploads/2019/05/Disability-research-publication-version-March-2018-Updated-save-Mar19.pdf>
9. Vedam S, Stoll K, Martin K, Rubashkin N, Patridge S, Thordason D, et al. The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care. PLoS ONE. 2017;12(2):e0171804. Available from: <https://doi.org/10.1371/journal.pone.0171804>
10. Vedam S, Stoll K, Rubashkin N, Martin K, Miller-Vedam Z, Hayes-Klein H, et al. The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. SSM – Population Health. 2017;3:201-210. Available from: <https://doi.org/10.1016/j.ssmph.2017.01.005>
11. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP. Disrespectful and abusive treatment during facility delivery in Tanzania: A facility and community survey. Health Policy Plan. 2018;33(1):e26-33. Available from: <https://doi.org/10.1093/heapol/czu079>
12. Asefa A, Bekele D, Morgan , Karmode M. Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. Reproductive Health. 2018;15:4. Available from: <https://doi.org/10.1186/s12978-017-0449-4>
13. Diamond-smith N, Treleaven E, Murthy N, Sudhinaraset M. Women's empowerment and experiences of mistreatment during childbirth in facilities in Lucknow, India : Results from a cross-sectional study. BMC Pregnancy and Childbirth. 2017;17:335. Available from: <https://doi.org/10.1186/s12884-017-1501-7>
14. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, et al. Respectful maternity care in Ethiopian public health facilities. Reproductive Health. 2017;14:60. Available from: <https://doi.org/10.1186/s12978-017-0323-4>
15. Dynes MM, Twentyman E, Kelly L, Maro G, Msuya AA, Dominico S, et al. Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania. Reproductive Health. 2018;15:41. Available from: <https://doi.org/10.1186/s12978-018-0486-7>