
**“EFFECTIVENESS OF STRUCTURED TRAINING PROGRAM
(STP) ON PROVIDER PERSPECTIVES REGARDING
RESPECTFUL MATERNITY CARE IN MATERNITY UNITS OF
SELECTED TERTIARY CARE HOSPITAL, BELAGAVI.”**

**Thesis Submitted to
THE KLE ACADEMY OF HIGHER EDUCATION AND RESEARCH,
BELAGAVI
(KLE DEEMED UNIVERSITY)**

**[Declared as Deemed-to-be-University u/s 3 & 12B of the UGC Act, 1956 vide
Govt. of India Notification No.F.9-19/2000-U.3 (A)]
(Accredited ‘A+’ Grade by NAAC) (3rd Cycle)
[Placed in Category ‘A’ by MoE (GoI)]**



**For the award of the degree of
Doctor of Philosophy
In
The Faculty of Nursing**

**By
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(Registration No: KLEU/Ph.D./20-21/DO1220029)**

**Under the Guidance of
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2025

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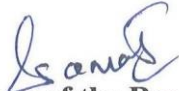
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Place: Belagavi

Mrs. Laxmi S Kamat

Date:

LIST OF ABBREVIATIONS

NHM	National Health Mission
LaQshya	Labour Room Quality Improvement Initiative Guideline
RMC	Respectful Maternity Care
WHO	World Health Organization
WRA	White Ribbon Alliance
IOM	Institute of Medicine
STP	Structured Training Program
OBG	Obstetrics and Gynaecology
PG	Post Graduate
MD	Doctor of Medicine
GNM	General Nursing and Midwifery
BSc (N)	Bachelor of Science in Nursing
P.B.BSc	Post Basic Bachelor of Science in Nursing
MSc (N)	Master of Science in Nursing
ANC	Antenatal Care
NICU	Neonatal Intensive Care Unit
MCH	Maternal and Child Health
OV	Obstetric Violence
CI	Confidence Interval
PPD	Postpartum Depression
CHC	Community Health Centres
PCMCS	Person-Centred Maternity Care Scale
SPSS	Statistical Package for the Social Sciences

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ABSTRACT

Background: Pregnancy is a unique, exciting, and often happy time in a woman's life, emphasizing the incredible creative and caring process. Complications can occur at any stage of pregnancy. So, timely obstetric care services are vital for addressing difficulties during pregnancy, labour, and the immediate postpartum period. The National Health Mission (NHM) has implemented numerous measures to reduce maternal and new-born mortality in India. One of the key initiatives is LaQshya, Labour Room Quality Improvement Initiative Guideline, this is a new, revolutionary initiative in the area of maternal health care that respect both the physiological and psychological needs of the pregnant mother and her family during childbirth. Respecting and understanding women can assist new-borns, who also have rights and deserve to be respected and recognized. Respectful Maternity Care (RMC) is a multipronged-focused approach that promotes strategies that respect human rights and are founded on ethical values.

Methodology: A quasi-experimental one group pre-test and post-test study was conducted among 370 healthcare providers and 370 postnatal mothers at Maternity Units of Selected Tertiary Care Hospital, Belagavi. The respondents selected through the purposive sampling technique. Baseline data, including socio-demographic characteristics, the knowledge questionnaires on Respectful Maternity Care and Person-Centred Maternity Care Scale were collected. The healthcare provides received Respectful Maternity Care training consisting 3 sessions, each lasting about 30 minutes. Data analysis was performed using descriptive and inferential statistics with SPSS version 22 software.

Results: The study found a significant mean post-test knowledge scores exceed the pre-test scores. Notably, in the pre-test, 237 (64.05%) participants had poor knowledge, 128 (34.59%) had average knowledge, and 5 (1.35%) had high knowledge. In the post-test, 19 (5.14%) had average knowledge and 351 (94.86%) had high knowledge, among healthcare providers socio-demographic parameters such as gender, educational status, and work experience are all associated ($p < 0.05$) with knowledge about respectful maternity care. Significant improvements in mother's satisfaction level is higher in End-line (68.35%) than the Base-line (63.35%). Postnatal mothers satisfaction level were significantly associated with age as seen by the calculated Chi-square values at $p < 0.05$.

Conclusion: In accordance with the findings of this investigation, Respectful maternity care is vital in delivering excellent services that encourage women to cherish continuing to accessing medical facilities. The perspective of midwives on respectful care are brought into focus in this study, which demonstrates a thorough comprehension of the essential components that go into providing safe, courteous, and outstanding maternity care. Nurse administrators should be accountable for obtaining opinions from labouring women, nurses and other healthcare professionals should receive comprehensive educational initiatives about respectful maternity care.

Keywords: Post-natal, RMC, Tertiary care hospital, Knowledge, Maternity units, Healthcare provider.

CHAPTER - 1

INTRODUCTION

1.1 Background of the Study

Pregnancy is a unique, exciting, and often happy time in a existence of a woman, highlighting the incredible artistic and caring plan of actions. Parturiency begins on the very first day of the last phase of menstruation and normally completes in birthing at 38-40 duration of gravidity. Throughout gestation, a woman experience physiological fluctuations occur; yet, her biological system may not be able to adjust to these modifications. Adverse effects can occur during any phase of gestation. Thus, appropriate reproductive medical attention is vital for addressing difficulties throughout childbirth, labour, and the early period following childbirth.¹

In every nation and community across the globe, conception and motherhood are significant milestones in the life of mother and families, marking a period of heightened susceptibility. The idea of “safe motherhood” is typically limited to physical well-being; however, the experience of giving birth is also a crucial transition, imbued with profound individual and regional importance for both the mother and her family members. Since parenthood pertains specifically to mother, concerns of equal opportunities for women and gender-based violence are fundamental aspects of obstetric services.²

In the fiscal year 2020, more than 4 million children were delivered in institutions across India, while just over 277 thousand were born at home. The overall statistics depict an increasing trend in hospital or primary health centre deliveries compared to home births. This reflects a positive advancement in India's initiatives to enhance maternity care services.²

The National Health Mission (NHM) has implemented numerous measures to reduce maternal and new-born mortality in India. Among the significant initiatives is LaQshya, Labour Room Quality Improvement Initiative Guideline, is an essential initiative that offers recommendations for enhancing the intra-partum and immediate postpartum care provided in the labour room and maternity operation theatre. This is a new, revolutionary initiative in the area of maternal health care that respect both the physiological and psychological needs of the pregnant mother and her family during childbirth. Childbirth is a challenging and exhausting procedure, yet women's bodies were intended to give birth.³

Respecting and understanding women can assist new-borns, who also have rights and deserve to be respected and recognized. RMC is a multipronged- targeted technique that promotes strategies that honor the rights of humanity and are founded on ethical values. The components of the RMC are: "Respect for Autonomy, Dignity, Empathy, Privacy, Confidentiality, Feelings, choices and preferences, and expectations of mothers and new-borns. Including companionship during maternity and continuing care during labour and delivery and to prevent injury and abuse." Improving the physical environment and resources; inflict lasting harm and emotional suffering; offering equitable maternity care.⁴

In 2018, the World Health Organization (WHO) highlighted the importance of the quality of communication between women and their healthcare providers, stating that positive interactions are crucial for favourable childbirth results. This communication entails healthcare professionals treating women with dignity and offering necessary information and emotional support throughout labour and delivery. Respectful Maternity Care (RMC) has been considered an important method for enhancing the excellence and efficiency of midwifery Services. This is described and

considered as universal fundamental human rights based on ethical standards and consideration for the female emotions, esteem, decisions, and desires. In fact, Respectful Maternity Care is a care perspective that priorities the fundamental rights of women, new-borns, and families, as well as improving connect to research-based healthcare. Whereas addressing the specific requirements and desires for pregnant women and newborns.⁵

The WRA (White Ribbon Alliance) has established seven different categories of Respectful Maternity Care throughout Pregnancy using an approach founded on rights, comprising assault physically, non-consented care, anonymous care, non-dignified care, inequality, and care desertion, and facility confinement. Although, functional elements of Respectful Maternity Care elements about specific views, actions, or norms in the investigation and execution of programs generally differ.³

There have been reports and records of disrespectful and cruel approaches during childbirth in medical facilities across the globe. The use of Respectful Maternity Care (RMC) has been progressively promoted in recent years, with a focus on the significance of fundamental professional ethics and the consideration of psychological, social, and cultural dimensions of health care delivery as vital elements of care. Even though medical care is merely one aspect of RMC, neglecting to give attention to the well-being of women and new-borns by imposing redundant or harmful behaviors may be regarded as abusive and disrespectful.⁶

The elements of Respectful Maternity Care throughout pregnancy and delivery based on the viewpoints of the delivering women and health care providers have been the subject of numerous studies conducted worldwide. In general, these elements include delivering safe and prompt care, encouraging positive interactions between midwives and women, safeguarding confidentiality, actively participating in the

delivery technique, obtaining women's consent before doing treatments, informing women about processes, protecting confidentiality for patients, and encouraging autonomy of decision-making with regard to pregnancy and delivery place. From the perspective of the labouring woman, respectful attitude on the part of cares is essential for enhancing the quality of treatment and birth satisfaction. This is turning into an essential component of maternal health care.⁷

Respectful maternity care strongly leads to patient satisfaction throughout birthing, including the quality of both physical interactions and inter-personal relationships between the care provider and the expectant woman. Recognizing the importance of improving maternity care and the need to prepare for better health care services in RMC, the main goals are to assess the care delivered in maternity care facilities using appropriate instruments and to balance various medical and communicational components of treatment.⁸

1.2 Need for the study

Human rights are fundamental rights that everyone has, regardless of years of age, citizenship, area of residence, gender, national or ethnic origin, color, cultural background, mother tongue and any other attribute. Fundamental rights for humanity are frequently stated and regulated by legislation mechanisms, such as agreements among nations. International protection of Human Rights policy establishes States' responsibilities to behave in specified ways or abstains from acting in a manner that reverence, safeguard, and satisfy individuals' and groups' rights as humanity and fundamental liberties³

Satisfaction is defined as an individual's emotions of happiness or sadness when comparing the outcome of a product to their demands. Patient fulfillment has become an essential component of health care facility and medical administration practices around the world.⁹

In the last 20 years, client-centered or patient-centered care has gained international recognition as an aspect of high-quality healthcare as a whole. According to the Institute of Medicine (IOM), high-quality healthcare should be prompt, efficient, patient- or client-centered, safe, and equitable. "Care that is respectful of and responsive to individual client or patient preferences, needs, and values, and ensuring that client's or patient's values guide all clinical decisions" is how client- or patient-centered care was described.¹⁰

One of the most significant and unforgettable moments in a woman's life is giving birth, and she should have the support of her chosen companion and caregivers. It is important that women are treated with dignity and respect during this time. Disrespectful maternity care is still a major issue in both developing and developed nations, though. Abuse and disrespect are two of the biggest obstacles that prevent women from accessing healthcare, particularly in developing nations, which makes it difficult to bring down maternal morbidity and mortality rates.⁴

Maternal fulfillment with the manner of providing delivery services. May have both immediate and long-term impacts on the well-being of both the mother and the new-born. Unfavorable response on the delivery experience instantly increases the chance of depressive disorders after childbirth and unhappiness, while also changing maternal views towards future pregnancies and manner of delivery. However, several of the reported detrimental effects were mirrored in a variety of Health consequences, comprise mortality among mothers and babies, postpartum infections, psychological

state of health, and sanitary concordance. Expressions of accomplishment are vital to preserving the health of mothers and delivering continuing excellent health care services for mother and child health.⁷

The WHO issued a unified announcement on addressing abuse and mistreatment during pregnancy and childbirth, highlighting the need of women's participation in increasing excellence of care and abolishing disrespectful attitudes. The declaration was then extended into the core suggestions, RMC methods, which are based on human rights and are expected to result in better birth and labour experiences for women, as well as equity in the health-care system.⁵

The Respectful Maternity Care Charter: Universal Rights of Mothers and New-borns were developed by the Global RMC Council, a wide range of stakeholder groups with perspectives from advocacy, rights for humanity, clinical, and academic disciplines. It outlines and explains the rights of women and new-borns receiving maternity care in a healthcare centre.⁴

A quantitative study has been conducted to assess the impact of an awareness program on antenatal women's knowledge of respectful maternity care (RMC) in a selected West Bengal hospital. The success of the awareness training was demonstrated by the significant difference between the experimental and control groups' mean post-test knowledge scores. The study also discovered a strong correlation between women's socioeconomic level and their knowledge scores based on their educational background. The study has consequences for various nursing speciality. The report suggests conducting a qualitative investigation and survey on RMC adherence.¹⁶

Hence this study aimed to assess effectiveness of training programme on health care provider's perspectives on respectful maternity care. Additionally collect the feed-back of care received in health care facility by postnatal mothers to assess the satisfaction level of mother regarding respectful maternity care

1.3 Title of the study

Effectiveness of Structured Training Program (STP) on Provider Perspectives regarding Respectful Maternity Care in Maternity Units of Selected Tertiary Care Hospitals, Belagavi.

1.4 Objectives

Primary objective

- To assess the effectiveness of structured training program on health care provider perspectives regarding Respectful Maternity Care (RMC).

Secondary objectives

- To assess the satisfaction level of Respectful Maternity Care (RMC) among Post-natal mothers.

1.5 Research hypotheses

All hypotheses will be tested at the significance level of 0.05.

H0₁: There will no significant variation between the mean pre-test and post-test scores regarding RMC among health care providers after the administration of structured training program.

H0₂: There will be no significant difference between mean base-line and end-line regarding satisfaction level of Respectful Maternity Care (RMC) scores among Post-natal mothers.

1.6 Assumptions

The study assumes that:

- Implementing a respectful maternity care training program enables healthcare providers to understand the critical importance of treating patients with dignity, respect, and empathy throughout maternity care.
- The findings of the study aid stakeholders, including policymakers and healthcare providers in implementing changes and improving maternity care services.

1.7 Delimitations

The study is delimited to:

- Health care provider those who are working in the maternity wards.
- Single tertiary care hospital.
- Recently delivered, admitted in the postnatal ward, and accessible for data collection.

1.8 Operational Definitions

- a. Health care provider:** OBG PG – MD, Registered Nurse (GNM, BSc, P.B.BSc, MSc) and Health assistants.
- b. Perspectives:** Knowledge
- c. Structured Training Program:** In this study, Training program includes planned teaching of 3 sessions with health care provides related to Respectful Maternity Care which is given by the researcher. Each session lasts around 30 minutes, and all topics are covered via videos, flash cards, hand-outs, models, and demonstrations. The education program material is designed to meet the needs of the program participants and adheres to aspects of RMC given by WHO and Ministry of Health & Family Welfare guidelines.

Aspects of RMC emphasized during the training:

1. Providers introducing themselves to the women
2. Calling women by their names
3. Asking women how they are feeling
4. Allowing women to have a support person of their choice
5. Ensuring privacy during examinations
6. Explaining examinations, procedures, and medications
7. Obtaining consent before procedures,
8. Communicating findings of examinations to women and their families
9. Encouraging the women and their families to ask questions
10. Allowing women to move during labour and birth in their preferred position

The following topics are included:

Sessions	Content	Time (90 min)
I	➤ Introduction – meaning , importance ➤ Categories of RMC : • Physical Abuse • Non dignified care • Non consented care • Non confidential care • Discrimination • Withholding the care • Detention In the facilities	10min 20min
II	➤ Needs of RMC for Health Care Workers ➤ Universal rights of child bearing women ➤ Obstetrical violence – meaning manifestation ➤ Prevention and elimination of violence during childbirth	5min 10min 10min 5min

III	➤ Challenges and barriers	10min
	➤ Introducing online module The online module titled “Implementing Respectful Maternity Care in Healthcare Facility”. This is prepared by the White Ribbon Alliance India and available in Aasrtika Foundation platform.	20min

- d. **Respectful Maternity Care:** in this study refers to care designed for and delivered to all women in an approach that protects their independence, anonymity, and concealment, serves as protection from abuse and mistreatment, and allows for informed decision-making and continuous assistance during gestation and childbirth.
- e. **Maternity Units:** In this study includes Labour Room, Labour OT, ANC ward, ANC OPD, NICU, Post-natal ward, MCH ward of selected Tertiary Care Hospital, Belagavi.

1.9 Conceptual Framework

A conceptual framework is an established visual representation of the key ideas, concepts, and relationships fundamental to a specific field of study or activity. It acts as a guide for comprehending, evaluating, and interpreting incidents in a particular scenario. Researchers and practitioners establish a foundation for their work by constructing a conceptual framework, fostering consistency, coherence, and clarity throughout the process. Immogene King's goal attainment theory is the foundation for the present research, as it is ideally suited to evaluating the effectiveness of a Structured Training Program (STP) on Provider Perspectives regarding Respectful Maternity Care in Maternity Units of Selected Tertiary Care Hospital.

According to King's goal attainment theory, a process of interaction happens when nurses and patients collaboratively determine goals and wrestle with how to

accomplish goal. This approach focuses goal-setting, exchange of information, and compassionate care with a focus on respect for patients and the patient-nurse relationship. Consequently, trust and patient satisfaction have to be mutually beneficial.¹¹

The components of King's goal attainment theory include:

- Role
- Perception
- Judgment
- Action
- Reaction
- Interaction
- Transaction

Role: A person's function refers to their position within the social system, which is shaped by certain rules and obligations. In this study, the goal of the investigator is to provide healthcare providers comprehensive Respectful Maternal Care training with the objective to enhance the understanding of RMC.

Perception: Perception is the vitality that a person adopts from the world around them, which is subsequently converted, processed, and stored. The researcher feels that maternal health should prioritize dignity, equity, and respect for women throughout pregnancy, childbirth, and postpartum care. Despite advances in maternal health services, disrespect and abuse during childbirth continues to occur globally, impacting women's physical and emotional well-being. Training healthcare providers in respectful maternity care serves as essential for address the issue and improving maternal outcomes.

Judgment: Judgment complies with the nursing objective of aiding individuals in sustaining their good health so that they can efficiently carry out their duties with excellence. The researcher obtains essential data then assesses health-care providers and mothers' willingness to participate.

Interaction: Interaction is an action involves two or more entities (people, objects, systems, or phenomena) influencing, communicating, or acting on one another. Requires goal-directed vision and conversation. The researcher communicates information regarding respectful maternity care to health care providers through continuous interaction.

Action: Action refers to a willingness or aptitude to accomplish a goal. The researcher executes the intervention by training health care providers on respectful maternity care. Meanwhile, enlighten postnatal mothers on the rights of childbearing women and RMC.

Transaction: A transaction is an encounter between an individual and the surroundings around them with the objective of accomplishing a particular aim. In this investigation, transaction signifies evaluating the efficacy of Respectful Maternity Care training for healthcare providers. The researcher explains the program's benefits to healthcare providers and postnatal mothers, proposes attainable objectives, and uses evaluation measures to assess their perceptions and levels of care satisfaction.

Health care providers evaluated by using the validated structured knowledge questionnaires and the post natal mothers are by using Person-Centred Maternity Care Scale. Scale scores classify the healthcare provider knowledge as adequate, moderate and inadequate. While the Person-Centred Maternity Care Scale assess the postnatal mothers satisfaction level of care. Following the intervention, the investigator

determines in the event the established goals were attained. If the objectives are not accomplished, or if the scores reveal poor/negative outcomes, feedback is required to improve the intervention further.

The goal of a healthcare provider is to assist with clients preserve their good health so they are able to carrying out their roles efficiently. According to King's goal attainment theory, healthcare providers and clients communicate, determine accepted objectives, and work collaboratively to achieve these goals.

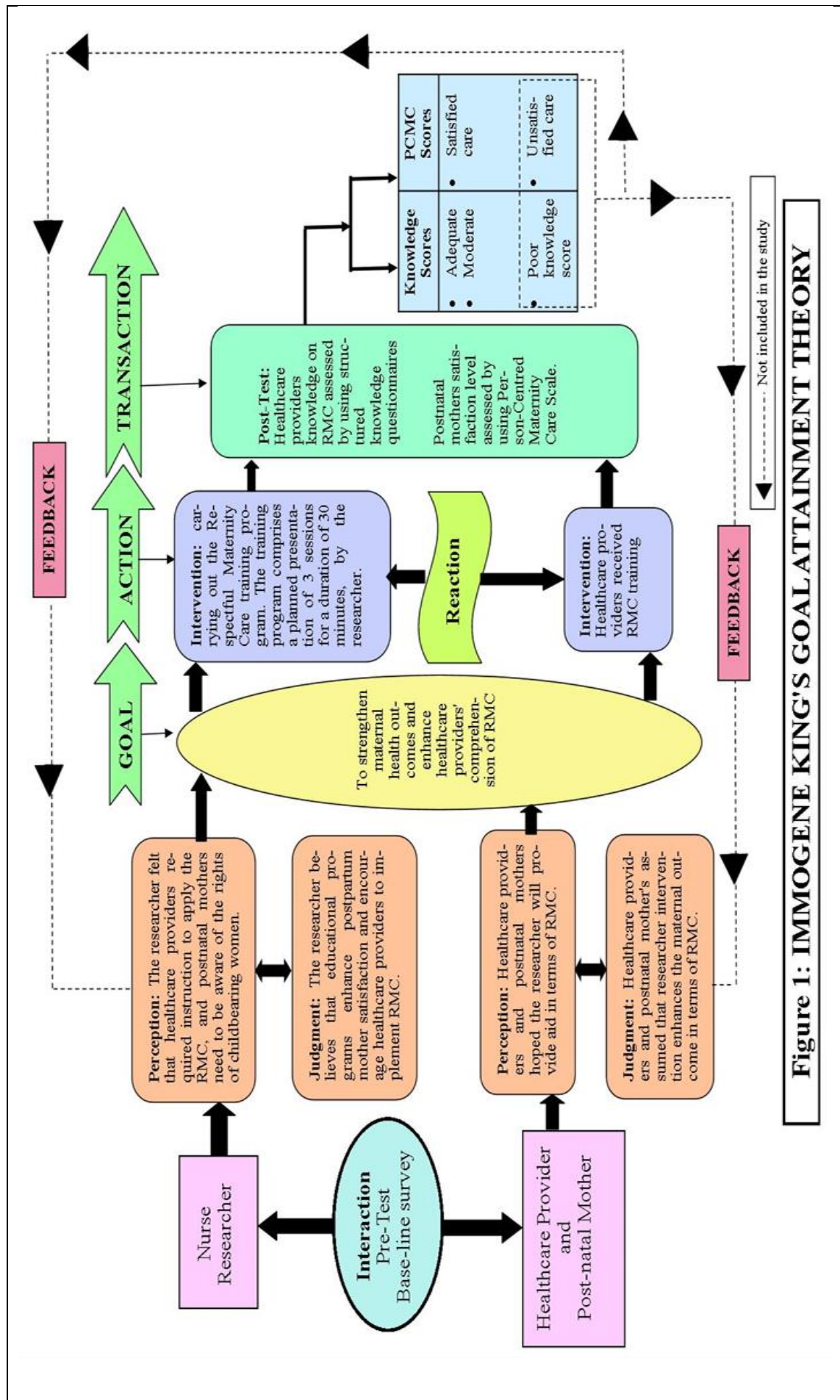


Figure 1: IMMOGENE KING'S GOAL ATTAINMENT THEORY

CHAPTER – 2

REVIEW OF LITERATURE

A literature review provides insight into current theoretical and scientific knowledge by critically synthesizing the results of previous research on a selected issue. It entails assessing and synthesizing different research, emphasizing what is understood and what is still unknown. Literature reviews are an essential part of the research process because they allow researchers to become acquainted with the body of existing knowledge. The purpose of literature reviews is to educate readers on established knowledge and concepts related to the research topic by giving a summary of previous research on a particular issue.

In the framework of the current study, the researcher did a comprehensive literature review to gain a better knowledge of the problem and acquire relevant information. This comprehensive review sought to strengthen the current study by combining findings from prior research.

2.1 Studies related to Obstetric Violence

A qualitative descriptive study was conducted in Rio Grande, Rio Grande do Sul basic health units between January and May 2019. To understand how multiparous women notice their experiences with violence during pregnancy. The study included twenty community-based multiparous women. Interviews were used to gather data, which were then sent for content analysis. Established two subcategories: Obstetric violence in primiparous women, wherein the female participants were subjected to verbal abuse for cooperating during the expulsion of the foetus during labour; Obstetric violence in multiparous women, wherein the women experienced physical and verbal abuse because they had a large number of children. As a result

many women are victims of obstetric abuse at medical facilities. They will carry the trauma with them for the rest of their life. Accepting violent conduct during labour and birth should be avoided in order to provide respectful and nondiscriminatory care.¹²

In 2021, a cross-sectional research of 325 midwives was carried out in Spain. This study looks at midwives' perceptions of the prevalence of obstetric violence (OV), their understanding of it, and the professional variables that may be related to these perceptions. Nearly all of the midwives (92.6%, 301) were familiar with the phrase OV, however 74.8% (214) did not think it was the same as malpractice. Additionally, 26.5% (86) reported routinely observing OV, whereas 56.9% (185) reported observing it infrequently. In contrast, not informing women was just regarded as bad treatment; most midwives view physical aggression as OV. Although the majority of midwives were aware of the word OV, most did not think it could apply to some behaviour that were listed in the international definitions of OV, such as failing to identify oneself or providing a woman with information.¹³

A qualitative inductive method using individual testimony. The study employed a theme qualitative content analysis. To find out what Swedish women who reported having a bad birth experience thought the term "obstetric violence" meant. Twelve women who reported having a bad or traumatic birth experience and had given birth within the last three years. The main conclusions demonstrated that the women had been subjected to physical and psychological assault during childbirth, which may be considered "obstetric violence." The studies of the women's experiences yielded four categories: Absence of consent and information, including inadequate information and the inability to take part in decisions pertaining to the employment process, Inadequate pain management, which included excruciating pain

without any kind of respite, Lack of security and trust, where women encountered rude and technical professionals, mistreatment, including threats of violence from midwives, and comparisons of childbirth to rape. According to the study, women in Sweden face physical and psychological assault during childbirth, which they refer to as "obstetric violence." Obstetric violence is a complicated phenomenon. In order to protect the rights of women giving birth, quality assurance is necessary since abuse of women during childbirth may be a serious issue. High-quality development programs are necessary to protect the rights of women giving birth and to encourage considerate and encouraging care for new mothers.¹⁴

A community-based cross-sectional survey was carried out among 661 randomly chosen women in the Gedeo Zone in South Ethiopia. From May 1 to May 30, 2020, to evaluate the prevalence of obstetric violence and related factors among women in South Ethiopia's Gedeo Zone during childbirth. Approximately 79.7% (527) of the 661 mothers who were involved in the study experienced obstetric violence, with a 95% confidence interval (CI) of 76.9-82.8. The main characteristics linked to obstetric violence were length of stay (AOR = 0.5367, 95%CI = 0.28,0.86), ANC utilisation (AOR = 2.365, 95%CI = 1.62-3.21), educational status (AOR = 2.2573, 95%CI = 1.44,3.54), and experiencing complications during labour and delivery (AOR = 3.1382, 95%CI = 2.34,5.17). Obstetric violence was at a high severity. The most prevalent type of obstetric violence was non-consented and non-dignified care, which can cause a woman to choose home birth over care in a medical facility, which raises maternal morbidity and death significantly.¹⁵

In 2019, a cross-sectional observation investigation was conducted in Spain on 782 mothers had given birth within the previous year. To investigate the link between perceived obstetric violence and a probability of postpartum depression. The average

EPDS score was 8.34 points (SD = 3.80), with 25.4% (199) at risk of PPD (≥ 10 points). Risk variables for PPD were multiparity (aOR: 1.62, 95% CI:1.10-2.39), neonatal NICU admission (aOR: 1.93, 95% CI: 1.06-3.51), verbal obstetric violence (aOR: 2.02, 95% CI: 1.35-3.02), and psycho-affective obstetric violence (aOR: 2.65, 95% CI: 1.79-3.93). The impression of support during pregnancy, birth, and the puerperium was discovered to be a protective factor: aOR 0.15 (95% CI: 0.04-0.54) for women who reported enough support, and aOR 0.13 (95% CI: 0.0-0.45) for women who got much support. Study concludes that PPD is a risk factor for one in four women. PPD risk was higher among multiparous women, those whose newborn needed NICU hospitalization, those who did not have partner support, and those who were subjected to verbal or psycho-affective obstetric abuse.¹⁶

2.2 Studies related to Health care provider perception on RMC

A quantitative approach was utilized to evaluate the midwife-led RMC educational training program for nursing staff and the satisfaction among postnatal mothers receiving treatment in Maternity Tertiary Care Hospital Chennai. Using a one-group pretest-posttest design. There are 30 staff nurses and 30 postnatal mothers. The study's findings revealed that the pretest score for knowledge was 8.20, while the posttest score was 12.77, indicating a 4.57-point difference, which is extremely significant. Regarding staff nurses' practice, the pretest score was 13.97, and the posttest score was 22.20. Thus, the difference is 8.23, demonstrating the success of the midwife-led RMC education training program among nursing staffs. The degree of satisfaction amongst postpartum mothers was 4.70 in the pretest and increased to 8.03 in the posttest, demonstrating the effectiveness of a midwife-led respectful maternity care education program among staff nurses. The study found that extra

education is critical for updating knowledge, promoting best practices among staff nurses, and increasing satisfaction among postnatal moms in their care.¹⁷

A mixed-methods research used focus groups two months after the intervention to examine the experiences of implementing RMC in maternity facilities and a quantitative survey of training participants before and after the intervention to gauge their opinions of RMC. 64 care providers from three hospitals in southern Ethiopia were given access to 3 days RMC training as part of the intervention. In accordance with the results, participants frequently reported experiencing mistreatment during labour, including seeing private inspections performed (39.1%) and using physical force (21.9%) during the preceding 30 days. Furthermore, 29.7% of respondents said they had mistreated a woman. The participants' views and attitudes on RMC were positively impacted, and their knowledge of women's rights during delivery increased as a result of the training. In conclusion, RMC cannot be improved by training alone unless it is viewed through the lens of strengthening health systems to resolve bottlenecks, particularly the rights of birth care professionals.¹⁸

A study was done to promote respectful maternity care in three districts of Ethiopia. Over a 27-month period, data from 17 health centres and three hospitals were collected to assess the privacy and availability of birth companions during labour and childbirth. One district witnessed a significant increase in the percent of births that included two characteristics of respectful mother health care services: privacy and birth companionship (with short and long-term regression coefficients of 18 and 27%, respectively), whereas the other two districts saw mixed outcomes. The short-term regression coefficient in one of the districts was 26%, but it did not last long, whereas the long-term coefficient in the other district was 77%. Testimonial

films assisted clinicians in viewing their care through the eyes of their clients, and quality improvement training and coaching assisted them in reflecting on the root causes of this sort of treatment and developing successful remedies. The study concluded that using a multipronged strategy, with the RMC intervention incorporated in a quality enhancement paradigm, contributed to improve RMC in an exhaustive way.¹⁹

Non-experimental an exploratory study was done to investigate the attitude and knowledge towards RMC among nursing staff in selected hospitals in Pune, India. The research investigation was carried out on 100 subjects. The selective sampling technique was used to choose study subjects from nursing staff employed in certain health care setting. A comprehensive knowledge questionnaire and an attitude Likert scale were utilized. The findings found that 61% of staff nurses had average understanding of RMC, whereas 83% had a highly positive attitude towards respectful maternity care. The investigation reported that nursing staff had an moderate range of knowledge and an exceptionally favourable attitude, with a slightly negative correlation between knowledge and attitude. There was no significant association between staff nurses' level of knowledge and attitude towards respectful maternity care and demographic variables.²⁰

A one-group pre-experimental study including a pre-test and post-test was done to evaluate the efficacy of a structured instruction program on staff nurses understanding of respectful maternity care at SCPM Hospital in Gonda. The tool's reliability was $r = 0.82$ and the data was analysed using both descriptive and inferential statistics. The results of the investigation revealed that the post-test mean Knowledge score was greater than the pre-test mean score. There was a substantial

difference in knowledge level ($p < 0.001$). This investigation indicated that the staff nurses' knowledge has been strengthened by the structured teaching program.²¹

A descriptive study evaluated the effectiveness of a structured instruction program on RMC within nurses from the OBG wards at District Women Hospital and Rohilkhand Medical College and Hospital in Bareilly, Uttar Pradesh. The experimental group had a considerably higher mean post-test knowledge score (23.83 ± 2.87) compared to the control group's mean post-test knowledge score (6.73 ± 2.88), indicating the efficiency of a structured training program. The chi-square test found a strong connection between knowledge score and gender. The study was concluded, and the findings show that after implementing a systematic education program, the knowledge score level about respectful maternity care improved. As a result, the structured instructional method worked well.²²

A cross-sectional study was carried out to find out what staff nurses and resident physicians thought about the availability of RMC at work, to investigate the relationship between respondents' characteristics and their attitudes about RMC, and to investigate perceived obstacles. There are 78 staff nurses and resident physicians assigned to the study hospital's labour room. According to the results, providers had an average age of 30.5 years and 3.1 years of work experience. Approximately 83.3% of the responders were female, and two-thirds were resident physicians. Over 60% of the providers had RMC training. With the exception of presenting themselves to women, permitting birthing companions, and letting women take the position of choice, providers felt that most RMC-related activities were desired. Training status was substantially correlated with opinions regarding RMC. The biggest obstacle to delivering the best RMC was thought to be uncooperative women. According to the

study's findings, training providers can enhance the standard of care at birth and enforce RMC best practices.²³

Over the past few decades, the idea of "Respectful Maternity Care (RMC)" has grown and changed to encompass a variety of viewpoints and paradigms. RMC is a human right in addition to being an essential part of high-quality care. During conception and delivery, interactions between a woman and the maternity care system and providers are fundamental. In 2014, "Every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth," the WHO said in a declarations advocating for the evasion and eradication of impolite behavior and mistreatment throughout childbearing. Unwillingness to nurse, a low quality of life, and a strained mother-child attachment are just a few of the detrimental consequences of a traumatic birthing experience. A focus on quality and RMC is still essential for enhancing maternal health worldwide, especially as the number of experienced birth attendants and facility-based births continues to increase.²⁴

Every woman has a legal entitlement to receive the highest attainable health, which includes the right to honorable, compassionate treatment throughout gestation and postpartum. The WHO said in a statement advocating for the prevention and eradication of disrespect and abuse during childbirth. Unwillingness to nurse, a low quality of life, and a strained mother-child attachment are just a few of the detrimental consequences of a traumatic birthing experience. A focus on quality and RMC is still essential for enhancing maternal health worldwide, especially as the number of experienced birth attendants and facility-based births continues to increase. As a result, I invite the health systems in several states, including Andhra Pradesh, to implement Maathru Samman Pants in order to uphold women's fundamental human

right to dignity, which goes beyond preventing death and illness. The effects of this invention (Maathru Samman Pants) should not be restricted to India alone; rather, other medical facilities around the world ought to take it into consideration.²⁵

A study was carried out to evaluate nurse midwives knowledge, attitudes, and practices regarding respectful maternity care in Bhutan's referral hospitals. 83 nurse midwives who worked in three regional referral hospitals pregnancy and delivery units, According to the results, four out of five respondents were aware of and exercised a woman's right to communication and information during the delivery process. However, providers reported their experiences seeing occurrences that are characterised as abusive in maternal health literatures and were found to be deficient in certain areas of knowledge and practices linked to respecting women's choices and rights during birthing. Detrimental causes included inadequate facilities, overworked workers, and inadequate training. According to the study's findings, some RMC components were not properly applied. Improving maternal health services requires educating providers about women's rights to respectful care. To practice RMC, an adequate setting must be provided by the individual health facility. It is advised that future research on RMC from the receiver end be conducted.²⁶

A qualitative investigation was undertaken between September and December 2018 in two Tehrani public non-teaching hospitals, Iran, to investigate Iranian midwives' perspectives of respectful maternity care during labour and childbirth. A purposive sampling strategy was used to conduct 24 midwives with over a year of experience participated in semi-structured interviews. working in labour and birthing facilities. The data was analysed using a content analysis approach to find concepts. Three concepts were identified: "showing empathy", "women-centered care", and "protecting rights". Compassion indicates both "establishing a friendly relationship"

and "being with women". Care concentrating on women included "keeping women safe" and "participating in decision making". Upholding rights represented the requirement for "safeguarding dignity" in addition to "giving equal care" and "preparing an appropriate environment". Midwives from Iran saw RMC as more Rather than exclusively eliminating maltreatment. Delivering supportive care to women through amicable the very initial step was communication towards delivering respectable obstetric services. Respectable service is also fostered by delivering secure medical services using based on evidence practices, including women in her protection and creating an appropriate environment for women, families, and care.²⁷

An exploratory nationwide online survey was done to assess students studying nursing and midwifery perspectives of RMC and the occurrence of inappropriate care given to mothers in China. Determine the prevalence and views of respectful maternity care, as well as the associated characteristics; explore whether witnessing disrespectful care changes people's perspectives of respectful maternity care. Positive attitudes about respectful maternity care were prevalent among the 733 students. Approximately one-fifth of incidents involved disrespect, with physical abuse, a lack of communication, and late treatment being the most commonly reported. Female students of Han ethnicity who majored in midwifery had a higher grasp of respectful maternity care, completed a longer internship/practicum, and reported fewer incidences of disrespect. To enhance RMC in China, systemic reforms are required. RMC should be a necessary component of registration in advance for nurses and midwives. courses. It is appropriate to encourage children to identify poor practices and discuss excellent practices in a secure learning environment.²⁸

To find out how respectful maternity care serves as the cornerstone of maternity services in London, a qualitative descriptive investigation was carried out.

While 25 participant responses were examined, four categories and six subcategories were found to be indicative of respectful maternity care. The following were the categories and subcategories: the birth environment (client-centered care and caring in the birth environment), managerial support (a supportive work environment), interpersonal facet of care (qualities of healthcare providers), and healthcare professional behaviour (ethical conduct and professional attributes related to education and training). In order to guarantee the best possible outcomes for women, families, and communities, midwives stressed the significance of comprehending respectful maternity care. But because maternity care is complicated, it is important for administrators, midwives, and politicians to understand and value the different components that make up respectful care because doing so can greatly improve its successful implementation.²⁹

The mixed-methods approach to systematic investigation was carried out using the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) criteria. To assemble and assimilate findings from investigations, the JBI (Joanna Briggs Institute) conducted Mixed-methods systematic evaluations. Several records were investigated. JBI critical evaluation checklists for quasi-experimental, cross-sectional, and qualitative investigations were employed, along with a mixed-methods appraisal tool. Data from quantitative studies supported the effectiveness of programs to improve midwives' and nurses' knowledge/perceptions of compassionate maternity care. Findings from qualitative research show that Continuing higher education, rather than only once solutions, and the engagement of other health service professionals and managerial workers engaged in childbirth services, would assist encourage courteous patient services. The study recognises that respectful maternity care education initiatives are required in high, middle, and low-income nations.³⁰

A cross-sectional investigation of prenatal and postpartum women consulting MSI maternity clinics in Kenya and Tanzania before and after the RMC educational approach. Healthcare providers accomplished surveys before and after the workshop on days 1, 90, and 180 to assess modifications to their awareness and behaviors, and perceptions of desired RMNC practices. The findings show that these training interventions can improve healthcare providers' knowledge, attitudes, and perceptions of RMC procedures. Patients reported a more pleasant experience with their maternity care after the training.³¹

2.3 Studies related to post-natal mother perception and satisfaction of RMC

A quasi-experimental study was carried out in a particular West Bengali hospital to assess the impact of an awareness campaign on pregnant women's knowledge of respectful maternity care (RMC). 60 pregnant women were admitted to the prenatal ward of the Medical College & Hospital (MCH) in Kolkata (30 in each of the experimental and control groups). The experimental group's average knowledge score after the test (32.53) was considerably greater than their average knowledge score before the test (18.50), according to the results [t (df29) = 43.84, $p < 0.05$, $p < 0.01$]. The success of the awareness training was demonstrated by the significant difference [t (df 58) = 9.99, $p < 0.05$, $p < 0.01$] between the experimental and control groups' mean post-test knowledge scores. The study also discovered a strong correlation between socioeconomic level (2 df 1 = 6.04, $p < 0.05$) and the knowledge score of women with educational qualifications (2 df 1 = 6.54, $p < 0.05$). The study has significance for various nursing specialization. The report suggests conducting a qualitative investigation and Report on RMC Conformity.³²

A cross-sectional study was undertaken Out of 231 mothers with kids under 2 years old who had sustained institutional births and visited immunization centres. Assessment of Respectful Maternity Care during Childbirth: Mothers' Experiences in Manipur. The respondents' mean (standard deviation) age was 28.9 ± 5.8 years, according to the results. 96.5% of people reported having experienced abuse of some kind, with the "Facility and Environment" domain having the highest occurrence (77.5%). Compared to other types of health facilities, women who gave birth in public tertiary care facilities were substantially more likely to experience abuse in the areas of "Dignity and Respect," "Support and Care," "Facility and Environment," and "Predictability and Transparency" ($P < 0.05$). According to the study's findings, practically all of the participants (96.5%) experienced abuse in one way or another. In order to promote dignified maternal health-care services, more action, discussion, research, and advocacy are required on this crucial public health issue.³³

A cross-sectional study of 246 women from a tertiary care hospital in Odisha was conducted using a questionnaire to measure the level of RMC and its impediments. The study found that more over one-third of women reported positive RMC. Women rated environment, resources, dignified care, and non-discrimination high. However, non-consented and non-confidential care received low ratings. Health care personnel perceived barriers to RMC delivery as a inadequate legislation, job stress, challenges with language, a no cooperative mother, the absence of materials, recruitment, and issues with confidentiality and communication. The study indicated that improving organizational laws and regulations, materials, guidelines, and monitoring of health services providers on liberty of women during childbirth will increase the level of excellence treatment and lead to more pleasant birth experiences.³⁴

A cross-sectional survey employing a validated 30-item, 90-point person-centred maternity care (PCMC) scale of women (n = 660) who gave birth in 25 birth facilities across four districts in Malawi in March 2020. Aim to explain how women view their maternity care experiences. The mean PCMC score was 57.5 (range 21–84), with communication and autonomy receiving the lowest score (12.4 out of 27). Women reported being denied the presence of a birth companion during labour (49.4%) or delivery (60.3%); providers failing to introduce themselves (81.1%); providers failing to obtain consent prior to procedures/examinations (42.4%); women feeling unable to ask questions (40.9%); and being excluded from care decisions (61.5%). Few women reported being routinely mistreated physically (2%) or verbally (3.5%), although almost all had access to water and power (>95%). While a lack of social support and communication with patients was prevalent, physical and verbal abuse as well as a lack of basic amenities was uncommon. While facility/system parameters, such as facility type and sector, were not predictive of RMC, maternal features, such as timing of ANC and maternal or infant problems, were. Encouraging patient and companion involvement in treatment and improving provider communication skills will be necessary for ongoing efforts to promote respectful care.³⁵

The study used a pre-post, mixed-method design and was conducted in 6 public health at the secondary level institutions in two rural districts of Southern Sindh, Pakistan. To encourage psychosocially supportive and respectful maternity care (S-RMC) at public health facilities, The cumulative degree of overall mistreatment decreased significantly from baseline to end-line, with a 50% relative drop ($P < .001$). The following categories of mistreatment showed similar changes: lack of supportive care (52%), verbal abuse (72%), physical abuse (75%), inadequate

interaction (60%), anonymous healthcare services (78%), health sector circumstances and restrictions (25%), non-inclusive care (28%), and stigma and discrimination (82%). Additionally, we found that the percentage of women who had anxiety and depression symptoms before and after the intervention was significantly lower. In addition to strengthening governance, accountability, and health information systems, this intervention increased the capability of maternity teams. A thorough assessment of its efficacy in a variety of contexts is necessary, considering its potential to encourage a respectful and encouraging delivery in public health institutions.³⁶

A facility-based cross-sectional survey was carried out among mother's who gave birth at public hospitals in the Hadiya Zone of South Ethiopia, From March 1 to March 30, 2020. To investigate and evaluate the state of respectful maternity care and related elements in order to close the gap. Respectful maternal care was provided to 67.8% (95% CI: 62.4-70.8%) of women, according to this study. Respectful maternity care was considerably associated to being married [AOR: 2.17, 95% CI (1.03-6.93)], having a caesarean section [AOR: 2.48, 95% CI (1.03-5.97)], and not having any problems during childbirth [AOR: 4.37, 95% CI (1.41-13.56)]. In this investigation, the RMC level was moderate. Unmarried women and women with labour problems, regardless of delivery method, should be the focus of efforts targeted to improve respectful maternity care.³⁷

A qualitative study aimed at finding out how certain fabricated facility birth experience of care characteristics affected the expressed preferences of rural Nigerian women for a hypothetical delivery location. Of the 426 women, 425 had complete data for the discrete choice experiment. Most were married (95%) and of the Fulani ethnic group (60%). Nearly half (45%) lacked formal schooling. All of the parameter estimates showed the expected signals of internal validity. Good health system

conditions had the biggest impact on the choice of delivery location, followed by the lack of sexual abuse and the absence of verbal and physical violence. Insufficient institutional environment was linked to the highest utility and had the greatest detrimental influence on priorities for childbirth at an establishment. This included a terrible birthing atmosphere with no sense of confidentiality and an ambiguous cost. In northeast Nigeria, rural women's expressed preferences for the place of delivery were significantly impacted by the possibility of having a bad experience giving birth in a facility. The results of the study further highlight the significant correlation between facility delivery experience and use. In order to guarantee that women desire to use the services offered, efforts must be made to resolve unsatisfactory facility birth experiences and promote respectful maternity care in order to achieve universal health coverage.³⁸

A cross-sectional study conducted at the University Clinical Hospital Mostar, Department of Obstetrics & Gynaecology aims to identify areas for improvement at a tertiary hospital and assess how satisfied mothers who gave birth at term are with the hospital care they obtained. An entire group of 100 mothers participated in the research. Results Satisfaction with midwives' communication and attitude to women in the birth room was substantially higher (4.7 ± 0.6) as compared to obstetricians-gynaecologists (4.5 ± 0.8). Midwives received higher ratings for giving breastfeeding information (4.5 ± 0.8) compared to their response time to a call bell (4.2 ± 1.0). Respondents had the lowest satisfaction with hygiene (bathroom, shower, and rooms) and food quality (average grades 3.8 ± 1.1 and 3.9 ± 1.0 , respectively). Mothers who had previously given birth at the same hospital reported similar levels of satisfaction with their current stay. In conclusion While improving the standard of nutrition and

hygiene should be required, it is advised that medical and non-medical workers have good communication skills in order to preserve mothers' satisfaction with birthing.³⁹

A cross-sectional survey of 4192 women who gave birth naturally in a maternity care facility in Shanghai, China, between March and June 2019. to explain the maternity care experience of Chinese women under the supervision of a midwife and assess how satisfied they were with it. In this study, 87.7% of the women had a Midwife and a family member present during delivering. 75.6% of patients received epidural anaesthesia, whereas 23.2% required an episiotomy. Free positioning during the first stage of labour and free positioning during the second stage of labour and delivery were used in 84.3 and 67.9% of cases, respectively. Moderate to severe perineal pain and oedema were reported by 43.1% and 12.2% of participants, respectively. Midwife-led prenatal counselling, the presence of a Midwife and a family member, Lamaze breathing techniques, warm perineal compresses, epidural anaesthesia, free positioning throughout the initial stage of labour, and midwives' postpartum guidance all resulted in a high degree of satisfaction. Perineal discomfort and oedema were associated with lower levels of satisfaction. Women in this conduct surveys reported high levels of satisfaction with midwife-led maternity care. This happiness is most likely due to the midwife's prenatal counselling and the ability to have a Doula and a family member present during birthing. Other intangible elements that improved satisfaction levels included Lamaze breathing methods, warm perineal compresses, epidural anaesthesia, and free posture during the first stage of labour, and early skin-to-skin contact.⁴⁰

In order to evaluate mothers' satisfaction with health extension services and related characteristics in the Southern Ethiopia's Gamo Goffa Zone: a community-based cross-sectional investigation was carried out, 478 women were participated

between 1st and 28th February 2018. The total percentage of mothers who reported satisfaction with health extension programs was 37.4%, with a 95% confidence interval (33-44%). Mothers who earn a high monthly income for their families [AOR = 4.66 (95% CI: 1.1, 20.6)], husbands who took part in the program for health extension [AOR = 4.02 (95% CI: 2.0, 8.1)], recent involvement in health extension program scheduling [AOR = 5.75 (95% CI: 2.0, 16.5)], and recognition as an excellent family [AOR = 2.23 (95% CI: 1.1, 4.6)] had a greater rate of satisfaction with health extension services. Women in the research area reported low satisfaction with health extension services. Higher monthly household earnings, participation of spouses and wives in health extension initiatives, and Being a part of an ideal family were all connected with greater pleasure. Interference to improve women's fulfillment with extension of health services should concentrate on their and their spouses' involvement in service planning and implementation at the home level. Similarly, expanding the experiences of model families in the community would improve satisfaction levels.⁴¹

A cross-sectional survey of 610 mothers during their discharge from five public hospitals. To examine the amount of RMC experienced by women during childbirth in Rwanda's Eastern Province health institutions. The majority of respondents (70.2%) expressed feeling Respectful Maternity Care. The most praised Respectful Maternity Care items (above 90%) were food and fluid intake (98.5%), non-discrimination (96.2%), access to basic services (96.1%), and privacy (91.3%). The chi-square analysis found a link between declared excellent Respectful Maternity Care and married status (p-value = 0.006), occupation (p-value = 0.001), and mode of delivery (p-value = 0.001). In multivariate logistic regression, Caesarean section delivery was related with high RMC with a p-value of 0.001, and the adjusted odds

ratio was 2.11 with a confidence interval [1.40-3.17]. The extremely high level of appreciation for the reported RMC products and attention should continue. All moms should be treated with the highest respect throughout childbirth, regardless of the method of delivery, and they should receive the most RMC possible.⁴²

Women in eight secondary and tertiary hospitals across four of the nation's six geopolitical zones participated in five focus group discussions (FGDs). To glance at how women in Nigeria's secondary and tertiary hospitals perceive about the maternity services they receive there. Few individuals reported they were satisfied with the level of care they received during their prenatal, postnatal, and intrapartum periods. Many expressed areas of discontent with the level of care, or were completely unsatisfied. Poor staff attitudes, lengthy wait times, inadequate attention to labouring women, exorbitant service costs, and inadequate facilities were among the reasons for discontent. These kinds of discontent were cited as the causes of women's frequent preference for traditional maternity care over contemporary facility-based treatment. Reducing maternal morbidity and mortality in Nigeria, improving access to maternal health care, and reducing women's dissatisfaction with contemporary facility-based health care will all depend on a women-friendly approach to maternal health care delivery that is founded on an adequate response to women's concerns and experiences of health care.⁴³

A descriptive cross-sectional study was done to investigate women's perceptions of RMC during facility-based childbirth among 100 post-natal mothers admitted to the post-natal ward at New Civil Hospital in Surat. The data suggest that 90 percent of the women stated that they perceived the overall dimensions of RMC, with a mean score of 82.83 and a standard deviation of 12.83229, whereas the other 10% did not sense it. The average score for friendly care is 83.00, with a standard

deviation of 14.41187, and 90 percent of post-natal women reported receiving friendly care. The abuse-free care dimension had the highest average score of 90.00, with a standard deviation of 13.6782, and 98 percent of post-natal moms reported receiving abuse-free care. In terms of timely care, the average score is 81.4 with a standard deviation of 16.0609, and 89 percent of postpartum women reported receiving timely care. The average score in the privacy maintained category is 81.5, with a standard deviation of 18.27815, and 89 percent of postnatal mothers reported receiving privacy maintained. In the newborn care section, the average score was 82.83 with a standard deviation of 17.51 73, and 84 percent of post-natal mothers reported receiving care for their child.⁴⁴

A thorough descriptive assessment that uses Review documents to emphasize program features, facilitators, and difficulties that affect LaQshya's capacity to evaluate quality, as well as an analysis of its characteristics of measurement to the WHO Standards for Maternal and Newborn Care 352 quality indicators. Strives to enhance intrapartum care by reducing problems, enforcing protocols, and encouraging respectful maternal care (RMC). Study concludes that LaQshya is an effective model for assessing excellent of care that outperforms existing universal evaluation instruments. To maximise its prospective, we recommend bolstering the governing structures in districts and providing customised RMC and other modern quality processes training programs. Further,, broadening its estimate of excellence measures to efficiently examine health care provider responsibility, outcome for patients, liberty, supervision of employees, and health facility leadership will significantly strengthen the organization's ability to evaluate quality improvements.⁴⁵

A cross-sectional survey was conducted in Ghana, Guinea, Myanmar, and Nigeria as part of the WHO project 'How women are treated during facility-based childbirth' to investigate maltreatment of women during birth. This analysis includes 2672 women, over one-third of women (35.4%) reported mistreatment, yet overall satisfaction and recommendation of the facility were high (88.4% and 90%). Women who experienced mistreatment were less satisfied with their care compared to those who did not encounter verbal abuse (adjusted odds ratio (AOR) 4.52, 95% CI 3.50 to 5.85) nor had short waiting times (AOR 5.12, 95% CI 3.94 to 6.65). Women who reported no physical or verbal abuse or discrimination were more likely to suggest the facility to others (AOR 3.89, 95% CI 2.98 to 5.06). Women's experiences and satisfaction with care must be measured in order to evaluate quality and offer beneficial information for quality enhancement. By using these steps, health systems may be able to pinpoint and address the underlying issues influencing satisfaction metrics.⁴⁶

2.4 Studies related to Person-Centred Maternity Scale

A facility-based cross-sectional study was done in 2021 to investigate the level of person-centred maternity care and associated characteristics among mothers who gave delivery in selected public hospitals in Addis Abeba, Ethiopia. A total of 384 mothers participated in this study, with a 99.2% response rate. The percentage mean of respondents' Person Centred Maternity Care (PCMC) scores was 65.8%, with a percentage standard deviation of 17.06, and the total prevalence of PCMC was 65.8%. Person-centred maternity care was significantly associated with respondents who had no ANC follow-up ($\beta = -5.39$, 95% CI: -10.52, -0.26), < 4 Antenatal Care (ANC) follow-up ($\beta = -3.99$, 95% CI: -6.63, -1.36), delivered at night ($\beta = -3.95$, 95% CI: -5.91, -1.98), and experienced delivery complications ($\beta = -3.18$, 95% CI: -6.01, -

0.35). According to the study's findings, policymakers require to create and execute person-centred maternity care recommendations. Health care professionals should get training on patient and provider rights as well as the significance of person-centred maternity care. To improve the delivery of person-centred maternity care, hospital managers should increase the number of staff members who have received PCMC training, particularly at night. All moms who gave birth in the medical facility should receive person-centred maternity care from the providers.⁴⁷

A cross-sectional survey was done from August to October 2017 among recently delivered women at 40 government facilities in Uttar Pradesh, India (N=2018). The study's goal is to investigate the validity and reliability of the PCMC scale in India and compare the results to those obtained in the Kenya validation. The findings support a 27-item PCMC scale in India, with a possible score range of 0 to 81, as opposed to a 30-item PCMC scale in Kenya, with a possible score range of 0-90. The PCMC scale has high dependability (Cronbach alpha=0.85). Similar to Kenya, we can divide the items into three conceptual categories, which reflect subscales for "Dignity and Respect," "Communication and Autonomy," and "Supportive Care." The sub-scales are likewise relatively reliable (Cronbach alpha values range from 0.67 to 0.73). Furthermore, higher scores on the scale are associated with future plans to deliver at the same facility, indicating strong criterion validity. This study contributes to the PCMC literature by giving results from validating the PCMC scale in a new environment. The psychometric study utilising data from Uttar Pradesh, India, supports the Kenya analysis, indicating that the scale showed good content, construct, and criterion validity, as well as high reliability. The overlap in items shows that this scale can be used in a variety of settings to compare

women's experiences with treatment, as well as to guide and evaluate quality improvement efforts to promote complete PCMC.⁴⁸

To analyse the quality of person-centred maternity care and related characteristics among mothers who gave delivery, a cross-sectional study carried out within a facility was carried out at a few public healthcare facilities in Ethiopia's Addis Ababa, in 2021. 384 total mothers are participated in the investigation, with a 99.2% response rate. The results of this study demonstrated that, in comparison to earlier research, a significant percentage of mothers who gave birth at Addis Ababa's public hospitals received person-centred maternity care. Interventions can be used to control the elements influencing person-centred maternity care. As a result, policymakers ought to create and execute person-centred maternity care recommendations. Health care professionals should get training on patient and provider rights as well as the significance of person-centred maternity care. To improve the delivery of person-centred maternity care, hospital managers should increase the number of staff members who have received PCMC training, particularly at night. All moms who gave birth in the medical facility should receive person-centred maternity care from the providers.⁴⁹

This study was carried out in seven public hospitals in Enugu metropolis, Enugu State, South-east Nigeria, to explore midwives' perspectives of person-centred maternity care (PCMC). The average age of midwives was 41.8 ± 9.6 years. Approximately 53% of midwives have worked for ≥ 10 years, while 60% are junior midwives. Overall, 26%, 49%, and 25% of midwives had low, medium, or high PCMC levels, respectively. The average PCMC score was 54.06 (10.99). The high perception of PCMC subscales ranged from 6.5% (dignity and respect) to 19% (supportive care). No socio-demographic parameters significantly influenced

midwives' perceptions of PCMC. According to the study's findings, PCMC at public hospitals is inadequate from the standpoint of midwives. Midwives' demographic features do not appear to have a major impact on how they deliver PCMC. The study revealed areas in which midwives must develop abilities in order to provide PCMC.⁵⁰

A cross-sectional study was undertaken in China on 1235 post-partum mothers. The purpose of this study was to translate and assess the psychometric features of the Person-centred Maternity Care (PCMC) Scale among Chinese postpartum women. There were just three extracted common characteristics (dignity and respect, communication and autonomy, and supportive care), which explained 40.8% of the overall variation. In terms of internal consistency, the whole PCMC score has a Cronbach's alpha coefficient of 0.989 and split-half dependability of 0.852. The Chinese version of the PCMC is a reliable and accurate tool for evaluating person-centred care during childbirth in China.⁵¹

2.5 Justification for the study

In 2017, the Indian Government announced "LaQshya" (labour Room Quality Improvement Initiative) to enhance the benchmark of care in public health facilities' labour stations and obstetrics surgical theatres. It is a multifaceted approach aimed at the intrapartum and shortly postpartum phase. Its goal is to reduce unnecessary maternal and newborn mortality, morbidity, and stillbirths related with delivery care in the labour room and maternity operating theatre, as well as to ensure compassionate maternity care.

The program is being implemented in government medical colleges (MCs), as well as District Hospitals (DHs), Sub-District Hospitals (SDHs), and Community Health Centres (CHCs) with significant delivery loads. In order to meet the defined

goals, these selected institutions will obtain labour room certification and catalyse the facilities within institutions.⁸

In order to improve beneficiary satisfaction, the "LaQshya" program initiative brought an insight into the significance and importance of respectful maternity care (RMC).

Respectful maternity care (RMC) has gained popularity in the global conversations, although incidences of disrespect and abuse continue to pop up. While some study has revealed effective approaches for improving RMC, the literature on the subject remains limited⁹. This illustrates why this investigation is required.

Hence the researcher has selected this study to sensitizing health care provider for delivery of RMC, to improve quality of care during the intra-partum and immediate postpartum period and enhance satisfaction of beneficiaries.

Thus, our study highlights the effectiveness of the training package on health care provider perspectives of respectful maternity care and client satisfaction.

CHAPTER - 3

MATERIALS AND METHODS

Research methodology refers to the methods, techniques, and approaches used to collect and analyses the information utilized in a research endeavor. The methodology for investigation describes the overall pattern for organizing the technique for empirical inquiry, as well as the strategy for collecting valid and reliable data for the subject under examination.

This chapter discusses all of the research approaches implemented, research design, variables, study setting, study population, sample size, sampling strategy, sample selection criteria, tool description, data collection procedure, and data analysis plan.

3.1 Research Approach: The first step in conducting a research study is determining an investigation approach. It directs the investigator on what information to obtain and how to measure it, as well as potential inferences to be drawn from the information.

Considering the nature of the topic chosen for the present study and the objectives that needed to be met, a descriptive technique was thought to be appropriate for the present investigation.

3.2 Research Design: The researcher's overall strategy for gathering and evaluating data, including guidelines for improving the study's internal and external validity, is referred to as the research design. The methods the researcher used to produce factual and impartial information are outlined in the research design.

The goal of the study, the research methodology, and the variables to be examined all influence the design choice. The current study used a quasi-experimental research design with one group pre-test and post-test.

GROUP	PRETEST	INTERVENTION	POSTTEST
Healthcare provider	O1	X	O2
Postnatal mother	O1	Routine care given by the trained care provider on RMC	O2

Key notes

O1- Health care provider's pre-test perception of respectful maternity care and Base-line survey of RMC satisfaction level among postnatal mothers.

O2- Health care provider's post-test perception of respectful maternity care and End-line survey of RMC satisfaction level among postnatal mothers.

X - Respectful Maternity Care Training among health care provider.

3.3 Research setting: According to the nature of the study topic and the specific type of information required to answer it, settings are the more precise locations where collection of data takes place. The Maternity Units of Selected Tertiary Care Hospital, Belagavi, is the designated destination for the current research.

3.4 Research Population: A population is the aggregate amount of cases in where a researcher is interested. The current study population includes all health care providers in the maternity units and recently delivered women of Selected Tertiary Care Hospital, Belagavi. (The maternity units include the labour room, labour OT, ANC OPD, NICU, postnatal ward, MCH ward, and antenatal ward.)

3.5 Sample: The term sample refers to an element of a population that is representative of the total population. Therefore, it is a subset of the population elements. The current study sample includes all health care providers (OBG PG –MD, Registered Nurse, health assistance and Nursing interns) in the maternity units and recently delivered women of Selected Tertiary Care Hospital, Belagavi.

3.6 Sample Size: As per the published literature, proportion of knowledge regarding RMC in care provider is $P_1=61.6\%$ and $p_2=74.5\%$. Based on this sample size is calculated and determined with the assumptions of confidence interval =95%, power for the double population proportion =95% and attrition =10% from the formula below.

$$\frac{(Z_{1-\alpha/2} + Z_{1-\beta})^2 (p_1 q_1 + p_2 q_2)}{(p_1 - q_1)^2} \times 1.1$$

Where: -

P_1 and p_2 -refers to the proportion of provider knowledge regarding respectful maternity care

q- Is (1-p) absence of possibility

Considering the above formula the sample size is calculated as, $n= 366$ and rounded off 370

3.7 Sampling technique: Purposive sampling technique is implemented in the present study.

3.8 Sampling criteria: The sample selection was based on the following inclusion and exclusion criteria.

Inclusion criteria: All healthcare provider who works in the maternity units of the Selected Tertiary Care Hospital in Belagavi, including OBG PG-MD, registered nurses, and health assistants and Nursing interns.

Exclusion criteria: Health care provider who undergone any training / in-service education programme on RMC

3.9 Administrative and Ethical consideration:

Hospital Authority: The Director, Medical Superintendent, and Head of the Obstetrics and Gynaecology department of selected Tertiary Care Hospital in Belagavi, granted formal clearance.

Approval from Institutional Ethical committee: The ethical clearance was obtained on human subjects, from KAHER Ethical Committee (Ref. No. KAHER/EC/21-22/016)

Protection of Human rights: all the health care providers and recently delivered mothers who participated in the study provided informed consent. The researcher explained the nature and goal of the study to all participants. They were assured that their identities and the confidentiality of the information obtained would be protected.

3.10 Study Variables:

Independent variable: Structured Training Program regarding RMC

Dependent variable: Health care provider perspectives regarding RMC in terms of Knowledge, post-natal mothers' satisfaction level of RMC.

Socio-demographic variables: Sex, Age, Gender, educational qualification, Total work experience, marital status, Religion, Mother tongue, Experience in conducting labour.

3.11 Data collection instruments and techniques

3.11.1 Description of tool

The tool consists of:

Tool 1: Socio-demographic data (care provider)

It includes information such as Age (in year), sex, Gender, educational qualification, Marital status, Religion, Total work experience, Experience in conducting labour, Mother tongue.

Tool 2: Items on knowledge questionnaires on Respectful Maternity Care

It consists of 15 items on respectful maternity care, designed to assess the knowledge of health care providers, it is based on the components of RMC given by WHO and National Health Mission. Responses ranges from 12 to 15 correct answers: Adequate knowledge. 7 to 11 correct answers: Moderate knowledge. Less than 7: Inadequate knowledge, these scores were converted into percentages, and subjects were then divided into groups reflecting inadequate knowledge, moderate knowledge and adequate knowledge.

Scoring:

≤50% - Low level Knowledge

51-75% - Average Level of Knowledge

≥76% - High level knowledge

Tool 3: Socio-demographic data (post-natal mother)

It has characteristics like Age (in years), Educational status, Marital status, Occupation, Obstetrics score, Religion and Type of Family, Type of residence.

Tool 4: Satisfaction level post-natal mother (Person-Centred Maternity Care Scale)

A key element of high-quality maternity care is person-centred care during childbirth. PCMC is a standardized scale, PCMC scale has good reliability (Cronbach alpha = 0.85)⁴⁸ used to assess the post-natal mother satisfaction level of respectful maternity care. Scale was modified according to the setting and objectives of the study. It consist of 7 domains of RMC like- Dignity and Respect, Communication and autonomy, Supportive care, Privacy and confidentiality, Trust, Facility and environment and Predictability and transparency of payment. Each domain includes sub-points arranged in in a 2-point Likert scale: Yes, No and consisting both the positive and negative statements. These scores were transformed into percentages to classify participants as satisfied or dissatisfied depending on their scores.

3.11.2: Development of RMC training programme content

It was developed after a thorough study of existing literature, in accordance with guidelines established by both the World Health Organisation (WHO) and the National Health Mission (Government of India has launched “LaQshya” guidelines in 2017). Additionally, constructive discussion with guides and professionals has greatly contributed to its refinement. The researcher conducted a three-session, structured training program for healthcare providers during their free time. Each session lasted roughly 30 minutes, using videos, flashcards, online modules, hand-outs, and demonstrations. It culminated in the manner outlined below:

Sessions	Content	Time (90 min)
I	Introduction – meaning , importance ➤ Categories of RMC : • Physical Abuse • Non dignified care • Non consented care • Non confidential care • Discrimination • Withholding the care • Detention In the facilities	10 min 20 min
II	➤ Needs of RMC for Health Care Workers ➤ Universal rights of child bearing women ➤ Obstetrical violence – meaning manifestation Prevention and elimination of violence during childbirth	5 min 10 min 10 min 5 min
III	➤ Challenges and barriers ➤ Introducing online module The online module titled “Implementing Respectful Maternity Care in Healthcare Facility”. This is prepared by the White Ribbon Alliance India and available in Aasrtika Foundation platform.	10 min 20 min

3.11.3: Content validity of the tool

Experts examined the tool content validity after receiving the blueprint, objectives, checklist, and validation certificate. The validation process was carried out by a panel of four professionals from the OBG Nursing department, three doctors who specialist in Obstetrics and Gynaecology, and one professional midwife. Their helpful comments were thoroughly analysed, resulting in refinements to improve the tool content comprehensiveness.

3.11.4: Data collection procedure

- The data was obtained between February 2022 and January 2023.
- Ethical clearance obtained from ethical committee on human subjects, KAHER
- Formal permission was taken from the administrators of selected hospital.
- Health care workers were selected based on the inclusion and exclusion criteria.
- Informed consent was obtained from the Health care workers and mothers, assuring them the confidentiality and anonymity
- The purpose and need for the study was explained to them
- The socio-demographic and base-line survey were assessed with recently delivered women using Person-Centered Maternity Care Scale
- The socio-demographic data and pre-test from the health care provider were assessed using structured knowledge questionnaires.
- Intervention in the form of structured training program on health care providers, comprising of three sessions, each session lasting for approximately 30 minutes were given by the researcher during their free schedule.
- The post-test for health care provider were done 7 days after intervention (after completing the online module “Implementing Respectful Maternity Care in Healthcare facility” from Aastrica platform.
- The End-line survey were assessed from mother using the Person-Centered Maternity Care Scale
- Sensitize the post-natal mothers regarding universal rights of child bearing women and Respectful Maternity Care.

3.11.5 Data analysis

The data was processed to comply with the study objectives and hypothesis testing. Collected data was coded, entered, in a password protected computer. Data will be analysed by using software SPSS version 22, the data gathered were analysed using both descriptive and inferential statistical approaches. Descriptive statistics including frequency, mean, median and standard deviation were utilized to provide a comprehensive overview of the data. Inferential statistics including chi-square, Wilcoxon matched pairs test and dependent t-test were used to identify significant differences and associations among the groups, Statistical significance was determined using a p-value of <0.05 .

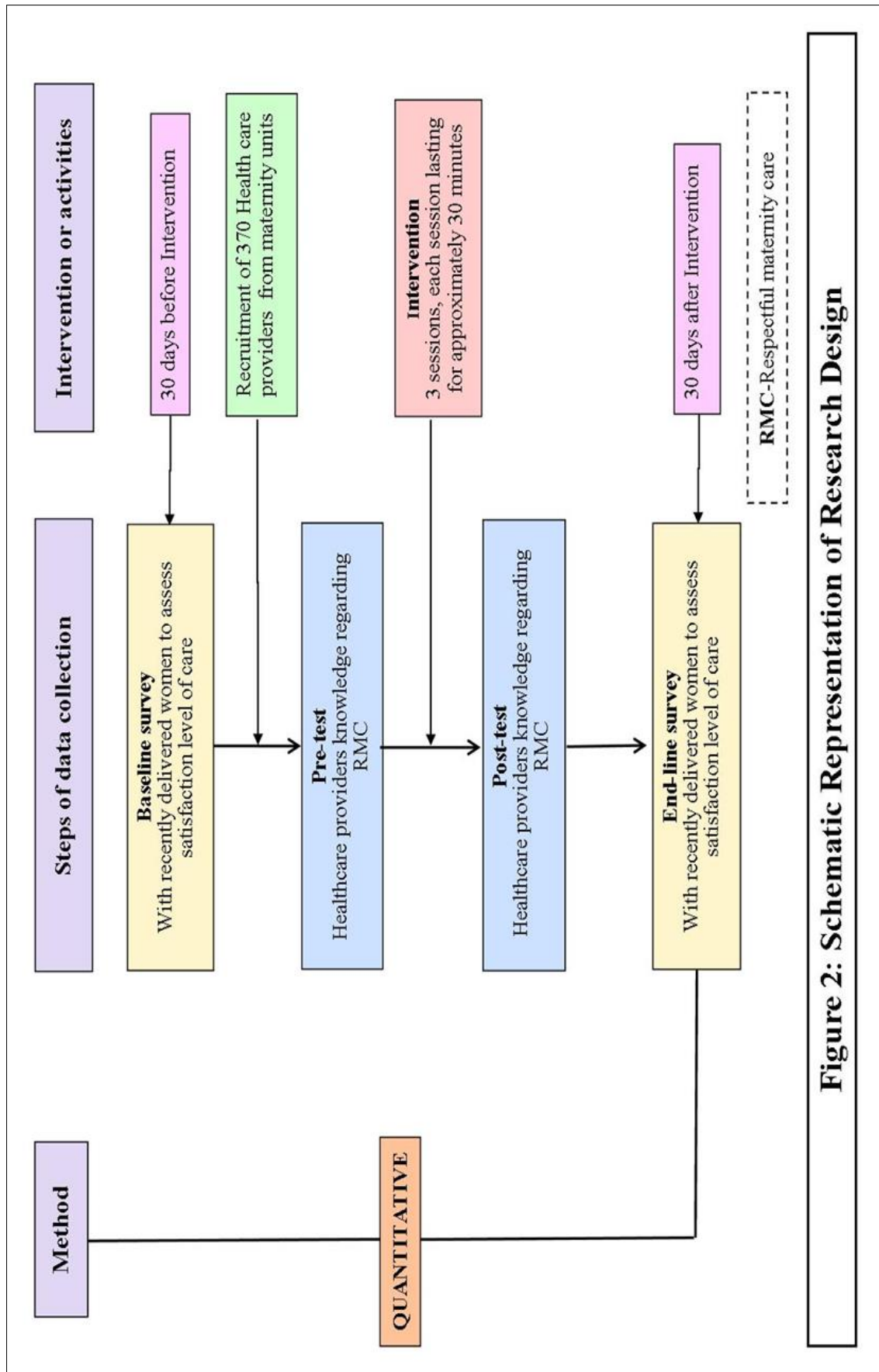


Figure 2: Schematic Representation of Research Design

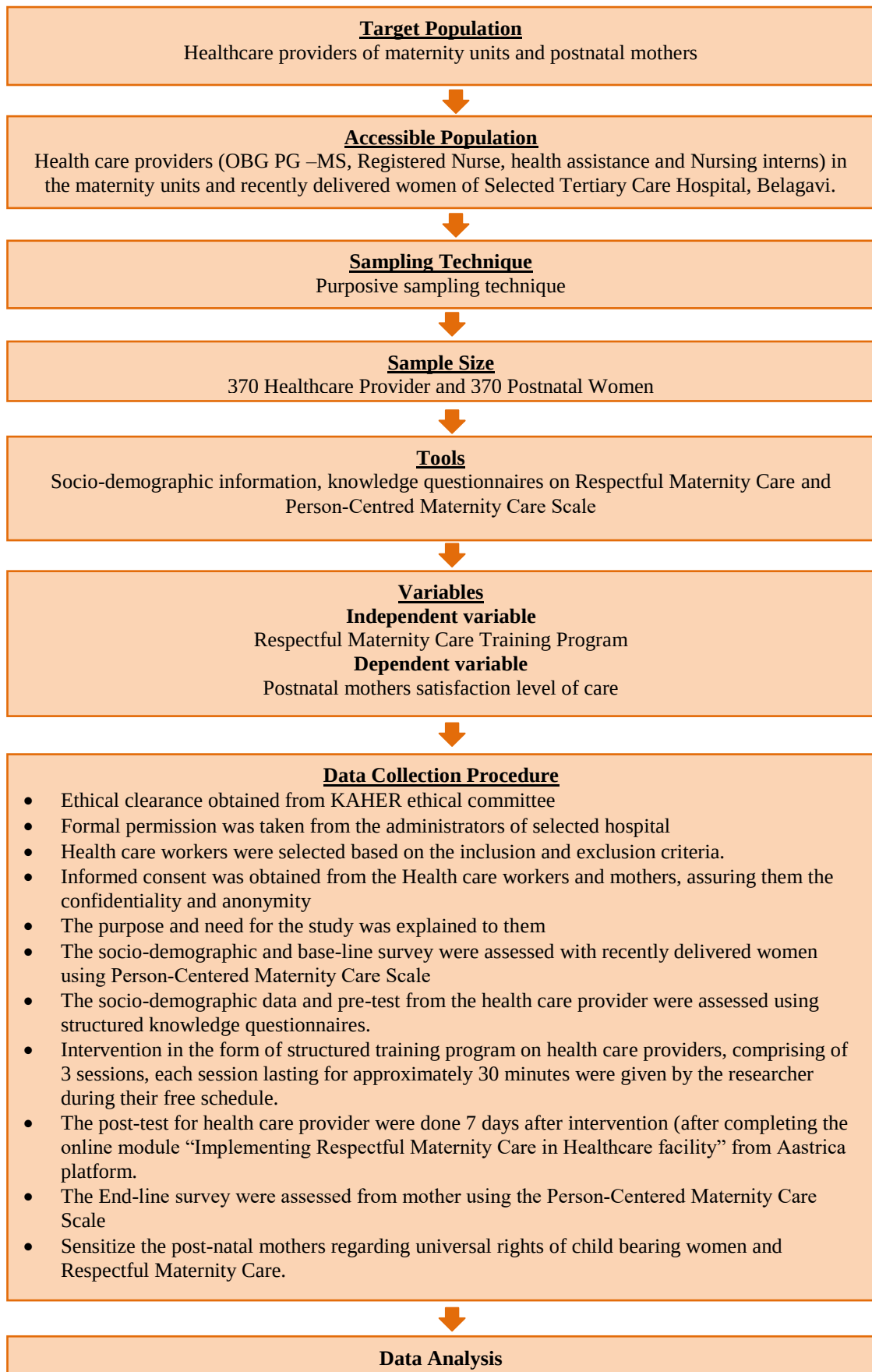


Figure 3: Schematic Representation of Research Methodology

CHAPTER – 4

RESULTS ANALYSIS

This chapter evaluates the data collected for the current investigation. Analysis entails calculating numerous metrics and investigating correlations between different data sets. It comprises organising and synthesizing data to resolve research questions and test hypotheses. To obtain significant insights into the study dependent at hand, the data were processed and analyzed in a systematic and cohesive manner that revealed patterns and correlations between data sets. The collected data was arranged, recorded, evaluated, and interpreted using both descriptive and inferential statistical approaches. MS Excel and SPSS version 22 software were used to analyse the data.

The data is evaluated and interpreted in accordance with the predetermined objectives to assess the Effectiveness of Structured Training Program (STP) on Provider Perspectives regarding Respectful Maternity Care.

Objectives

Primary objective

- To assess the effectiveness of structured training program on health care provider perspectives regarding Respectful Maternity Care (RMC).

Secondary objectives

- To assess the satisfaction level of Respectful Maternity Care (RMC) among Post-natal mothers.

Organization and Presentation of the Findings

Section IA: Socio-demographic data (care provider)

Section IB: Results of knowledge questionnaires on Respectful Maternity Care

Section IIA: Socio-demographic data (post-natal mother)

Section IIB: Results of satisfaction level post-natal mother (Person-Centred Maternity Care Scale)

Section IA: Socio-demographic data

Table 1: Socio demographic data of Healthcare provider

Profile	No of care providers	% of care providers
Age groups		
21-25	294	79.46
26-30	39	10.54
31-35	19	5.14
35 above	18	4.86
Gender		
Male	36	9.73
Female	334	90.27
Educations		
M.S OBG	21	5.68
MSC (N)	36	9.73
BSc/PBBSc	150	40.54
GNM	139	37.57
Others	24	6.49

Marital Status		
Married	70	18.92
Unmarried	300	81.08
Religion		
Hindu	187	50.54
Christian	110	29.73
Muslim	51	13.78
Others	22	5.95
Work experience		
1 year	112	30.27
2-5 years	158	42.70
5-10 years	66	17.84
>10years	34	9.19
Experience in labour		
1 year	303	81.89
2-5 years	41	11.08
5-10 years	26	7.03
Mother Tongue		
Kannada	141	38.11
Hindi	42	11.35
Marathi	74	20.00
Others	113	30.54
Total	370	100.00

The table above highlights the demographic features of care providers: 79.46% of the samples were between the ages of 21 and 25, 90.27% were female, 40.54% had a BSc/P.B.BSc education, 81.08% were unmarried, and 50.54% practiced Hinduism, 42.70% had 2-5 years of work experience, 81.89% had 1 year of labour experience, and 38.89% spoke Kannada as their mother tongue.

Section IB: Results of knowledge questionnaires on Respectful Maternity Care

Table 2: Comparison of Pre-test and post-test levels of knowledge

Levels	Pre-test		Post-test	
	No	%	No	%
Low level ($\leq 50\%$)	237	64.05	0	0.00
Average (51-75%)	128	34.59	19	5.14
High level ($\geq 76\%$)	5	1.35	351	94.86
Total	370	100.00	370	100.00
Wilcoxon matched pairs test, $Z=16.4202$, $p=0.0001^*$				

*** $p < 0.05$**

The comparison of the pre-test and post-test levels of RMC knowledge scores is shown in the above table, where the average post-test knowledge scores exceed the pre-test scores. Notably, in the pre-test, 237 (64.05%) participants had poor knowledge, 128 (34.59%) had average knowledge, and 5 (1.35%) had high knowledge. In the post-test, 19 (5.14%) had average knowledge and 351 (94.86%) had high knowledge.

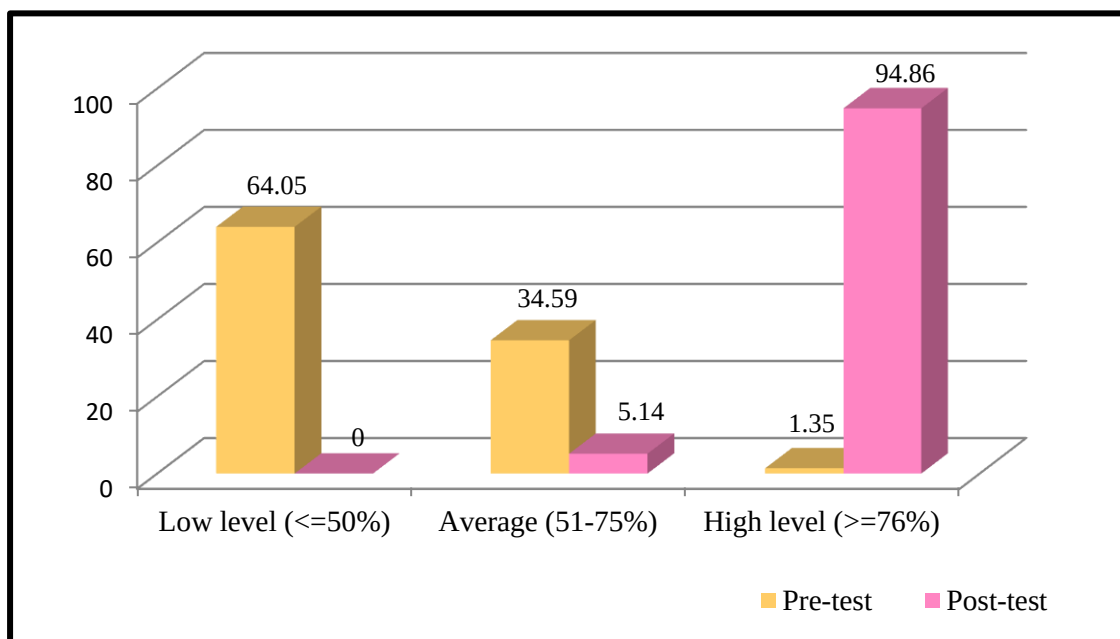


Figure 4: Shows comparison of Pre-test and post-test levels of knowledge

**Table 3: Comparison of pre-test and post-test knowledge towards RMC by
dependent t test**

Test	Mean	SD	Mean Diff.	SD Diff.	t-value	df	p-value
Pre-test	47.10	12.92	-44.13	15.44	-54.9729	369	0.0001*
Post-test	91.23	8.77					

***p<0.05**

Following the intervention, significant variations in awareness of RMC care were observed between pre-test and post-test scores. The dependent t test revealed statistical significance ($p < 0.05$) on comparing pre-test and post-test knowledge about RMC.

Table 4: Association between levels of pre-test knowledge with demographic characteristics

Profile	Levels of knowledge on RMC				Total	%	Chi-square	p-value
	Low	%	High	%				
Age groups								
21-25	190	64.63	104	35.37	294	79.46	3.9190	0.2700
26-30	28	71.79	11	28.21	39	10.54		
31-35	9	47.37	10	52.63	19	5.14		
35 above	10	55.56	8	44.44	18	4.86		
Gender								
Male	33	91.67	3	8.33	36	9.73	13.2060	0.0001*
Female	204	61.08	130	38.92	334	90.27		
Educations								
M.S OBG	0	0.00	21	100.0	21	5.68	105.0710	0.0001*
MSC (N)	3	8.33	33	91.67	36	9.73		
BSc/P.B.BSc	119	79.33	31	20.67	150	40.54		
GNM	96	69.06	43	30.94	139	37.57		
Others	19	79.17	5	20.83	24	6.49		
Marital Status								
Married	42	60.00	28	40.00	70	18.92	0.6160	0.4320
Unmarried	195	65.00	105	35.00	300	81.08		
Religion								
Hindu	127	67.91	60	32.09	187	50.54	7.5770	0.0560
Christian	59	53.64	51	46.36	110	29.73		

Muslim	35	68.63	16	31.37	51	13.78		
Others	16	72.73	6	27.27	22	5.95		
Work experience								
1 year	83	74.11	29	25.89	112	30.27	44.8500	0.0001*
2-5 years	117	74.05	41	25.95	158	42.70		
5-10 years	27	40.91	39	59.09	66	17.84		
>10years	10	29.41	24	70.59	34	9.19		
Experience in labour								
1 year	196	64.69	107	35.31	303	81.89	0.5170	0.7720
2-5 years	26	63.41	15	36.59	41	11.08		
5-10 years	15	57.69	11	42.31	26	7.03		
Mother Tongue								
Kannada	95	67.38	46	32.62	141	38.11	2.5720	0.4620
Hindi	26	61.90	16	38.10	42	11.35		
Marathi	42	56.76	32	43.24	74	20.00		
Others	74	65.49	39	34.51	113	30.54		
Total	237	64.05	133	35.95	370	100.00		

*p<0.05

The above table shows that socio-demographic parameters such as gender, educational status, and work experience are all associated ($p < 0.05$) with knowledge about respectful maternity care.

Section IIA: Socio-demographic data

Table 5: Base-line and End-line demographic characteristics of postnatal mothers.

Factors	Base-line		End-line	
	No of postnatal mother	% of postnatal mother	No of postnatal mother	% of postnatal mother
Age groups				
21-25	118	31.89	93	25.14
26-30	126	34.05	143	38.65
31-35	97	26.22	100	27.03
36 - 40	29	7.84	34	9.19
Educational status				
Primary	70	18.92	48	12.97
Secondary	92	24.86	89	24.05
Graduate	123	33.24	166	44.86
PG	85	22.97	67	18.11
Occupation				
Sedentary	73	19.73	72	19.46
Moderate	114	30.81	108	29.19
House Wife	148	40.00	162	43.78
Others	35	9.46	28	7.57
Obstetrical score				
Primi	201	54.32	191	51.62
Second	163	44.05	171	46.22
Multi	6	1.62	8	2.16

Religion				
Hindu	208	56.22	208	56.22
Christian	66	17.84	89	24.05
Muslim	89	24.05	68	18.38
Others	7	1.89	5	1.35
Type of family				
Nuclear	250	67.57	240	64.86
Joint	120	32.43	130	35.14
Type of resident				
Rural	95	25.68	92	24.86
Urban	275	74.32	278	75.14
Total	370	100.00	370	100.00

Above table exhibits the Base-line and End-line demographic features of postnatal mothers. 34.05%,38.65% of the samples were between the ages of 26 and 30, 33.24%, 44.86% were graduates, 40%, 43.78% were homemakers, 54.32%,51.62% were primi mothers, 56.22%, 56.22% practiced Hinduism, 67.57%,64.86% were from nuclear families, and 74.32%, 75.14% were from urban areas.

Section IIB: Results of satisfaction level of post-natal mother (Person-Centred Maternity Care Scale)

Table 6: Base-line and End-line results for postpartum mothers' satisfaction levels are compared using the Wilcoxon matched pairs test.

Time	Mean	SD	Mean Diff.	% of change	Z-value	p-value
Base-line	19.57	1.91	-1.03	-5.26	12.7023	0.0001*
End-line	20.60	1.89				

***p<0.05**

The above table shows a notable finding; the mean End-line satisfaction level scores are significantly higher than the Base-line satisfaction level scores by integrating the Wilcoxon matched pairs test. There was a statistically significant increase in post-natal mother satisfaction level of RMC care at the end of the study.

Table 7: Domain wise comparison of Base-line and End-line post-natal mother's satisfaction level by Wilcoxon matched pairs test

Variables	Time	Mean	SD	Mean Diff.	% of change	Z-value	p-value
Dignity and Respect	Base-line	3.75	1.56	-0.33	-8.80	8.2385	0.0001*
	End-line	4.08	1.23				
Communication and Autonomy	Base-line	5.41	1.09	-0.24	-4.45	6.9724	0.0001*
	End-line	5.65	1.05				
Supportive care	Base-line	2.49	0.88	-0.25	-10.11	8.1097	0.0001*
	End-line	2.74	0.84				
Privacy and confidentiality	Base-line	1.34	0.47	-0.12	-8.70	5.7115	0.0001*
	End-line	1.45	0.50				
Trust	Base-line	2.00	0.00	0.00	0.00	-	1.0000
	End-line	2.00	0.00				
Facility and environment	Base-line	3.24	0.81	-0.06	-2.01	2.3324	0.0197*
	End-line	3.30	0.80				
Predictability and transparency of payment	Base-line	1.36	0.48	-0.03	-1.98	2.8031	0.0051*
	End-line	1.39	0.49				

*p<0.05

The table compares post-natal mother satisfaction levels at baseline and end-line using Wilcoxon matched pairs test. Significant domains ($p < 0.05$) include Dignity and Respect, Communication and Autonomy, Supportive care, Privacy and confidentiality, Facility and environment, and Payment predictability and transparency.

Table 8: Domain wise percentage of mother's satisfaction level

S .NO	Domain	Base-line	End-line
1	Dignity and Respect	53.51%	58.22%
2	Communication and Autonomy	77.25%	80.69%
3	Supportive care	35.13%	54.75%
4	Privacy and confidentiality	66.75%	72.56%
5	Trust	100%	100%
6	Facility and environment	64.70%	66%
7	Predictability and transparency of payment	45.40%	46.30%
Total		63.24%	68.35%

The above table explains the Domain wise mother's satisfaction level is higher in End-line (68.35%) than the Base-line (63.35%).

Table 9: Association between Base-line satisfaction levels of postnatal mother with Base-line demographic factors

Factors	Base-line satisfaction levels				Total	%	Chi-square	p-value
	Below average	%	Above average	%				
Age groups								
21-25	97	82.20	21	17.80	118	31.89	9.3050	0.0260*
26-30	96	76.19	30	23.81	126	34.05		
31-35	70	72.16	27	27.84	97	26.22		
36 - 40	28	96.55	1	3.45	29	7.84		
Educational status								
Primary	57	81.43	13	18.57	70	18.92	1.1280	0.7700
Secondary	71	77.17	21	22.83	92	24.86		
Graduate	94	76.42	29	23.58	123	33.24		
PG	69	81.18	16	18.82	85	22.97		
Occupation								
Sedentary	61	83.56	12	16.44	73	19.73	3.0210	0.3880
Moderate	86	75.44	28	24.56	114	30.81		
House Wife	114	77.03	34	22.97	148	40.00		
Others	30	85.71	5	14.29	35	9.46		
Obstetrical score								
Primi	162	80.60	39	19.40	201	54.32	1.1760	0.5550
Second	124	76.07	39	23.93	163	44.05		
Multi	5	83.33	1	16.67	6	1.62		
Religion								
Hindu	168	80.77	40	19.23	208	56.22	1.6040	0.6590
Christian	49	74.24	17	25.76	66	17.84		

Muslim	69	77.53	20	22.47	89	24.05		
Others	5	71.43	2	28.57	7	1.89		
Type of family								
Nuclear	202	80.80	48	19.20	250	67.57	2.1250	0.1450
Joint	89	74.17	31	25.83	120	32.43		
Type of resident								
Rural	74	77.89	21	22.11	95	25.68	0.0430	0.8350
Urban	217	78.91	58	21.09	275	74.32		
Total	291	78.65	79	21.35	370	100.0 0		

***p<0.05**

The above table depicts statistically significant relationships between pre-test satisfaction level scores and demographic factor like age (9.30), as seen by the calculated Chi-square values at $p<0.05$.

CHAPTER- 5

DISCUSSION

The discussion chapter is a vital element of any research as it comprehends and analyses the findings in accordance with the research questions, objectives, and previous literature. In this chapter, the researcher conducts a thorough analysis of the findings, discussing their effects, significance, and relevance within the larger context of the area. By comparing and contrasting the findings with earlier studies, the discussion chapter highlights the research's contributions to the body of knowledge while also addressing any limits or unexpected results. This chapter promotes a better understanding of the research and opens up new paths for further investigation, providing insights into how the findings might be utilised in practice or used to inform future research initiatives.

The objective of the study was:

Primary objective

- To assess the effectiveness of structured training program on health care provider perspectives regarding Respectful Maternity Care (RMC).

Secondary objectives

- To assess the satisfaction level of Respectful Maternity Care (RMC) among Post-natal mothers.

5.1 Effectiveness of structured training program on health care provider perspectives

In the present study shows that among 370 health care providers, 34.59% were having moderately adequate knowledge, 64.05% were having inadequate knowledge and 1.35% of health care providers had adequate knowledge. These findings are in accordant with the study by Ms. Ayushi Sharma et Al, (2022)²², also shows that 66.6% of poor knowledge, 33.3% of average knowledge and 0.0% of good knowledge. Dhanya Devassy et Al, (2023)⁵², revealed that 65.2% nurses were having moderately adequate knowledge, 14.5% of nurses had inadequate knowledge, and 14% nurses had adequate knowledge. Anamika S. et Al, (2022)⁵³ shows that 65(65%) were having an inadequate degree of knowledge on RMC while 29(29%) were having moderate degree knowledge and 6(6%) were having adequate degree knowledge level on RMC. The study's findings suggest that there is a widespread need for healthcare providers to increase their knowledge of respectful maternity care.

In the present study findings revealed that there is a significant association with gender ($p=0.0001$), educational status ($p=0.0001$) and work experience ($p=0.0001$), whereas no significant association with age group ($p=0.2700$), marital status ($p=0.4320$), religion ($p=0.0560$) and experience in labour room ($p=0.7720$), mother tongue ($p=0.4620$). This aligns with the conclusions of a study accomplished by Ms. Blessy Mathew (2021)⁵⁴, results founds that there was significant association with number of deliveries where as there is no significant association between age, sex, education, years of experience, area of working and attending any midwifery related training. Ms.Laishram Lilileima Devi (2021)⁵⁵, illustrates that there is no significant relationship between staff nurses' knowledge regarding RMC and demographic variables. Age in years, educational background, clinical experience,

marital status and experience in the Obstetrics and Gynaecology Department. The variation in the research findings might be attributed to variations in the sample size and the region of investigation.

5.2 Satisfaction level of Respectful Maternity Care (RMC) among Post-natal mothers.

In the present study satisfaction level of post-natal mothers Base-line survey with respectful maternity care is 63.24%. This is consistent with the results gathered from an investigation conducted by Attanasio LB et. Al (2022)⁵⁶ reported that participants had a mean total score of 47.80 on the person-centered maternity care scale. Khalil M, et Al, (2022)⁵⁷ reported Women's Narratives of Disrespect and Abuse in Childbirth. Dr. TS Meena et. Al (2021)⁵⁸ clearly indicates the health providers are maintaining RMC care different domains in a uniformed manner and no patients were satisfied. Helen H et Al, (2023)⁵⁹ the systematic review comprised twenty-nine papers. The review was restricted to a theme analysis due to the limited number and diversity of quantitative studies. The hardship and consequences of mistreatment were emphasized from the viewpoints of both adolescents and healthcare professionals. The majority of research suggested that RMC interventions were necessary to raise the standard of maternity care. The study findings indicate that respectful maternity care is still in its initial phases, despite the fact that women are seeing and reporting positive changes in maternity care practices. To enhance maternal health outcomes for all women, there possesses to be a greater level of conversation, research, and advocacy on this essential public health and human rights concern.

In the present study satisfaction level of post-natal mothers End-line survey with respectful maternity care is 68.35%. This is matching the findings of Sharma B et. Al (2021)⁶⁰ shows that there was a marked enhancement in communication

between Health Care Providers and women in labor, i.e., address the woman by her name (100%), consent in advance of each clinical evaluation (93%), and Providing details concerning the development of labour after each examination (50%), manifest that there was a marked enhancement in interacting between Health Care Providers and women in labor, a quality improvement (QI) strategy is attainable and works efficiently as a behavior modification intervention for delivering dignified and consented care in established settings. Shwetha K et Al (2023)⁶¹ shows that respectful maternity care is still in its budding stage despite the fact that women are noticing and reporting positive changes in maternity care practices. Habib HH et. Al (2020)⁶² this study aims to assess the effectiveness of an intervention in strengthening RMC and reducing intrapartum mistreatment of adolescents. Babure ZK, et Al (2020)⁶³ the overall satisfaction of mothers with delivery service was 82% and study concludes that health workers should work together on identified factors to improve maternal satisfaction. The study's findings are expected to contribute to the body of knowledge on enhancing maternity healthcare and reducing maternal mortality, particularly among adolescents. A quality improvement approach is both feasible and advantageous as an interpersonal intervention to offer dignified and consented care in existing settings, In order to close this important research gap in healthcare organisations, the current study functions as a standard. More action, debate, research, and advocacy are required on this important public health and human rights issues as the goal is to enhance maternal health outcomes for all women.

CHAPTER – 6

SUMMARY

This chapter highlights the fundamental concepts, conclusions, and insights offered, enabling the reader to recall the most significant material. By describing the content, readers may quickly reference it and get a final clarification on the subject matter, which helps them understand the broader significance of the topic.

The current study was undertaken to evaluate the effectiveness of structured training program (STP) on provider perspectives regarding Respectful Maternity Care in maternity units of selected tertiary care Hospitals, Belagavi. 3 sessions of planned instruction on Respectful Maternity Care are provided by the researcher as part of the training program. Every topic is addressed via videos, flash cards, handouts, models, and demonstrations during the 30-minute sessions. The training course content is tailored to the participants' requirements and follows the Ministry of Health & Family Welfare's and WHO recommendations on RMC.

Objectives

Primary objective

- To assess the effectiveness of structured training program on health care provider perspectives regarding Respectful Maternity Care (RMC).
- To find an association between demographic characteristics and care provider perspectives regarding Respectful Maternity Care (RMC).

Secondary objectives

- To assess the satisfaction level of Respectful Maternity Care (RMC) among Post-natal mothers.
- To find an association between demographic characteristics and satisfaction level of Respectful Maternity Care (RMC) among Post-natal mothers.

Research Hypotheses

All hypotheses will be tested at the 0.05 level of significance.

H₀1: There will be no significant difference between mean pre-test and post-test scores regarding RMC among health care providers after the administration of structured training program.

H₀2: There will be no significant difference between mean base-line and end-line regarding satisfaction level of Respectful Maternity Care (RMC) scores among Post-natal mothers.

Major findings of the study:

As per the results of the study, the significant outcomes are as follows:

- In the present study 79.46% of the health care providers were between the ages of 21 and 25, 90.27% were female, 40.54% had a BSc/P.B.BSc education, 81.08% were unmarried, and 50.54% practiced Hinduism, 42.70% had 2-5 years of work experience, 81.89% had 1 year of labour experience, and 38.89% spoke Kannada as their mother tongue.
- In the pre-test 64.05 % of the participants were having inadequate knowledge, 34.59% were having moderately adequate knowledge and 1.35% were having adequate knowledge score on respectful maternity care.

- In the post-test 5.14% were having moderately adequate knowledge and 94.86% were having adequate knowledge score on respectful maternity care.
- The dependent t test of comparison of pre-test and post-test knowledge on RMC shows statistical significance ($p < 0.05$).
- Socio-demographic characteristics such as Gender($X^2 -13.2060$), Educational status ($X^2 -105.0710$) and work experience($X^2 -44.8500$) are shown significant associated with knowledge on respectful maternity care.
- Base-line and End-line demographic features of postnatal mothers. 34.05%,38.65% of the samples were between the ages of 26 and 30, 33.24%, 44.86% were graduates, 40%, 43.78% were homemakers, 54.32%,51.62% were primi mothers, 56.22%, 56.22% practiced Hinduism, 67.57%,64.86% were from nuclear families, and 74.32%, 75.14% were from urban areas.
- Base-line and End-line results for post-natal mothers' satisfaction levels are compared using the Wilcoxon matched pairs test its shows statistical significant association ($Z=12.7023$, $p=0.0001^*$).
- Domain wise mother's satisfaction level is higher in End-line(68.35%) than the Base-line (63.35%).
- Dignity and Respect (8.2385, $p=0.0001^*$), Communication and Autonomy (6.9724, $p=0.0001^*$), Supportive care (8.1097, $p=0.0001^*$), Privacy and confidentiality (5.7115, $p=0.0001^*$), Facility and environment(2.3324, $p=0.0197^*$), Predictability and transparency of payment(2.8031, $p=0.0051^*$) domains were statistically significant.

CHAPTER – 7

CONCLUSION

The conclusion chapter provides a final perspective on the research journey by reviewing the key findings, discussing the study's significance, generating recommendations for further research or practical applications, and also recognises the study's limitations and recommends strategies to improve them in future research initiatives. Finally, this chapter endeavors to bring together the study's contributions to the current body of knowledge and provide a clear conclusion to the research.

In accordance with the findings of this investigation, Respectful maternity care is vital in delivering excellent services that encourage women to cherish continuing to accessing medical facilities. The perspective of midwives on respectful care are brought into focus in this study, which demonstrates a thorough comprehension of the essential components that go into providing safe, courteous, and outstanding maternity care.

Regardless of age, gender, or race, all mothers have the right to be treated with dignity. For expecting mothers to have an incredible and satisfying journey to motherhood, administrators and healthcare professionals have to assist serving them with humanity.

Nurse administrators should be accountable for of obtaining opinions from labouring women, nurses and other healthcare professionals should receive comprehensive educational initiatives about respectful maternity care.

In order to eradicate obstetric violence, a change in perspective is required that includes advocacy, education, empowerment, infrastructure changes, and a women-centered and gender-sensitive approach to strengthening the health system.

Recommendations are made at the individual, community, health systems, and policy levels to ensure that every woman accomplishes her right to health and gives birth in an environment that she is honored and empowered.

NURSING IMPLICATIONS

1. Clinical Implications: Respectful Maternity Care (RMC) training for healthcare personnel has important clinical consequences. A vital step towards improving health outcomes, satisfaction of patients, and equality in maternity care. The following are the primary clinical implications associated with such education.

- Improved Maternal Health Outcomes
- Enhanced Neonatal Outcomes
- Reduction in Obstetric Violence
- Strengthened Patient-Provider Relationships
- Increased Patient Satisfaction
- Promotion of Human Rights
- Strengthening Healthcare Systems
- Adherence towards Global Standards

Hence, Training encourages acceptance with WHO and other worldwide standards, hence improving healthcare institutions reputation and credibility.

2. Community Implications: Respectful Maternity Care (RMC) training for healthcare providers broadly influences the community. These implications encourage dignity, empathy, and inclusivity, meanwhile RMC training for healthcare providers transforms community views, health outcomes, and social structures, culminating in a more prosperous and balanced society by accomplishing the Sustainable Development Goals (SDGs), especially those related to gender equality (protection of women's rights) and good health and

well-being (lowers maternal morbidity and death) and encouraging a sense of obligations and global responsibility in local communities.

3. **Nursing Education:** RMC training should be incorporated into OBG Nursing undergraduate and postgraduate programs to improve the curriculum by emphasizing the significance of dignity, respect, and patients' rights during delivery. This ensures that future nurses possess the skills for giving compassionate and ethical care. Respectful Maternity Care training improves nursing education by highlighting sympathetic, patient-centered care while reinforcing ethical principles. It trains nurses to offer high-quality, respectful care while establishing a rapport and it encourages students to conduct research and advocate for legislation that promote respectful and equitable maternal healthcare practices.
4. **Nursing Administration:** Respectful Maternity Care training strengthens nursing administration by cultivating a culture of respect, raising staff competency, assuring ethical compliance, and building patient trust. It provides administrators with tools to provide high-quality, patient-centered maternity care while also improving institutional reputation and teamwork. It boosts the institution's authenticity and competitiveness.
5. **Nursing Research:** New researchers can incorporate the respectful maternity care training program and postnatal mother satisfaction scores in assessing its efficacy across a spectrum of healthcare settings. RMC training improves nursing research by promoting patient-centered, ethical, and policy-relevant enquiries. It encourages the creation of evidence-based practices, instruments for evaluating respectful care, and solutions to structural challenges. Nursing research, viewed through this perspective, helps to improve the quality, equity, and outcomes of maternal care.

LIMITATIONS

Following were some of the limitations to this study:

- The study restricted geographic scope conflicts with the universality of its findings. By focusing primarily on a single setting, the study might not adequately represent the many different cultural, social, and regional variations found in larger populations, limiting the universality of its conclusions.
- Fear of criticism may keep honest reactions to misconduct concealment. RMC may not be accurately reflected in women self-reported perceived RMC. Bias in reporting may possible.
- The sample size was insignificant, mainly due to constrictive inclusion criteria. The study was designed to target healthcare providers who work in maternity wards. This selectivity raises queries regarding potential bias in the results, affecting the overall representativeness of the findings.

OUTCOME OF THE STUDY

- The study resulted in sensitising the healthcare providers by enhancing their knowledge and attitudes toward respectful maternity care.
- The study aids in evaluating the manner in which healthcare providers performance and patient satisfaction are affected by respectful maternity care training.
- The study made an impact on provider-patient relationships, the quality of maternity services, and the reinforcement of compassionate care.
- The study educate the postnatal mothers regards to the universal rights of childbearing women and the concept of Respectful Maternity Care.

RECOMMENDATIONS

Based on the outcomes of this study, the following recommendations can be committed:

- Healthcare organisations must schedule frequently comprehensive and continuous training programs that improve respectful maternity care practices and promote the well-being of both providers and patients in maternity units.
- The guidelines developed from this research on RMC can be adopted for management, policymaking, education, and research reasons, and they will be useful in improving the quality of services delivered to pregnant women.

In Research:

- A similar study can be accomplished for a larger sample size conducted in a multicenter institutional-based study would have incorporated including public and private health institutions to generalize the findings.
- A comparative analysis can be conducted on maternal services given by the public and private sectors.
- Mixed method study can be conducted to assess the in-depth rate of maternal perception on RMC.

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ANNEXURE - I

ETHICAL CLEARANCE LETTER



KLE ACADEMY OF HIGHER EDUCATION AND RESEARCH

(Formerly known as KLE University)

(Deemed-to-be-University established u/s 3 of the UGC Act, 1956)

Accredited 'A' Grade by NAAC (2nd Cycle)

Placed in Category 'A' by MHRD (GoI)

JNMC Campus, Nehru Nagar, Belagavi-590 010, Karnataka State, India

☎: 0831-2444444

FAX: 0831-2493777

Web: <http://www.kledeemeduniversity.edu.in>E-mail: info@kledeemeduniversity.edu.in

Ref.No.KAHER/EC/21-22/ 016

29th July 2021

To,
Ms. Laxmi Shivprasad Kamat
Part-Time Ph.D. Research Scholar,
2020-21 Batch, Faculty of Nursing,
KAHER, Belagavi.

Dear Research Scholar,

The KAHER Ethics Committee on Human Subjects for Ph.D. Research Project met on the 7th and 8th June, 2021 to consider your application for approval of the research project "Effectiveness of structured training program(STP) on provider perspectives regarding Respectful Maternity Care in Maternity Units of Selected Tertiary Care Hospital, Belagavi"

As there are no ethical issues involved in your proposed research project, the committee has provided approval for this research project.

You are requested to report to Ethical Committee of the following:

1. Any deviation from or change of the protocol.
2. Any changes in study documents.

(Dr. Sheetal U. Harakuni)

Member-Secretary

Ethical Committee (Human) for Ph. D. Research
KAHER, Belagavi.

(Dr. B.C. Kotintot)

Chairman

Ethical Committee (Human) for Ph. D. Research
KAHER, Belagavi.

CC to:

- Special Officer to Hon. Vice Chancellor, KAHER, Belagavi
- The Registrar, KAHER, Belagavi.
- The Director Research Foundation, KAHER, Belagavi.
- The Director Academic Affairs, KAHER, Belagavi.

ANNEXURE II

PERMISSION LETTER

 **KLES**
DR.PRABHAKAR KORE HOSPITAL
&
MEDICAL RESEARCH CENTRE
NEHRUNAGAR, BELAGAVI-590 010
KARNATAKA-INDIA

ಕೆ. ಎಲ್. ಇ. ಸಂಸ್ಥೆಯು
ಡಾ. ಪ್ರಭಾಕರ ಕೋರೆ ಆಸ್ಪತ್ರೆ ಮತ್ತು
ವೈದ್ಯಕೀಯ ಸಂಶೋಧನಾ ಕೇಂದ್ರ
ನೆಹರುನಗರ, ಬೆಳಗಾವಿ-590 010 ಕರ್ನಾಟಕ, ಇಂಡಿಯಾ
Phone : 0831-2473777 (16 lines)
Fax : 0831-2470732
E-Mail : medicaldirector@kleshospital.org
Website : www.kleshospital.org

REF.NO: KLES/Dr.PK-HOSP/ADM-CS/GEN/22-23/ 4662

Date: 06 August 2022

To
The Principal
KAHER Institute of Nursing Sciences
Nehru Nagar, Belagavi

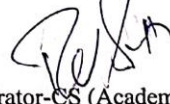
**Sub: Permission to conduct research study in KLES Dr Prabhakar Kore
Hospital and MRC, Belagavi**

Madam,

1. Kindly refer to your letter 28th July 2022 on the above mentioned subject.
2. After perusal, the Medical Director & Chief Executive has permitted Mrs Laxmi Kamat, Ph D Scholar, Faculty of Nursing, KAHER to conduct the research study. The topic chosen is entitled 'Effectiveness of structured training program (STP) on provider perspectives regarding respectful Maternity care in Maternity units of selected tertiary care hospitals, Belagavi' under the guidance of Dr Sudha A Raddi, Principal, KAHER, INS. The study would be entirely conducted at KLES Dr Prabhakar Kore Hospital and MRC, Belagavi in Paid Labour ward and Free labour ward for the duration of 10 months.
3. The hospital will not have any financial implications for the study.
4. As per the hospital policy, you are **NOT** permitted to give away any information/materials/ data/statistics of the hospital to a third party. You will not send the information gathered in the hospital for publication in any form to any individual/organization. You cannot modify, copy, reproduce, republish, upload, post, transmit or distribute materials of the hospital's documents. If published, the research outcome should mention the conflict of interest and financial/any reimbursement received by the beneficiary. The investigator's suitable acknowledgement of the institution about the source of research material obtained to be mentioned, which the institution will appreciate. We wish you the best of luck in your research endeavour.

Thanking you,

Yours faithfully,



Administrator-CS (Academics)
For Medical Director & Chief Executive

Copy to:

- ✓ Dr Sudha A Raddi-Guide- Principal, KAHER, INS
- Mrs Laxmi Kamat, Ph D Scholar, Faculty of Nursing, KAHER

Copy submitted to:

1. MD & CEO - Sir, for your kind information
2. Medical Superintendent, KLES Dr.PK Charitable Hospital, Belagavi -- Sir, for your information
3. Incharge - Paid labour ward, KLES Dr Prabhakar Kore Hospital & MRC, Belagavi
4. Incharge - Free labour ward, KLES Dr PK Charitable Hospital & MRC, Belagavi.
5. Guard file

Sushma D/ADM-CS/PL

ANNEXURE III

INFORMATION SHEET

Effectiveness of Structured Training Program (STP) on Provider Perspectives regarding Respectful Maternity Care in Maternity Units of Selected Tertiary Care Hospital, Belagavi.

Research Scholar: Mrs. Laxmi S Kamat

Supervisor: Prof (Dr.) Sangeeta Kharde

Introduction: We are requesting you to agree to participate in the study entitled “Effectiveness of Structured Training Program (STP) on Provider Perspectives regarding Respectful Maternity Care in Maternity Units of Selected Tertiary Care Hospital, Belagavi.” I am Mrs. Laxmi S Kamat, Research Scholar at KLE Academy of Higher Education and Research, under the guidance of Dr.Sangeeta Kharde, Dean Faculty of Nursing KAHER Institute of nursing Sciences, Belagavi.

Explanation of the procedure: In this study you will have to answer some questions about socio-demographic details and perception about Respectful Maternity Care with the help of questionnaire, followed by planned educational training program of three sessions for you and awareness for postnatal mother regarding rights of childbearing women and Respectful Maternity Care, the content for the educational training program is prepared based on the needs of the program participants and in accordance with guidelines established by both the World Health Organisation (WHO) and the National Health Mission (Government of India has launched “LaQshya” guidelines in 2017). This entire procedure will take approximately 30 minutes.

Possible Benefits: You may gain new Knowledge about Respectful Maternity Care and the rights of women during childbirth. As improving Respectful Maternity Care and eliminating the mistreatment of women during childbirth is a key strategy to improve maternal health.

Possible Risks: The tools employed for conducting the study is safe and as such are not likely to cause any harm to you.

Confidentiality: Your identity will not be revealed and all the information will be collected, coded so that no one will know your identity.

Withdrawal: Participation in study is voluntary. If you do not wish to participate in the study, at any point you can refuse. It is yours choice and it will be respected.

Cost of participation: The cost of the study will be borne by the researcher. There will be no additional cost to you for participating in this study.

Payment of participation: There will be no incentives to you for participating this study.

Publication Right: The result of this study may be used for publication. However, your identity will not be revealed.

Contact information: If you have any doubts or questions you can contact any time to:

Mrs. Laxmi S Kamat

Ph.D Research scholar,
KAHER Institute of Nursing Sciences,
Nehru Nagar, Belagavi-590010
Mobile No – 9741134992
Email id- laxmiskamat99@gmail.com

Prof. (Dr.) Sangeeta Kharde

Dean Faculty of Nursing
KAHER Institute of Nursing Sciences,
Nehru Nagar, Belagavi-590010
Mobile No – 9481322656

ANNEXURE IV**CONSENT FORM**

I have read this consent form and I have understood it. I have been given the opportunity to ask my query regarding the study & I have got satisfactory answers for them. I consent voluntarily to participate as a participant in this research.

Signature of participant: _____

Signature of Researcher: _____

Date:

Place:

If Illiterate: I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

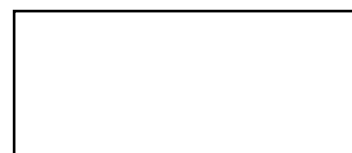
Name of the witness of participants: _____

Thumb print

Signature of witness: _____

Date:

Place:



Statement by the researcher: I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands above mentioned procedure.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Name of Researcher / person taking the consent _____

Signature of Researcher/ person taking the consent _____

Date _____

ಮಾಹಿತ ಪತ್ರ

ಬೆಳಗಾವಿಯ ಆಯ್ದ ತೃತೀಯ ಆರೈಕೆ ಆಸ್ಪತ್ರೆಯ ಹೆರಿಗೆ ಘಟಕಗಳಲ್ಲಿ ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆಯ ಬಗ್ಗೆ ಒದಗಿಸುವವರ ದೃಷ್ಟಿಕೋನಗಳ ಮೇಲೆ ರಚನಾತ್ಮಕ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮದ (ಎಸ್ಸಿಪಿ) ಪರಿಣಾಮಕಾರಿತ್ವ.

ಸಂಶೋಧನಾ ವಿದ್ಯಾರ್ಥಿ: ಶ್ರೀಮತಿ ಲಕ್ಷ್ಮೀ. ಎಸ್. ಕಾಮತ್

ಮೇಲ್ವಿಚಾರಕಿ: ಪ್ರೊ. (ಡಾ.) ಸಂಗೀತಾ

ಪರಿಚಯ: ಬೆಳಗಾವಿಯ ಆಯ್ದ ತೃತೀಯ ಆರೈಕೆ ಆಸ್ಪತ್ರೆಯ ಹೆರಿಗೆ ಘಟಕಗಳಲ್ಲಿ ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆಯನ್ನು ಒದಗಿಸುವ ದೃಷ್ಟಿಕೋನಗಳ ಮೇಲೆ ರಚನಾತ್ಮಕ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮದ (ಎಸ್ಸಿಪಿ) ಪರಿಣಾಮಕಾರಿತ್ವ" ಎಂಬ ಶೀರ್ಷಿಕೆಯ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪಿಕೊಳ್ಳಲು ನಾವು ನಿಮ್ಮನ್ನು ವಿನಂತಿಸುತ್ತಿದ್ದೇವೆ. ನಾನು ಶ್ರೀಮತಿ ಲಕ್ಷ್ಮೀ ಎಸ್. ಕಾಮತ್, ರಿಸರ್ಚ್ ಸ್ಕಾಲರ್, ಕೆಎಲ್‌ಇ ಅಕಾಡೆಮಿ ಆಫ್ ಹೈಯರ್ ಎಜುಕೇಶನ್ ಅಂಡ್ ರಿಸರ್ಚ್ ನಲ್ಲಿ, ಡಾ. ಸಂಗೀತಾ ಖರ್ಡೆ, ಡೀನ್ ಫ್ಯಾಕಲ್ಟಿ ಆಫ್ ನರ್ಸಿಂಗ್ ಕೇಹರ್ ಇನ್ಸ್ಟಿಟ್ಯೂಟ್ ಆಫ್ ನರ್ಸಿಂಗ್ ಸೈನ್ಸಸ್, ಬೆಳಗಾವಿ ಅವರ ಮಾರ್ಗದರ್ಶನದಲ್ಲಿ.

ಕಾರ್ಯವಿಧಾನದವಿವರಣೆ: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ನೀವು ಪ್ರಶ್ನಾವಳಿಯ ಸಹಾಯದಿಂದ ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆಯ ಬಗ್ಗೆ ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾ ವಿವರಗಳು ಮತ್ತು ಗ್ರಹಿಕೆಯ ಬಗ್ಗೆ ಕೆಲವು ಪ್ರಶ್ನೆಗಳಿಗೆ ಉತ್ತರಿಸಬೇಕಾಗುತ್ತದೆ, ನಂತರ ನಿಮಗಾಗಿ ಮೂರು ಸೆಷನ್‌ಗಳ ಯೋಜಿತ ಶೈಕ್ಷಣಿಕ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮ ಮತ್ತು ಹೆರಿಗೆಯ ನಂತರದ ತಾಯಂದಿರಿಗೆ ಮಕ್ಕಳ ಹಕ್ಕುಗಳ ಬಗ್ಗೆ ಜಾಗೃತಿ ಮತ್ತು ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆ, ಶೈಕ್ಷಣಿಕ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮದ ವಿಷಯವನ್ನು ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಭಾಗವಹಿಸುವವರ ಅಗತ್ಯಗಳ ಆಧಾರದ ಮೇಲೆ ಮತ್ತು ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ (ಡಬ್ಲ್ಯುಎಚ್‌ಒ) ಮತ್ತು ರಾಷ್ಟ್ರೀಯ ಆರೋಗ್ಯ ಮಿಷನ್ (ಭಾರತ ಸರ್ಕಾರ 2017 ರಲ್ಲಿ "ಲಕ್ಷ್ಯ" ಮಾರ್ಗಸೂಚಿಗಳನ್ನು ಪ್ರಾರಂಭಿಸಿದೆ) ಸ್ಥಾಪಿಸಿದ ಮಾರ್ಗಸೂಚಿಗಳಿಗೆ ಅನುಗುಣವಾಗಿ ತಯಾರಿಸಲಾಗುತ್ತದೆ. ಈ ಸಂಪೂರ್ಣ ಪ್ರಕ್ರಿಯೆಯು ಸುಮಾರು 30 ನಿಮಿಷಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳುತ್ತದೆ.

ಸಂಭಾವ್ಯಪ್ರಯೋಜನಗಳು: ನೀವು ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆ ಮತ್ತು ಹೆರಿಗೆಯ ಸಮಯದಲ್ಲಿ ಮಹಿಳೆಯರ ಹಕ್ಕುಗಳ ಬಗ್ಗೆ ಹೊಸ ಜ್ಞಾನವನ್ನು ಪಡೆಯಬಹುದು. ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆಯನ್ನು ಸುಧಾರಿಸುವುದು ಮತ್ತು ಹೆರಿಗೆಯ ಸಮಯದಲ್ಲಿ ಮಹಿಳೆಯರನ್ನು ಕೆಟ್ಟದಾಗಿ ನಡೆಸಿಕೊಳ್ಳುವುದನ್ನು ತೆಗೆದುಹಾಕುವುದು ತಾಯಿಯ ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸುವ ಪ್ರಮುಖ ಕಾರ್ಯತಂತ್ರವಾಗಿದೆ.

ಸಂಭಾವ್ಯಅಪಾಯಗಳು: ಅಧ್ಯಯನವನ್ನು ನಡೆಸಲು ಬಳಸಲಾಗುವ ಉಪಕರಣಗಳು ಸುರಕ್ಷಿತವಾಗಿರುತ್ತವೆ ಮತ್ತು ಅವು ನಿಮಗೆ ಯಾವುದೇ ಹಾನಿಯನ್ನುಂಟು ಮಾಡುವ ಸಾಧ್ಯತೆಯಿಲ್ಲ.

ಗೌಪ್ಯತೆ: ನಿಮ್ಮ ಗುರುತನ್ನು ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ ಮತ್ತು ನಿಮ್ಮ ಗುರುತನ್ನು ಯಾರೂ ತಿಳಿಯದಂತೆ ಎಲ್ಲಾ ಮಾಹಿತಿಯನ್ನು ಸಂಗ್ರಹಿಸಿ, ಕೋಡ್ ಮಾಡಲಾಗುತ್ತದೆ.

ಹಿಂತೆಗೆದುಕೊಳ್ಳುವಿಕೆ: ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದು ಸ್ವಯಂಪ್ರೇರಿತವಾಗಿದೆ. ನೀವು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಬಯಸದಿದ್ದರೆ, ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ನೀವು ನಿರಾಕರಿಸಬಹುದು. ಇದು ನಿಮ್ಮ ಆಯ್ಕೆಯಾಗಿದೆ ಮತ್ತು ಅದನ್ನು ಗೌರವಿಸಲಾಗುತ್ತದೆ.

ಭಾಗವಹಿಸುವಿಕೆವೆಚ್ಚ: ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸುವುದು ಸ್ವಯಂಪ್ರೇರಿತವಾಗಿದೆ. ನೀವು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಬಯಸದಿದ್ದರೆ, ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ನೀವು ನಿರಾಕರಿಸಬಹುದು. ಇದು ನಿಮ್ಮ ಆಯ್ಕೆಯಾಗಿದೆ ಮತ್ತು ಅದನ್ನು ಗೌರವಿಸಲಾಗುತ್ತದೆ.

ಭಾಗವಹಿಸುವಿಕೆಯಪಾವತಿ: ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮಗೆ ಯಾವುದೇ ಪ್ರೋತ್ಸಾಹಕಗಳು ಇರುವುದಿಲ್ಲ.

ಪ್ರಕಟಣೆಯಹಕ್ಕು: ಈ ಅಧ್ಯಯನದ ಫಲಿತಾಂಶವನ್ನು ಪ್ರಕಟಣೆಗಾಗಿ ಬಳಸಬಹುದು. ಆದಾಗ್ಯೂ, ನಿಮ್ಮ ಗುರುತನ್ನು ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ.

ಸಂಪರ್ಕಮಾಹಿತಿ: ನೀವು ಯಾವುದೇ ಅನುಮಾನಗಳು ಅಥವಾ ಪ್ರಶ್ನೆಗಳನ್ನು ಹೊಂದಿದ್ದರೆ ನೀವು ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಸಂಪರ್ಕಿಸಬಹುದು:

ಶ್ರೀಮತಿ ಲಕ್ಷ್ಮೀ ಎಸ್. ಕಾಮತ್
ಪಿ.ಎಚ್.ಡಿ ರಿಸರ್ಚ್ ಸ್ಕಾಲರ್,
ಕೋಶ ನರ್ಸಿಂಗ್ ಸೈನ್ಸಸ್,
ನೆಹರೂ ನಗರ, ಬೆಳಗಾವಿ-೫೯೦೦೦೦
ಮೊಬೈಲ್ ಸಂಖ್ಯೆ-೯೭೪೦೦೩೪೯೯೨

ಪ್ರೊ. (ಡಾ.) ಸಂಗೀತಾ ಕ
ಡೀನ್ ಫ್ಯಾಕಲ್ಟಿ ಆಫ್ ನರ್ಸಿಂಗ್
ಕೋಶ ನರ್ಸಿಂಗ್ ಸೈನ್ಸಸ್,
ನೆಹರೂ ನಗರ, ಬೆಳಗಾವಿ-೫೯೦೦೦೦
ಮೊಬೈಲ್ ಸಂಖ್ಯೆ-೯೪೪೦೩೨೨೬೫೬

ಸಮ್ಮತ ಪತ್ರ

ಈ ಒಪ್ಪಿಗೆ ಅರ್ಜಿಯನ್ನು ಓದಿದ್ದೇನೆ ಮತ್ತು ನಾನು ಅದನ್ನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದೇನೆ. ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ನನ್ನ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ನನಗೆ ಅವಕಾಶ ನೀಡಲಾಗಿದೆ ಮತ್ತು ನಾನು ಅವರಿಗೆ ತೃಪ್ತಿದಾಯಕ ಉತ್ತರಗಳನ್ನು ಪಡೆದಿದ್ದೇನೆ. ಈ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಾನು ಭಾಗವಹಿಸುವವರ ಸಹಿ: _____

ಸಂಶೋಧಕರ ಸಹಿ: _____

ದಿನಾಂಕ:

ಸ್ಥಳ:

ಅನಕ್ಷರಸ್ಥರಾಗಿದ್ದರೆ:

ಸಂಭಾವ್ಯ ಭಾಗವಹಿಸುವವರಿಗೆ ಒಪ್ಪಿಗೆ ಅರ್ಜಿಯ ನಿಖರವಾದ ಓದುವಿಕೆಗೆ ನಾನು ಸಾಕ್ಷಿಯಾಗಿದ್ದೇನೆ ಮತ್ತು ವ್ಯಕ್ತಿಗೆ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳುವ ಅವಕಾಶವಿದೆ. ವ್ಯಕ್ತಿಯು ಮುಕ್ತವಾಗಿ ಒಪ್ಪಿಗೆಯನ್ನು ನೀಡಿದ್ದಾರೆ ಎಂದು ನಾನು ದೃಢೀಕರಿಸುತ್ತೇನೆ.

ಭಾಗವಹಿಸುವವರ ಸಾಕ್ಷಿಯ ಹೆಸರು: _____

ಹೆಚ್ಚರಳಿನ ಮುದ್ರಣ

ಸಾಕ್ಷಿಯ ಸಹಿ: _____

ದಿನಾಂಕ:

ಸ್ಥಳ:

ಸಂಶೋಧಕರ ಹೇಳಿಕೆ:

ನಾನು ಸಂಭಾವ್ಯ ಭಾಗವಹಿಸುವವರಿಗೆ ಮಾಹಿತಿ ಹಾಳೆಯನ್ನು ನಿಖರವಾಗಿ ಓದಿದ್ದೇನೆ ಮತ್ತು ಭಾಗವಹಿಸುವವರು ಮೇಲೆ ತಿಳಿಸಿದ ಕಾರ್ಯವಿಧಾನವನ್ನು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದಾರೆ ಎಂದು ನನ್ನ ಸಾಮರ್ಥ್ಯಕ್ಕೆ ತಕ್ಕಂತೆ ಖಚಿತಪಡಿಸಿಕೊಂಡಿದ್ದೇನೆ.

ಭಾಗವಹಿಸುವವರಿಗೆ ಅಧ್ಯಯನದ ಬಗ್ಗೆ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ಅವಕಾಶ ನೀಡಲಾಗಿದೆ ಮತ್ತು ಭಾಗವಹಿಸುವವರು ಕೇಳಿದ ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳಿಗೆ ಸರಿಯಾಗಿ ಮತ್ತು ನನ್ನ ಸಾಮರ್ಥ್ಯಕ್ಕೆ ತಕ್ಕಂತೆ ಉತ್ತರಿಸಲಾಗಿದೆ ಎಂದು ನಾನು ದೃಢೀಕರಿಸುತ್ತೇನೆ. ಒಪ್ಪಿಗೆಯನ್ನು ನೀಡಲು ವ್ಯಕ್ತಿಯನ್ನು ಒತ್ತಾಯಿಸಲಾಗಿಲ್ಲ ಮತ್ತು ಒಪ್ಪಿಗೆಯನ್ನು ಮುಕ್ತವಾಗಿ ಮತ್ತು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ನೀಡಲಾಗಿದೆ ಎಂದು ನಾನು ದೃಢೀಕರಿಸುತ್ತೇನೆ.

ಈ ಮಾಹಿತಿಯುಕ್ತ ಒಪ್ಪಿಗೆ ಅರ್ಜಿಯ ಪ್ರತಿಯನ್ನು ಭಾಗವಹಿಸುವವರಿಗೆ ಒದಗಿಸಲಾಗಿದೆ.

ಸಂಶೋಧಕರ ಹೆಸರು/ಒಪ್ಪಿಗೆ ಪಡೆಯುವ ವ್ಯಕ್ತಿ: _____

ಒಪ್ಪಿಗೆಯನ್ನು ತೆಗೆದುಕೊಳ್ಳುವ ಸಂಶೋಧಕ/ವ್ಯಕ್ತಿಯ ಸಹಿ: _____

ದಿನಾಂಕ:

माहिती पत्रक:

निवडक टर्शरी केअर हॉस्पिटल, बेळगावच्या प्रसूती विभागांमध्ये आदरयुक्त प्रसूती काळजी प्रदान करण्याच्या दृष्टीकोनातून संरचित प्रशिक्षण कार्यक्रमाची (एसटीपी) परिणामकारकता.

संशोधन अभ्यासक: श्रीमती लक्ष्मी एस. कामत

पर्यवेक्षक: प्रा. (डॉ.) संगीता खर्डे

परिचय: आम्ही तुम्हाला विनंती करत आहोत की, 'बेलगावीच्या निवडक टर्शरी केअर हॉस्पिटलच्या प्रसूती विभागांमध्ये आदरयुक्त प्रसूती काळजी प्रदान करण्याच्या दृष्टीकोनांवरील संरचित प्रशिक्षण कार्यक्रमाची (एसटीपी) परिणामकारकता' या शीर्षकाच्या अभ्यासात सहभागी होण्यासाठी तुम्ही सहमती दर्शवा. मी श्रीमती लक्ष्मी एस कामत, के. एल. ई. अकॅडमी ऑफ हायर एज्युकेशन अँड रिसर्चमधील रिसर्च स्कॉलर, डॉ. संगीता खर्डे, डीन फॅकल्टी ऑफ नर्सिंग केहेर इन्स्टिट्यूट ऑफ नर्सिंग सायन्सेस, बेळगाव यांच्या मार्गदर्शनाखाली आहे.

प्रक्रियेचे स्पष्टीकरण: या अभ्यासामध्ये तुम्हाला सामाजिक-जनसांख्यिकीय तपशील आणि आदरयुक्त प्रसूती काळजीविषयीच्या समजुतीविषयीच्या काही प्रश्नांची उत्तरे प्रश्नावलीच्या मदतीने द्यावी लागतील, त्यानंतर तुमच्यासाठी तीन सत्रांचा नियोजित शैक्षणिक प्रशिक्षण कार्यक्रम आणि प्रसूतीनंतरच्या मातांसाठी प्रसूती महिलांच्या हक्कांविषयी जागरूकता आणि आदरयुक्त प्रसूती काळजी, शैक्षणिक प्रशिक्षण कार्यक्रमाची सामग्री कार्यक्रमातील सहभागींच्या गरजेनुसार आणि जागतिक आरोग्य संघटना (डब्ल्यूएचओ) आणि राष्ट्रीय आरोग्य अभियान (भारत सरकारने 2017 मध्ये "लक्ष्य" मार्गदर्शक तत्त्वे सुरू केली आहेत) या दोघांनी स्थापित केलेल्या मार्गदर्शक तत्त्वांनुसार तयार केली आहे. या संपूर्ण प्रक्रियेला सुमारे 30 मिनिटे लागतील.

संभाव्य फायदे: तुम्हाला प्रसूतीदरम्यान आदरयुक्त प्रसूती काळजी आणि महिलांच्या हक्कांविषयी नवीन ज्ञान मिळू शकेल. आदरयुक्त प्रसूती काळजी सुधारणे आणि प्रसूतीदरम्यान महिलांशी होणारा गैरवर्तन दूर करणे हे मातेचे आरोग्य सुधारण्यासाठीचे एक प्रमुख धोरण आहे.

संभाव्य धोके: अभ्यास करण्यासाठी वापरली जाणारी साधने सुरक्षित आहेत आणि त्यामुळे तुम्हाला कोणतीही हानी होण्याची शक्यता नाही.

गोपनीयता: तुमची ओळख उघड केली जाणार नाही आणि सर्व माहिती गोळा केली जाईल, कोड केली जाईल जेणेकरून कोणालाही तुमची ओळख कळणार नाही.

माघार घेणे: तुमची ओळख उघड केली जाणार नाही आणि सर्व माहिती गोळा केली जाईल, कोड केली जाईल जेणेकरून कोणालाही तुमची ओळख कळणार नाही.

सहभागाचा खर्च: अभ्यासाचा खर्च संशोधक उचलेल. या अभ्यासात सहभागी होण्यासाठी तुम्हाला कोणताही अतिरिक्त खर्च येणार नाही.

सहभागाची देयके: अभ्यासाचा खर्च संशोधक उचलेल. या अभ्यासात सहभागी होण्यासाठी तुम्हाला कोणताही अतिरिक्त खर्च येणार नाही.

प्रकाशनाचा अधिकार: या अभ्यासाचा निकाल प्रकाशनासाठी वापरला जाऊ शकतो. मात्र, तुमची ओळख उघड केली जाणार नाही.

संपर्क माहिती: तुम्हाला काही शंका किंवा प्रश्न असल्यास तुम्ही कधीही संपर्क साधू शकता:

श्रीमती लक्ष्मी एस. कामत प्रा.

Ph.D रिसर्च स्कॉलर,

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(डॉ.) संगीता खर्डे

डीन फॅकल्टी ऑफ नर्सिंग

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संचयित फॉर्म

मी हा संमती अर्ज वाचला आहे आणि मला तो समजला आहे. मला अभ्यासाबाबत माझे प्रश्न विचारण्याची संधी देण्यात आली आहे आणि मला त्यांची समाधानकारक उत्तरे मिळाली आहेत. या संशोधनात सहभागी होण्यासाठी मी स्वेच्छेने संमती देतो.

सहभागीची स्वाक्षरी: _____

संशोधकाची स्वाक्षरी: _____

तारीख:

ठिकाण:

निरक्षर असल्यास: मी संभाव्य सहभागीला संमतीपत्राचे अचूक वाचन करताना पाहिले आहे आणि त्या व्यक्तीला प्रश्न विचारण्याची संधी मिळाली आहे. त्या व्यक्तीने मुक्तपणे संमती दिली आहे याची मी पुष्टी करतो.

सहभागींच्या साक्षीदाराचे नाव: _____

अंगठ्याची छाप

साक्षीदाराची स्वाक्षरी: _____

तारीख:

ठिकाण:

संशोधकाचे विधान: मी संभाव्य सहभागीला माहिती पत्रक अचूकपणे वाचले आहे आणि माझ्या क्षमतेनुसार सहभागीला वर नमूद केलेली प्रक्रिया समजते याची खात्री केली आहे.

मी पुष्टी करतो की सहभागी व्यक्तीला अभ्यासाबद्दल प्रश्न विचारण्याची संधी देण्यात आली होती आणि सहभागी व्यक्तीने विचारलेल्या सर्व प्रश्नांची उत्तरे योग्यरित्या आणि माझ्या क्षमतेनुसार देण्यात आली आहेत. मी पुष्टी करतो की त्या व्यक्तीला संमती देण्यास भाग पाडले गेले नाही आणि संमती मुक्तपणे आणि स्वेच्छेने दिली गेली आहे. या माहितीपूर्ण संमती अर्जाची प्रत सहभागी व्यक्तीला देण्यात आली आहे.

संमती घेणाऱ्या संशोधकाचे/व्यक्तीचे नाव : _____

संमती घेणाऱ्या संशोधक/व्यक्तीची स्वाक्षरी: _____

तारीख:

ANNEXURE V

PART-I: SECTION-A

DEMOGRAPHIC VARIABLES OF THE CARE PROVIDER

Sample code_____

Date_____

Instructions: Dear respondent, you are requested to go through the following and put a tick mark [✓] against the options which are appropriate to you.

1.	Age a. 21 – 25 years b. 26 – 30 years c. 31 – 35 years d. 35 above	() () () ()
2.	Sex a. Male b. Female	() ()
3.	Educational qualification a. M.S OBG b. MSc Nursing (OBG) c. BSc / PBBSc Nursing d. GNM / Diploma Course e. Other	() () () () ()
4.	Marital Status a. Married b. Unmarried c. Widow	() () ()
5.	Religion a. Hindu b. Christian c. Muslim d. Others	() () () ()
6.	Total Work Experience a. 1 year b. 2-5 years c. 5-10 years d. > 10 years	() () () ()
7.	Experience in conducting labour a. 1 year b. 2-5 years c. 5-10 years d. > 10 years	() () () ()
8.	Mother Tongue a. Kannada b. Hindi c. Marathi d. Other	() () () ()

PART-I: SECTION-B
KNOWLEDGE QUESTIONNAIRES
(Respectful Maternity Care)

1.	LaQsha programme launched in India on a. 22 nd May 2000 b. 16 th June 2021 c. 11 th December 2017 d. 30 th September 2022	() () () ()
2.	Aims of LaQsha programme a. Ensure quality in maternal care b. Promote Respectful Maternity Care c. a and b d. Promise Reproductive health	() () () ()
3.	Full form of RMC a. Repeated Maternity Condition b. Respectful Maternity Care c. Respectful Modern Care d. Routine Mother Care	() () () ()
4.	The categories of Disrespect and Abuse is defined by a. Brower and Hill b. Nilkanth Anand Purandare c. Mother Theresa d. Crystal Bennett	() () () ()
5.	Meaning of respectful maternity care a. Respectful Nursing Care b. Respectful for Institution Policy c. Provide facility to the mother d. Respect for human rights of every women	() () () ()
6.	Concept of RMC except a. Respect and Dignity b. Free from harm c. Liberty and autonomy d. Disregard of a women's needs	() () () ()
7.	Strategies of RMC a. Continuous support during labour b. Physical abuse c. Left alone and unattended d. Unequal treatment	() () () ()
8.	Disrespect and abuse is divided into ----- major categories a. 4 b. 7 c. 10 d. 15	() () () ()
9.	Human right in maternity care a. Right to information b. Non confidential care c. Right for disrespectful care d. Right to discrimination	() () () ()

10.	The physical abuse includes a. Used physical force b. Bitten, Slapped and Pinched c. Episiotomy given or sutured without Anaesthesia d. All of the above	() () () ()
11.	The non-confidential care is a. Provider disclosed personal/medical history to third party b. Provide the privacy c. Required number of staff attend the labour d. Respect the mothers choice	() () () ()
12	Women feel abandoned when/if a. Left alone and unattended b. Essential care provided c. Encouraged to call if needed d. Discharge advice given	() () () ()
13	The non-consented care is except a. Provider did not introduced self b. Provider obtain the consent prior to procedure c. Provider did not explain the procedure and expectation d. Provider updates the progress	() () () ()
14	The equitable care and free of discrimination for the women is received by a. Non-medical person b. Nursing staff c. Particular community people d. All health care providers	() () () ()
15	General recommendations to promote RMC care- a. Straitening training b. Developing clinical guidelines and protocol c. Strengthening local laws and regulations d. All of the above	() () () ()

12 to 15 correct answers: Adequate knowledge.

7 to 11 correct answers: Moderate knowledge.

Less than 7: Inadequate knowledge

PART-II: SECTION-A

DEMOGRAPHIC VARIABLES OF THE POSTNATAL MOTHER

1.	Age	
	a. 21-25 years	()
	b. 26-30 years	()
	c. 31-35 years	()
	d. 36-40 years	()
2.	Educational status	
	a. Primary education	()
	b. Secondary education	()
	c. Graduate	()
	d. Post graduate	()
3.	Marital status	
	a. Single	()
	b. Married	()
	c. Divorce	()
	d. Widow	()
4.	Occupation	
	a. Sedentary	()
	b. Moderate	()
	c. House wife	()
	d. Others	()
5.	Obstetrical score	
	a. Primi	()
	b. Second gravid	()
	c. Multigravida	()
6.	Religion	
	a. Hindu	()
	b. Christian	()
	c. Muslim	()
	d. Others	()
7.	Type of family	
	a. Nuclear family	()
	b. Joint family	()
	c. Extended family	()
8.	Type of resident	
	a. Rural	()
	b. Urban	()

PART-II: SECTION-B
EXPERIENCES OF POST-NATAL MOTHER
(Person-Centered Maternity Care Scale)

Domain	Variables	Response	
		Yes	No
Dignity and respect	1. Feel about the amount of time you waited Short : () Long ()		
	2. Did the doctors, nurses, or other health-care providers introduce themselves to you when they first came to see you		
	3. Did the doctors, nurses, or other health-care providers call you by your name		
	4. Did the doctors, nurses, or other staff at the facility treat you with respect		
	5. Did the doctors, nurses, and other staff at the facility treat you in a friendly manner		
	6. Did you feel the doctors, nurses, or other health providers shouted at you, scolded, insulted, threatened, or talked to you rudely		
	7. Did you feel like you were treated roughly like pushed, beaten, slapped, pinched, physically restrained, or gagged		
Communication and autonomy	1. Did you feel like the doctors, nurses, or a staff at the facility involved you in decisions about your care		
	2. During the delivery, do you feel like you were able to be in the position of your choice		
	3. Did the doctors, nurses or other staff at the facility speak to you in a language you could understand		
	4. Did they ask your permission/consent before doing procedures on you		
	5. Explain to you why they were doing examinations or procedures on you		
	6. Did they explain to you why they were giving you any medicine		
	7. Did you feel you could ask the doctors, nurses, or other staff at the facility any questions you had		
Supportive care	1. Did the doctors and nurses at the facility talk to you about how you were feeling		

	2. Did the doctors, nurses, or other staff at the facility try to understand your anxieties		
	3. When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention		
	4. Do you feel the doctors or nurses did everything they could to help control your pain		
	5. Were you allowed to have someone you wanted to stay with you during labour		
Privacy and confidentiality	1. During examinations in the labour room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed		
	2. Do you feel like your health information was or will be kept confidential at this facility		
Trust	1. Did you feel the doctors, nurses, or other staff at the facility took the best care of you		
	2. Did you feel you could completely trust the doctors, nurses, or other staff at the facility with regard to your care		
Facility and environment	1. Do you think there was enough health staff in the facility to care for you		
	2. Thinking about the labour and postnatal wards, did you feel the health facility was crowded		
	3. Thinking about the wards, washrooms, and the general environment of the health facility, will you say the facility was clean		
	4. Was there water in the facility		
	5. Was there electricity in the facility 223 (96.5) 8 (3.5)		
	6. In general, did you feel safe in the health facility		
Predictability and transparency of payment	1. In general, did you feel safe in the health facility		
	2. Did the doctors, nurses, or other staff at the facility ask you or your family for money other than the official cost		
	3. Were you or your family asked to buy anything from outside the health facility for your care		

ಭಾಗ-II: ವಿಭಾಗ-ಎ

ಪೋಸ್ಟಲ್ ತಾಯಿಯ ಡೆಮೋಗ್ರಾಫಿಕ್ ವೈವಿಧ್ಯಗಳು

1.	ವಯಸ್ಸು a. 21-25 ವರ್ಷ b. 26-30 ವರ್ಷ c. 31-35 ವರ್ಷ d. 36-40 ವರ್ಷ	() () () ()
2.	ಶೈಕ್ಷಣಿಕ ಸ್ಥಾನಮಾನ a. ಪ್ರಾಥಮಿಕ ಶಿಕ್ಷಣ b. ಮಾಧ್ಯಮಿಕ ಶಿಕ್ಷಣ c. ಪದವಿ d. ಸ್ನಾತಕೋತ್ತರ ಪದವಿ	() () () ()
3.	ವೈವಾಹಿಕ ಸ್ಥಿತಿ a. ಅವಿವಾಹಿತರು b. ವಿವಾಹಿತರು c. ವಿಚ್ಛೇದನ d. ವಿಧವೆ	() () () ()
4.	ಉದ್ಯೋಗ a. ಕುಳಿತು ಕೆಲಸ ಮಾಡುವುದು b. ಮಧ್ಯಮ c. ಮನೆ ಕೆಲಸ d. ಇತರರು	() () () ()
5.	ಪ್ರಸೂತಿ ಸ್ಕೋರ್ a. ಮೊದಲ ಗರ್ಭಧಾರಣೆ b. ಎರಡನೇ ಗರ್ಭಧಾರಣೆ c. ಎರಡಕ್ಕಿಂತ ಹೆಚ್ಚು ಗರ್ಭಧಾರಣೆ	() () ()
6.	ಧರ್ಮ. a. ಹಿಂದೂ b. ಕ್ರಿಶ್ಚಿಯನ್ c. ಮುಸ್ಲಿಂ d. ಇತರರು	() () () ()
7.	ಕುಟುಂಬದ ಪ್ರಕಾರ a. ಅಣ್ಣ ಕುಟುಂಬ b. ಜಂಟಿ ಕುಟುಂಬ c. ವಿಸ್ತರಿಸಿದ ಕುಟುಂಬ	() () ()
8.	ನಿವಾಸಿಯ ಪ್ರಕಾರ a. ಗ್ರಾಮೀಣ b. ನಗರವಾಸಿಗಳು	() ()

ಭಾಗ-II: ವಿಭಾಗ-ಬಿ
ಪೋಸ್ಟ್-ನಟಲ್ ತಾಯಿಯ ಅನುಭವಗಳು
(ವ್ಯಕ್ತಿ ಕೇಂದ್ರಿತ ಹರಿಗೆ ಆರೈಕೆ ಸ್ಕೇಲ್)

ಡೊಮೇನ್	ಗುಣಲಕ್ಷಣಗಳು	ಪ್ರತಿಕ್ರಿಯೆ	
		ಹೌದು	ಇಲ್ಲ
ಘನತೆ ಮತ್ತು ಗೌರವ	1. ನೀವು ಎಷ್ಟು ಸಮಯ ಕಾಯುತ್ತಿದ್ದೀರಿ ಎಂಬುದರ ಬಗ್ಗೆ ಯೋಚಿಸಿ a. ಚಿಕ್ಕದು:() ಉದ್ದ:()		
	2. ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಆರೋಗ್ಯ ರಕ್ಷಣೆ ನೀಡುಗರು ನಿಮ್ಮನ್ನು ನೋಡಲು ಮೊದಲು ಬಂದಾಗ ತಮ್ಮನ್ನು ತಾವು ನಿಮಗೆ ಪರಿಚಯಿಸಿಕೊಂಡರೇ?		
	3. ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಆರೋಗ್ಯ ರಕ್ಷಣೆ ನೀಡುಗರು ನಿಮ್ಮನ್ನು ನಿಮ್ಮ ಹೆಸರಿನಿಂದ ಕರೆದಿದ್ದಾರೆಯೇ?		
	4. ಅಲ್ಲಿನ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಗಳು ನಿಮ್ಮನ್ನು ಗೌರವದಿಂದ ನಡೆಸಿಕೊಂಡಿದ್ದಾರೆಯೇ?		
	5. ಇಲ್ಲಿನ ವೈದ್ಯರು, ದಾದಿಯರು ಮತ್ತು ಇತರ ಸಿಬ್ಬಂದಿಗಳು ನಿಮ್ಮನ್ನು ಸ್ನೇಹಪರವಾಗಿ ನಡೆಸಿಕೊಂಡಿದ್ದಾರೆಯೇ?		
	6. ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಆರೋಗ್ಯ ಪೂರೈಕೆದಾರರು ನಿಮ್ಮ ಮೇಲೆ ಕೂಗಿದರು, ಗದರಿಸಿದರು, ಅವಮಾನಿಸಿದರು, ಬೆದರಿಕೆ ಹಾಕಿದರು ಅಥವಾ ನಿಮ್ಮೊಂದಿಗೆ ಅಸಭ್ಯವಾಗಿ ಮಾತನಾಡಿದರು ಎಂದು ನೀವು ಭಾವಿಸಿದ್ದೀರಾ?		
	7. ನಿಮ್ಮನ್ನು ಸ್ಥೂಲವಾಗಿ ತಳ್ಳಿದಂತೆ, ಹೊಡೆದಂತೆ, ಕಪಾಳಮೋಕ್ಷ ಮಾಡಿದಂತೆ, ಚುಚ್ಚಿದಂತೆ, ದೈಹಿಕವಾಗಿ ನಿರ್ಬಂಧಿಸಿದಂತೆ ಅಥವಾ ಬಾಯಿ ಮುಚ್ಚಿದಂತೆ ಪರಿಗಣಿಸಲಾಗಿದೆ ಎಂದು ನಿಮಗೆ ಅನ್ನಿಸುತ್ತದೆಯೇ?		
ಸಂವಹನ ಮತ್ತು ಸ್ವಾಯತ್ತತೆ	1. ನಿಮ್ಮ ಆರೈಕೆಯ ನಿರ್ಧಾರಗಳಲ್ಲಿ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಸೌಲಭ್ಯದಲ್ಲಿರುವ ಸಿಬ್ಬಂದಿ ನಿಮ್ಮನ್ನು ತೊಡಗಿಸಿಕೊಂಡಿದ್ದಾರೆ ಎಂದು ನಿಮಗೆ ಅನ್ನಿಸುತ್ತದೆಯೇ?		
	2. ಜನ್ಮ ನೀಡುವಾಗ, ನೀವು ನಿಮ್ಮ ಆಯ್ಕೆಯ ಸ್ಥಾನದಲ್ಲಿ ಇರಲು ಸಾಧ್ಯವಾಯಿತು ಎಂದು ನಿಮಗೆ ಅನ್ನಿಸುತ್ತದೆಯೇ?		
	3. ಅಲ್ಲಿನ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಗಳು ನಿಮಗೆ ಅರ್ಥವಾಗುವ ಭಾಷೆಯಲ್ಲಿ ನಿಮ್ಮೊಂದಿಗೆ ಮಾತನಾಡಿದ್ದಾರೆಯೇ?		

	4. ನಿಮ್ಮ ಮೇಲೆ ಕಾರ್ಯವಿಧಾನಗಳನ್ನು ಮಾಡುವ ಮೊದಲು ಅವರು ನಿಮ್ಮ ಅನುಮತಿ/ಒಪ್ಪಿಗೆಯನ್ನು ಕೇಳಿದ್ದಾರೆಯೇ?		
	5. ಅವರು ನಿಮ್ಮ ಮೇಲೆ ಏಕೆ ಪರೀಕ್ಷೆಗಳು ಅಥವಾ ಕಾರ್ಯವಿಧಾನಗಳನ್ನು ಮಾಡುತ್ತಿದ್ದರು ಎಂಬುದನ್ನು ನಿಮಗೆ ವಿವರಿಸಿ.		
	6. ಅವರು ನಿಮಗೆ ಯಾವುದೇ ಔಷಧವನ್ನು ಏಕೆ ನೀಡುತ್ತಿದ್ದಾರೆಂದು ಅವರು ನಿಮಗೆ ವಿವರಿಸಿದ್ದಾರೆಯೇ?		
	7. ಆ ಸೌಲಭ್ಯದಲ್ಲಿದ್ದ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಯನ್ನು ನೀವು ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಬಹುದೆಂದು ನೀವು ಭಾವಿಸಿದ್ದೀರಾ?		
ಪೂರಕ ಆರೈಕೆ	1. ಸೌಲಭ್ಯದಲ್ಲಿದ್ದ ವೈದ್ಯರು ಮತ್ತು ದಾದಿಯರು ನೀವು ಹೇಗೆ ಭಾವಿಸುತ್ತಿದ್ದೀರಿ ಎಂಬುದರ ಬಗ್ಗೆ ನಿಮ್ಮೊಂದಿಗೆ ಮಾತನಾಡಿದ್ದೀರಾ?		
	2. ಅಲ್ಲಿನ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಗಳು ನಿಮ್ಮ ಆತಂಕಗಳನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳಲು ಪ್ರಯತ್ನಿಸಿದ್ದಾರೆಯೇ?		
	3. ನಿಮಗೆ ಸಹಾಯದ ಅಗತ್ಯವಿದ್ದಾಗ, ಆ ಸೌಲಭ್ಯದಲ್ಲಿದ್ದ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಗಳು ಗಮನ ಹರಿಸಿದರು ಎಂದು ನಿಮಗೆ ಅನ್ನಿಸಿದೆಯೇ?		
	4. ನಿಮ್ಮ ನೋವನ್ನು ನಿಯಂತ್ರಿಸಲು ವೈದ್ಯರು ಅಥವಾ ದಾದಿಯರು ತಮ್ಮ ಕೈಲಾದ ಎಲ್ಲವನ್ನೂ ಮಾಡಿದ್ದಾರೆ ಎಂದು ನೀವು ಭಾವಿಸುತ್ತೀರಾ?		
	5. ಹೆರಿಗೆಯ ಸಮಯದಲ್ಲಿ ನಿಮ್ಮೊಂದಿಗೆ ಇರಲು ಬಯಸುವ ಯಾರನ್ನಾದರೂ ಹೊಂದಲು ನಿಮಗೆ ಅನುಮತಿ ನೀಡಲಾಗಿದೆಯೇ?		
ಗೌಪ್ಯತೆ	1. ಹೆರಿಗೆ ಕೊಠಡಿಯಲ್ಲಿನ ಪರೀಕ್ಷೆಗಳ ಸಮಯದಲ್ಲಿ, ನೀವು ಬಟ್ಟೆ ಅಥವಾ ಕಂಬಳಿಯಿಂದ ಮುಚ್ಚಿಕೊಂಡಿದ್ದೀರಾ ಅಥವಾ ಸ್ಟ್ರೀನಿಂಗ್ ಮಾಡಿದ್ದೀರಾ?		
	2. ಈ ಸೌಲಭ್ಯದಲ್ಲಿ ನಿಮ್ಮ ಆರೋಗ್ಯ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿಡಲಾಗುತ್ತಿತ್ತು ಅಥವಾ ಇಡಲಾಗುವುದು ಎಂದು ನಿಮಗೆ ಅನಿಸುತ್ತದೆಯೇ?		
ನಂಬಿಕೆ	1. ಆ ಸೌಲಭ್ಯದಲ್ಲಿದ್ದ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಗಳು ನಿಮ್ಮನ್ನು ಅತ್ಯುತ್ತಮವಾಗಿ ನೋಡಿಕೊಂಡರು		

	ಎಂದು ನೀವು ಭಾವಿಸಿದ್ದೀರಾ?		
	2. ನಿಮ್ಮ ಆರೈಕೆಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಸೌಲಭ್ಯದಲ್ಲಿರುವ ಇತರ ಸಿಬ್ಬಂದಿಯನ್ನು ನೀವು ಸಂಪೂರ್ಣವಾಗಿ ನಂಬಬಹುದೆಂದು ನೀವು ಭಾವಿಸಿದ್ದೀರಾ?		
ಸೌಲಭ್ಯ ಮತ್ತು ಪರಿಸರ	1. ನಿಮ್ಮನ್ನು ನೋಡಿಕೊಳ್ಳಲು ಸೌಲಭ್ಯದಲ್ಲಿ ಸಾಕಷ್ಟು ಆರೋಗ್ಯ ಸಿಬ್ಬಂದಿ ಇದ್ದರು ಎಂದು ನೀವು ಭಾವಿಸುತ್ತೀರಾ?		
	2. ಹೆರಿಗೆ ಮತ್ತು ಪ್ರಸವಾನಂತರದ ವಾರ್ಡ್‌ಗಳ ಬಗ್ಗೆ ಯೋಚಿಸಿದಾಗ, ಆರೋಗ್ಯ ಸೌಲಭ್ಯವು ಕಿಕ್ಕಿರಿದು ತುಂಬಿದೆ ಎಂದು ನಿಮಗೆ ಅನಿಸಿದೆಯೇ?		
	3. ವಾರ್ಡ್‌ಗಳು, ಶೌಚಾಲಯಗಳು ಮತ್ತು ಆರೋಗ್ಯ ಸೌಲಭ್ಯದ ಸಾಮಾನ್ಯ ಪರಿಸರದ ಬಗ್ಗೆ ಯೋಚಿಸಿದರೆ, ಸೌಲಭ್ಯವು ಸ್ವಚ್ಛವಾಗಿತ್ತು ಎಂದು ನೀವು ಹೇಳುತ್ತೀರಾ?		
	4. ಸೌಲಭ್ಯದಲ್ಲಿ ಸಾಕಷ್ಟು ನೀರಿನ ಪೂರೈಕೆ ಇದೆಯೇ?		
	5. ಸೌಲಭ್ಯದಲ್ಲಿ ವಿದ್ಯುತ್ ಇದೆಯೇ?		
	6. ಸಾಮಾನ್ಯವಾಗಿ, ನೀವು ಆರೋಗ್ಯ ಸೌಲಭ್ಯದಲ್ಲಿ ಸುರಕ್ಷಿತವಾಗಿದ್ದೀರಾ?		
ಪಾವತಿಯ ಪಾರದರ್ಶಕತೆ	1. ಸಾಮಾನ್ಯವಾಗಿ, ನೀವು ಆರೋಗ್ಯ ಸೌಲಭ್ಯದಲ್ಲಿ ಸುರಕ್ಷಿತವಾಗಿದ್ದೀರಾ?		
	2. ಈ ಸೌಲಭ್ಯದಲ್ಲಿರುವ ವೈದ್ಯರು, ದಾದಿಯರು ಅಥವಾ ಇತರ ಸಿಬ್ಬಂದಿಗಳು ನಿಮ್ಮನ್ನು ಅಥವಾ ನಿಮ್ಮ ಕುಟುಂಬವನ್ನು ಅಧಿಕೃತ ವೆಚ್ಚವನ್ನು ಹೊರತುಪಡಿಸಿ ಬೇರೆ ಹಣವನ್ನು ಕೇಳಿದ್ದಾರೆಯೇ?		
	3. ನಿಮ್ಮ ಆರೈಕೆಗಾಗಿ ಆರೋಗ್ಯ ಸೌಲಭ್ಯದ ಹೊರಗಿನಿಂದ ಏನನ್ನಾದರೂ ಖರೀದಿಸಲು ನಿಮ್ಮನ್ನು ಅಥವಾ ನಿಮ್ಮ ಕುಟುಂಬವನ್ನು ಕೇಳಲಾಗಿದೆಯೇ?		

भाग-II: विभाग-अ
पोस्टनेटल आईचे डेमोग्राफिक क्हेरिएबल्स

1.	वय a. 21-25 वर्षे b. 26-30 वर्षे c. 31-35 वर्षे d. 36-40 वर्षे	() () () ()
2.	शैक्षणिक स्थिती a. प्राथमिक शिक्षण b. माध्यमिक शिक्षण c. पदवीधर d. पदव्युत्तर पदवी	() () () ()
3.	वैवाहिक स्थिती a. अविवाहित b. विवाहित. c. घटस्फोट d. विधवा.	() () () ()
4.	व्यवसाय a. गतिहीन b. मध्यम. c. घरगुती पत्नी d. इतर	() () () ()
5.	प्रसूतीचा गुणांक a. प्राथमिक b. दुसरा ग्रेविड c. मल्टीग्रेविडा	() () ()
6.	धर्म. a. हिंदू b. ख्रिश्चन c. मुस्लिम d. इतर	() () () ()
7.	कुटुंबाचा प्रकार a. अणु कुटुंब b. संयुक्त कुटुंब c. विस्तारित कुटुंब	() () ()
8.	रहिवाशांचा प्रकार a. ग्रामीण b. शहरी	() ()

भाग-II: विभाग-ब
जन्मानंतरच्या मातेचा अनुभव
(व्यक्ती-केंद्रित प्रसूती काळजी प्रमाण)

डोमेन	कॅरेक्टरिस्टिक्स	प्रतिसाद	
		होय	नाही
प्रतिष्ठा आणि आदर करा	1. तुम्ही किती वेळ वाट पाहिली याचा अनुभव घ्या a. लघुरूप: () लांब: ()		
	2. डॉक्टर, परिचारिका किंवा इतर आरोग्य सेवा पुरवठादार जेव्हा पहिल्यांदा तुम्हाला भेटायला आले, तेव्हा त्यांनी तुमची ओळख करून दिली का?		
	3. डॉक्टर, परिचारिका किंवा इतर आरोग्य सेवा पुरवठादारांनी तुम्हाला तुमच्या नावाने हाक मारली का?		
	4. रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचाऱ्यांनी तुमच्याशी आदराने वागले का?		
	5. रुग्णालयातील डॉक्टर, परिचारिका आणि इतर कर्मचाऱ्यांनी तुमच्याशी मैत्रीपूर्ण वागणूक दिली का?		
	6. डॉक्टर, परिचारिका किंवा इतर आरोग्य सेवा पुरवठादारांनी तुमच्यावर आरडाओरडा केला, फटकारले, अपमान केला, धमकावले किंवा तुमच्याशी असभ्यपणे बोलले असे तुम्हाला वाटले का?		
	7. तुम्हाला ढकलले गेले, मारहाण केली गेली, थप्पड मारली गेली, चिमटा मारला गेला, शारीरिकरित्या नियंत्रित केले गेले किंवा तोंड बंद केले गेले असे तुम्हाला वाटले का?		
संवाद आणि स्वायत्तता	1. या सुविधेतील डॉक्टर, परिचारिका किंवा कर्मचारी तुमच्या काळजीबाबतच्या निर्णयांमध्ये तुमचा समावेश करतात असे तुम्हाला वाटले का?		
	2. डिलिव्हरीच्या वेळी, तुम्ही तुमच्या पसंतीच्या स्थितीत आहात असे तुम्हाला वाटते का?		
	3. रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचारी तुमच्याशी तुम्हाला समजेल अशा भाषेत बोलले का?		
	4. तुमच्यावर प्रक्रिया करण्यापूर्वी त्यांनी तुमची परवानगी/संमती मागितली होती का?		
	5. ते तुमच्यावर परीक्षा किंवा प्रक्रिया का करत होते ते तुम्हाला समजावून सांगा.		

	6. ते तुम्हाला कोणतेही औषध का देत होते हे त्यांनी तुम्हाला समजावून सांगितले का?		
	7. तुम्हाला वाटले का की तुम्ही रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचाऱ्यांना तुमचे काही प्रश्न विचारू शकाल का?		
सहाय्यक काळजी	1. तुम्हाला कसे वाटत होते याबद्दल रुग्णालयातील डॉक्टर आणि परिचारिका तुमच्याशी बोलल्या का?		
	2. रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचाऱ्यांनी तुमची चिंता समजून घेण्याचा प्रयत्न केला का?		
	3. जेव्हा तुम्हाला मदतीची गरज होती, तेव्हा रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचाऱ्यांनी लक्ष दिले असे तुम्हाला वाटले का?		
	4. तुमच्या वेदनेवर नियंत्रण ठेवण्यासाठी डॉक्टर किंवा परिचारिकांनी सर्वतोपरी प्रयत्न केले असे तुम्हाला वाटते का?		
	5. प्रसूतीदरम्यान तुम्हाला तुमच्याबरोबर रहायचे असलेल्या एखाद्याला ठेवण्याची तुम्हाला परवानगी होती का?		
गोपनीयता	1. प्रसूतीच्या खोलीतील परीक्षांदरम्यान, तुम्ही कापडाने किंवा कंबळाने झाकलेले होते का किंवा पडद्याने स्क्रीन केलेले होते जेणेकरून तुम्हाला उघडेपणा जाणवू नये		
	2. तुमची आरोग्यविषयक माहिती या सुविधेत गोपनीय ठेवण्यात आली होती किंवा ठेवली जाईल असे तुम्हाला वाटते का?		
विश्वासाईता	1. रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचाऱ्यांनी तुमची सर्वोत्तम काळजी घेतली असे तुम्हाला वाटले का?		
	2. तुमच्या देखभालीच्या बाबतीत तुम्ही रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचाऱ्यांवर पूर्णपणे विश्वास ठेवू शकता असे तुम्हाला वाटले का?		
सुविधा आणि पर्यावरण	1. तुमची काळजी घेण्यासाठी त्या ठिकाणी पुरेसे आरोग्य कर्मचारी होते असे तुम्हाला वाटते का?		
	2. प्रसूतीपूर्व आणि प्रसूतीनंतरच्या रुग्णसंख्येचा विचार करता, तुम्हाला आरोग्य सुविधेत गर्दी असल्याचे वाटले का?		
	3. वॉर्ड्स, स्वच्छतागृहे आणि आरोग्य सुविधेच्या सामान्य वातावरणाचा विचार करता, ती सुविधा स्वच्छ होती असे तुम्ही सांगाल का?		
	4. सुविधा केंद्रामध्ये पाण्याचा चांगला पुरवठा होता का?		

	5. सुविधा केंद्रामध्ये वीज होती का?		
	6. सर्वसाधारणपणे, तुम्हाला आरोग्य केंद्रात सुरक्षित वाटले का?		
अंदाज आणि देयक पारदर्शकता	1. सर्वसाधारणपणे, तुम्हाला आरोग्य केंद्रात सुरक्षित वाटले का?		
	2. रुग्णालयातील डॉक्टर, परिचारिका किंवा इतर कर्मचारी तुमच्याकडे किंवा तुमच्या कुटुंबाकडे अधिकृत खर्चाशिवाय इतर पैसे मागतात का?		
	3. तुम्हाला किंवा तुमच्या कुटुंबाला तुमच्या देखभालीसाठी आरोग्य सुविधेबाहेरून काही खरेदी करण्यास सांगितले होते का?		

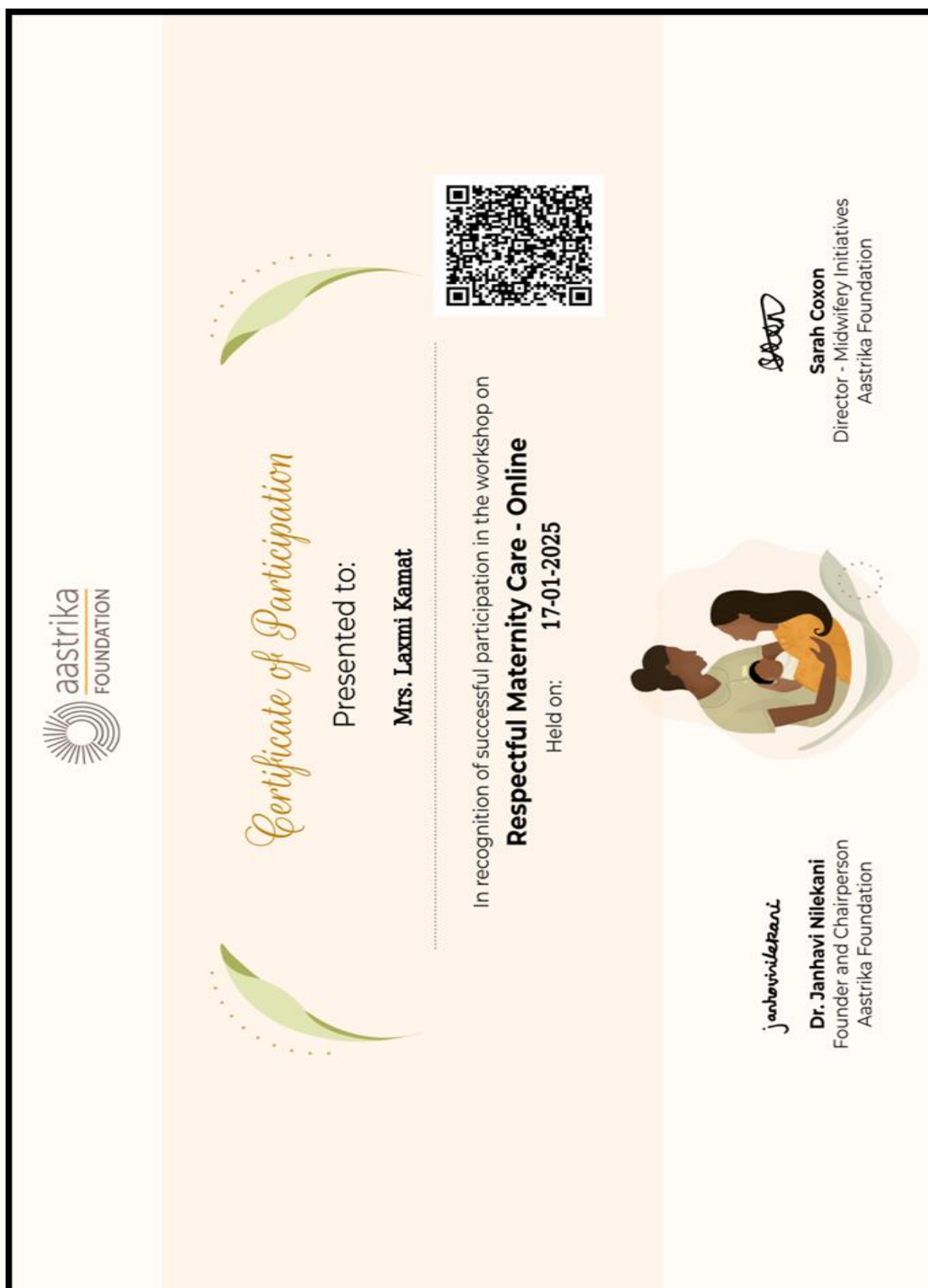
ANNEXURE VI

CERTIFICATES

   	   
KLE ACADEMY OF HIGHER EDUCATION AND RESEARCH (Deemed-to-be-University) Accredited 'A+' Grade by NAAC (3rd Cycle) INSTITUTE OF NURSING SCIENCES NEHRU NAGAR, BELAGAVI <i>National Conference</i>	KLE ACADEMY OF HIGHER EDUCATION AND RESEARCH (Deemed-to-be-University) Placed in 'Category A' by MoE, (GoI) INSTITUTE OF NURSING SCIENCES NEHRU NAGAR, BELAGAVI <i>National Conference</i>
<i>Certificate of Award</i>	
Is here by awarded to	
Dr./Prof./Mr./Ms./Mrs. <u>Laxmi. Kamat.</u> has Presented Paper/ Poster in National Conference on "Fostering Innovation in Midwifery: Moving forward in maternal & Newborn Care" in association with SOMI and TNAI (KSB), organized by KAHER Institute of Nursing Sciences Belagavi, Karnataka, India, on 22nd and 23rd March 2024	
Title of the Paper/Poster: <u>"The satisfaction levels of post-natal mothers with the respectful maternity care (RMC) at a tertiary care hospital, Belagavi."</u>	
<u>G. J. S.</u> TNAI President	<u>Neel</u> SOMI Secretary
<u>S. Anand</u> Organizing Secretary	<u>Quint</u> Organizing Chairperson







ANNEXURE VII

Respectful Maternity Care training programme

Aspects of RMC training programme

1. Providers introducing themselves to the women
2. Calling women by their names
3. Asking women how they are feeling
4. Allowing women to have a support person of their choice
5. Ensuring privacy during examinations
6. Explaining examinations, procedures, and medications
7. Obtaining consent before procedures,
8. Communicating findings of examinations to women and their families
9. Encouraging the women and their families to ask questions
10. Allowing women to move during labour and birth in their preferred position.

INDEX

Sessions	Content	Time (90 min)
I	Introduction – meaning , importance ➤ Categories of RMC : • Physical Abuse • Non dignified care • Non consented care • Non confidential care • Discrimination • Withholding the care • Detention In the facilities	10 min 20 min
II	➤ Needs of RMC for Health Care Workers ➤ Universal rights of child bearing women ➤ Obstetrical violence – meaning manifestation Prevention and elimination of violence during childbirth	5 min 10 min 10 min 5 min
III	➤ Challenges and barriers ➤ Introducing online module The online module titled “Implementing Respectful Maternity Care in Healthcare Facility”. This is prepared by the White Ribbon Alliance India and available in Aasrtika Foundation platform.	10 min 20 min

GENERAL OBJECTIVE: The Respectful Maternity Care training programme is developed to impart knowledge and performance regarding Respectful Maternity Care.

CENTRAL OBJECTIVE: At the end of the respectful maternity care training programme staff nurses will be able to gain adequate knowledge and attitude regarding respectful maternity care.

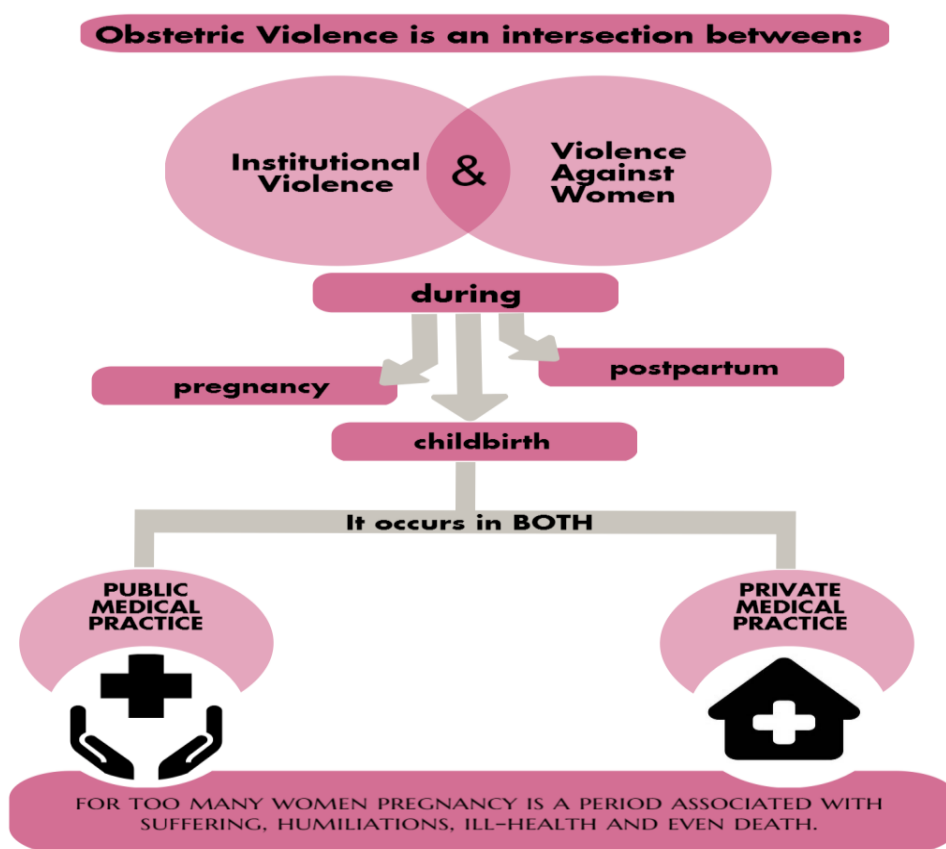
SPECIFIC OBJECTIVES: At the end of the respectful maternity care training programme, the staffs will be able to:

- I. Define Respectful Maternity Care.
- II. Identify concept of Respectful Maternity Care.
- III. Describe Respectful Maternity Care is lifesaving.
- IV. Enlist types of abuse and disrespect and human rights in Maternity Care.
- V. Recognize multi-stakeholder in Respectful Maternity Care.
- VI. Explain underlying factors of disrespectful and abusive in Maternity Care.
- VII. Enumerate general recommendations.

Introduction: Obstetric violence is a form of mistreatment, abuse, or neglect that individuals may experience during pregnancy, labor, childbirth, and postpartum care. It encompasses physical, verbal, and psychological harm inflicted by healthcare providers in medical settings, often as a result of systemic issues such as gender discrimination, medical paternalism, and lack of informed consent. This violation of human rights affects birthing individuals worldwide, disproportionately impacting marginalized communities.

Despite growing awareness, obstetric violence remains a widespread yet underreported issue, leading to negative physical and emotional consequences for those affected. It can manifest in various ways, including unnecessary medical interventions, denial of pain relief, coercion, lack of respect for autonomy, and even physical and verbal abuse. The consequences extend beyond childbirth, affecting long-term maternal health and trust in the healthcare system.

Addressing obstetric violence requires legal recognition, systemic reforms, and a shift toward respectful maternity care. By promoting patient-centered approaches, advocating for informed consent, and ensuring accountability within healthcare institutions, society can work toward eliminating obstetric violence and upholding the dignity and rights of birthing individuals.



Significant progress has been made globally in maternal and neonatal health (MNH) care, and both maternal and neonatal mortality rates have dropped in recent decades. Even when services are available, care may be compromised by social, ethnic and cultural barriers, an unwelcoming reception at the health care facility, lack of privacy and information for the client, and disrespect and abuse. Bowser and Hill's landmark review of evidence for disrespect and abuse in facility-based childbirth (2010) identified numerous examples, including physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care, and detention in facilities⁵. They noted that women avoid seeking care in health facilities because of mistreatment, thus compromising the achievement of Millenium Development Goal 5—improve maternal health.

IMPACTS OF OBSTETRIC VIOLENCE:

1. Physical Impacts

- **Injuries and Complications:** Unnecessary episiotomies, forced C-sections, excessive force during delivery or failure to manage labor properly can lead to severe injuries.
- **Chronic Pain and Disabilities:** Some medical interventions performed without consent or proper care can cause long-term pain, incontinence, or pelvic floor disorders.
- **Infections and Medical Complications:** Unsanitary conditions, forced procedures, or neglect can increase the risk of infections and other postpartum health complications.

- **Increased Maternal and Infant Mortality:** In extreme cases, neglect or poor medical care can lead to life-threatening complications for both mother and baby.

2. Psychological and Emotional Impacts

- **Post-Traumatic Stress Disorder (PTSD):** Many survivors of obstetric violence experience symptoms of PTSD, including flashbacks, nightmares, and severe anxiety.
- **Depression and Anxiety:** The experience of mistreatment during childbirth can lead to postpartum depression, generalized anxiety, and other mental health disorders.
- **Fear of Future Pregnancies:** Many women who experience obstetric violence may avoid future pregnancies due to fear of experiencing similar trauma.
- **Loss of Trust in Healthcare Providers:** Victims may become hesitant to seek medical care in the future, increasing health risks for themselves and their children.

3. Social and Relational Impacts

- **Strained Relationships:** The trauma of obstetric violence can affect relationships with partners, family members, and even the newborn, impacting bonding and emotional well-being.
- **Stigma and Shame:** In some cultures, speaking about birth-related trauma is discouraged, leaving victims feeling isolated and unsupported.
- **Work and Economic Consequences:** Physical and psychological trauma can lead to an inability to return to work, resulting in financial difficulties.

4. Legal and Ethical Impacts

- **Violation of Human Rights:** Obstetric violence is considered a violation of women's reproductive rights and bodily autonomy.
- **Legal Battles:** Some victims may seek justice through legal action, though many face barriers due to lack of awareness or systemic issues in the healthcare and legal system.



Obstetric violence has profound and far-reaching consequences that affect individuals physically, emotionally, and socially. Addressing this issue requires systemic changes in healthcare policies, legal protections, and awareness campaigns to ensure respectful and dignified maternity care.

Respectful Maternity Care: Some countries, such as Venezuela, Argentina, and Mexico, have laws specifically recognizing obstetric violence. However, many places still lack legal protections, leaving victims without clear avenues for justice. The World Health Organization (WHO) has acknowledged disrespect and abuse in maternity care as a global issue.

RMC is universal human right due for every child bearing women in every health system around the world where in many interventions aim to improve the access to skilled birth care; much attention has to be focus on quality of relationship with care givers during maternity care.

CONCEPT OF RESPECTFUL MATERNITY CARE.

“Respectful Maternity Care” (RMC) is an approach that:

- Focuses on the interpersonal aspect of maternal care.
- Emphasizes the fundamental rights of the mother, new-born and families, including protecting the mother- baby pair.
- Recognizes that all childbearing women need and deserve respectful care and protection of the women’s right to choice and preferences.

**TYPES OF ABUSE AND DISRESPECT:**

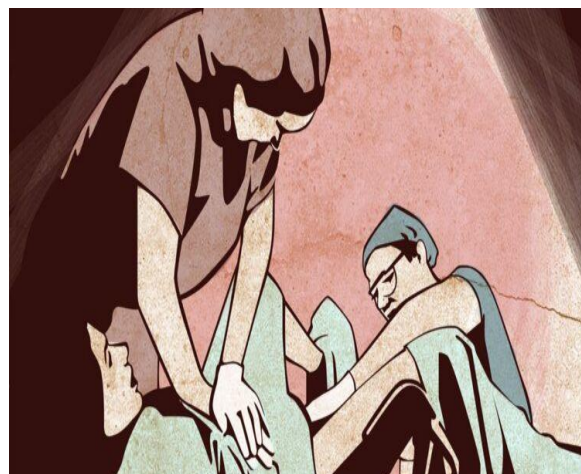
1. Physical Abuse
2. Non-consented care
3. Non-confidential care
4. Non-dignified care (including verbal abuse)
5. Discrimination based on specific attributes
6. Abandonment or denial of care
7. Detention in facilities

**HUMAN RIGHT IN MATERNITY CARE****1. Physical Abuse:** Freedom from harm and ill treatment

- Used any physical force or abrasive behaviour with women, including slapping or hitting or any gesture towards slapping or hitting.
- Touched or Obstetrical examination done inappropriately.
- Fluid denied to the women during delivery.
- Physical comfort not provided (e.g. Raising head end of table, giving pillow, mattress, back massage or verbal comfort)

- Pain- relief medication (e.g. local anaesthesia during episiotomy and while suturing the episiotomy) not given.
- Provider threatens or presents disastrous consequences for women or her baby if their instructions are not followed (e.g. if she does not bear down her baby's head will stuck baby will be a still born).

2. Non-consented care: Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice wherever possible



- Provider does not introduce self to the women or to her birth companion
- Birth companion not allowed remaining with women during labor and they were not allowed to ask questions.
- Questions were not responded in clear polite and truthful manner (e.g. after checking fetal heart or NST
- Explanation not provided to the women in labor on how to push during contraction and relax when contraction disappears.
- No information given regarding money expenditure if any complication occurs
- No information given regarding New born Vaccination to the mother or family member



4. Non-confidential care: Confidential, privacy

- While doing obstetrical examination no privacy is provided (sending out the male companion, no female provider along the side of women if male doctor is examining the patient)
- No screens or curtains provided during obstetrical examination
- Inappropriate exposure of unexamined parts during examination
- Clients records are not maintained confidentiality where they can be read by others not involved in care
- Discussing about the patient with social stigmatic condition (HIV, HbsAG, or any psychiatric disorders) with the person not involved in patient care



Maintaining Confidentiality

4. Non-dignified care (including verbal abuse):

Dignity, respect

- Greet the patient
- Staff speaks impolitely to woman and companion
- Woman or her companion not permitted to do any cultural practices, which are not harmful for mother or baby (e.g. prayer)
- Use of unsterile /unclean drapes/mackintosh/linen on labour table during delivery or shifting.
- Improper hand washing by health professionals during care or delivery or touching the unsterile field after wearing sterile gloves.
- Using unsterile or rusted articles in patient care.

- Woman labour table are not cleaned after every delivery or not even giving then fresh gown after delivery
- Unpredictable and Unwanted financial demands (e.g. being forced to wait longer while those with more money are seen first)
- Commenting and making fun of the patient condition.

5. Discrimination based on specific attributes: Equality, freedom from discrimination, equitable care

- Unequal treatment -verbal and physical disrespect of woman based on any specific attributes (e.g. disability, caste, religion, presence of too many relatives , grand multipara, unwed mother, wearing dirty clothes, uneducated, unhooked case, referred case, does not have any money for medicine, forced to make out pocket expenditure)
- Refusal to attend during night duty for night delivery or care for woman
- Provider demonstrated favouritism (towards relatives or friends)
- Neglects the care for the patient who were not present on their bed according to providers convenience

6. Abandonment or denial of care: Right to timely health care and to the highest attainable level of health



- Essential care (periodic examination of vitals, etc) not provided to the women
- Women discouraged to call if needed

- Left alone and unattended
- Discharge advice not given

- Provider had no time to explain concern or treatment after discharge
- Woman felt ignored post-delivery (no counselling for breast feeding, perineal care and postures to be maintained).

7. Detention in facilities: Liberty, autonomy, self-determination, and freedom from coercion.

- Women detained against their will
- The facility has a policy of not providing care, medicine or investigations for women who do not pay
- Demands made for informal payments /baksheesh /bribe

POTENTIAL CONTRIBUTORS TO AND IMPACT OF DISRESPECTFUL AND ABUSIVE IN RESPECTFUL MATERNITY CARE

- Policy
- Facility infrastructure, physical resources, and commodities.
- Human resources.
- Knowledge and practice of health care providers.
- Knowledge and skill development
- Management (National level factors – poor distribution and management of human resource).
- Ethnicity (cultural belief) gender, socio-economic.
- Communities.

Policy

- National policy: lack of regulations and legal frameworks for health rights; failure to enforce existing laws or to apply policy or laws.

- Institutional policy: client rights and RMC not reflected in institutional policy; lack of, or failure to use, protocols, guidelines, and performance standards related to RMC; ignorance of the existing laws related to pregnancy, labor, and delivery care; norms that exclude fathers, family members, friends, traditional birth attendants (TBAs), and doulas from the labor and birth process.
- Cross-cutting issues(national/institutional/community): women and communities unaware of women's rights in policy, or of laws that protect them; health care providers do not respect norms or rules and so work in an undisciplined way.

Facility infrastructure, physical resources, and commodities

- Lack of adequate infrastructure (physical space and environment).
- Lack of essential supplies and equipment.
- Poor facility conditions including extreme overcrowding with patient sharing beds, poor sanitation.
- Lack of resources for facilitating normal birth, e.g., birth stools, floor mats; lack of informational materials related to respectful maternity care.
- Few or no supplies for community midwives who work in rural/remote sites.

Human resources

- Inadequate staffing and resources, and little reward leading to high stress and frustration among skilled birth attendants (SBAs).
- Acute shortages of health workers.
- Staff underpaid or not paid.
- Few midwives participating in maternity care; and lack of credibility for midwives within the medical community.

- The thoughts and ideas of the medical hierarchy predominate over the thoughts of other care providers.
- Poor communication among medical professionals, with resistance to dialogue and change.
- Lack of support for the work of traditional midwives in remote areas; lack of motivation and interest in improving quality of services; health workers who have no love for the profession and no compassion for women; staff frustrated.
- Health worker attitudes: lack of “humanism” among professionals; lack of empathy and commitment of care providers.
- Few professionals with holistic vision that support RMC.

Knowledge and practice of health care providers

- Authoritarian culture in health services with socialization of health care providers into a hierarchical system of care; denigration of midwives by obstetricians.
- Lack of knowledge and skills of staff, including limited understanding of the normal, physiologic birth process and how to facilitate it.
- Lack of awareness of rights and gender issues; lack of harmonization of clinical care and treatment with respect for the woman as an individual.
- Attention focused on specific clinical issues without regard to a woman’s beliefs or culture or an understanding of the emotional and physical needs of women and babies.
- Outdated practices not supported by evidence.
- Professional resistance to changing practice routines based on evidence.
- Institutional/professional culture of performing unnecessary cesarean sections and/or overuse of unnecessary technology.

- Health team exercises power over people seeking care, with women being seen a “patient” with pathology rather than as an equal person who can participate in her own care.
- Abusive care as punishment for traditional practices.
- Institutionalized discrimination by ethnicity and socio-economic position.
- Pervasive levels of corruption in all areas of health services; institutional culture that assimilates and “normalizes” the practices of violence.

Knowledge and skill development

- Professional pre-service education: gaps in the education of professionals; outdated curricula in pre-service institutions, which do not emphasize respectful care or evidence based approaches. Medicalized care, rather than woman-centered care, is taught in preserves education; lack of RMC in undergraduate training of health teams; poor behavioral practices learned during trainings by senior professionals; lack of training sites that can serve as a model for provision of RMC.
- In-service education/training: lack of training and updating in best practices and respectful care.
- Lack of positive role models.

Management

- National level factors: poor distribution and management of human resources; managerial and political leadership with little knowledge about RMC issue; poor management of service delivery system; leaders and decision makers not chosen for technical ability but for political and economic reasons.

- Institutional/facility management: poor care and use of human resources; TBAs¹¹ are not allowed to work in facilities; lack of supportive supervision; lack of individual and institutional accountability and mechanisms that ensure RMC; lack of incentives for good and penalties for bad practices on health care; limited numbers of beds in facilities force health care providers to discharge women and their newborns earlier than is safe.

Ethnicity, gender, socio-economic, and culture

- Ethnicity/culture: belief that traditional but harmful practices should be preserved; lack of respect for minority cultures.
- Society: lack of respect for basic human and civil rights prevalent in the society.
- Gender: disempowerment and low status of women; influence of culture “to give birth with pain;” paradigm of care where the woman is the object and not the subject.
- Socio-economic: institutionalized racism/classism by providers from high socio-economic background and different ethnicity/cultural background from clients.
- Culture: generalized lack of respect and disregard for human life; lack of respect for the woman’s culture.

Communities

- Lack of awareness among pregnant women and families of their rights.
- Lack of understanding of healthy practices during pregnancy, labor and birth.
- Limited demands from mothers for quality care services.
- Lack of information through the media.
- Lack of availability of community-level service providers, such as community midwives.

STRATEGIES TO PROMOTE RESPECTFUL MATERNITY CARE.



Strengthening training



Implementing quality improvement approaches



Developing clinical guidelines and protocols



Implementing community activities including campaign



Strengthening local laws and regulation



Continuous support during labour



Choice of birth companions during labour and birth



The right of Information and privacy



Freedom of movement during labour



Choice of positions during labour



Improvement of working conditions and respectful and collaborative relationships among all cadres of health workers



Good communication between client and provider



Prevention of disrespect and abuse and institutional violence



Support of the mother baby pair



Empowerment of the woman and her family to become active participants in Healthcare

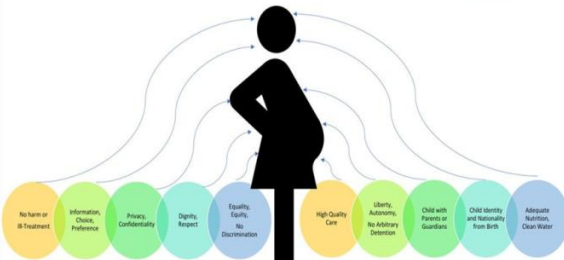
CONCLUSION: Disrespectful and abusive care of women during their pregnancies has been shown to be a barrier for women accessing health care services for antenatal care and delivery. The Respectful Maternity Care Charter addresses the issue of disrespect and abuse toward women and newborns utilizing maternal and newborn care services.

ANNEXURE VII

Respectful Maternity Care Awareness Pamphlet to Mother

10 Importance of Respectful Maternity Care

Women are more likely to have positive experiences when they feel respected and supported.

Respectful Maternity Care

- <https://www.ideas42.org/wp-content/uploads/2021/05/42-Respectful-Maternity-Care-Design-Guide.pdf>
- <https://platform.who.int/docs/default-source/mca-documents/policy-documents/operational-guidance/afg-mn-32-01-operational-guidance-2017-eng-523476805-respectful-maternity-care-providers.pdf>

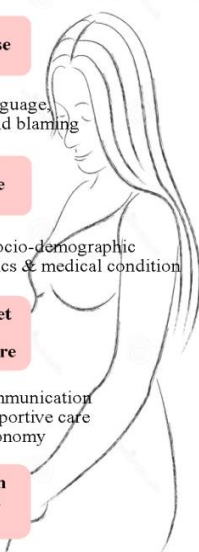
Respectful Maternity Care



Respectful Maternity Care (RMC) as a fundamental human right that ensures the safety and rights of women during labour and childbirth. RMC is based on a rights-based approach and aims to improve the quality and utilization of maternity care.

Obstetrics Violence can be manifested through:

Use of force, physical restraints	Physical abuse
Harsh language, Threats and blaming	Verbal abuse
Based on socio-demographic characteristics & medical condition	Sexual abuse
Lack of informed consent & confidentiality Neglect & abandonment	Stigma & Discrimination
Lack of communication Lack of supportive care Loss of autonomy	Failure to meet professional standard of care
Lack of resources Lack of policies Facility culture	Poor rapport
	Health system conditions & constraints



I Have the Right of



- Respect**
- Equity**
- Consent**
- Privacy**
- Safety**
- Participation**

10 ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆಯ ಪ್ರಾಮುಖ್ಯತೆ

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Respectful Maternity Care

References:
<https://www.idsa42.org/wp-content/uploads/2021/05/42-Respectful-Maternity-Care-Design-Guide.pdf>
<https://platform.who.int/docs/default-source/ncs-documents/policy-documents/operational-guidance/afg-rms-32-01-operational-guidance-2017-eng-323476805-respectful-maternity-care-providers.pdf>

ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆ

ಹೆರಿಗೆ ಮತ್ತು ಹೆರಿಗೆಯ ಸಮಯದಲ್ಲಿ ಮಹಿಳೆಯರ ಸುರಕ್ಷತೆ ಮತ್ತು ಹಕ್ಕುಗಳನ್ನು ಖಾತ್ರಿಪಡಿಸುವ ಮೂಲಭೂತ ಮಾನವ ಹಕ್ಕಾಗಿ ಗೌರವಾನ್ವಿತ ಹೆರಿಗೆ ಆರೈಕೆ (ಆರ್ಎಫ್ಸಿ).ಆರ್. ಎಂ. ಸಿ. ಯು ಹಕ್ಕು ಆಧಾರಿತ ವಿಧಾನವನ್ನು ಆಧರಿಸಿದೆ ಮತ್ತು ಹೆರಿಗೆ ಆರೈಕೆಯ ಗುಣಮಟ್ಟ ಮತ್ತು ಬಳಕೆಯನ್ನು ಸುಧಾರಿಸುವ ಗುರಿಯನ್ನು ಹೊಂದಿದೆ.

ಪ್ರಸೂತಿ ಹಿಂಸಾಚಾರವನ್ನು ಈ ಕೆಳಗಿನವುಗಳ ಮೂಲಕ ವಳಪಡಿಸಬಹುದು:

ಬಲದ ಬಳಕೆ, ದೈಹಿಕ ನಿರ್ಬಂಧ.

ಮೌಖಿಕ ನಿಂದನೆ

ಕಿರುಕುಳ

ಕಳಂಕ ಮತ್ತು ತಾರತಮ್ಯ

ತಿಳುವಳಿಕೆಯುಳ್ಳ ಒಮ್ಮಿಗೆ ಗೌಪ್ಯತೆಯ ಕೊರತೆ ನಿರ್ಲಕ್ಷ್ಯ ಮತ್ತು ತ್ಯಜಿಸುವಿಕೆ

ಕಳಪೆ ಬಾಂಧವ್ಯ

ಸಂಪನ್ಮೂಲಗಳ ಕೊರತೆ ನೀತಿಗಳ ಕೊರತೆ ಸೌಲಭ್ಯದ ಕೊರತೆ

ದೈಹಿಕ ದುರ್ಬಳಕೆ

ಕಠಿಣ ಭಾಷೆ, ಬೆದರಿಕೆ ಮತ್ತು ಆರೋಪ.

ಲೈಂಗಿಕ ಕಿರುಕುಳ

ಸಾಮಾಜಿಕ-ಜನಸಂಖ್ಯಾ ಗುಣಲಕ್ಷಣಗಳು ಮತ್ತು ವೈದ್ಯಕೀಯ ಸ್ಥಿತಿಯ ಆಧಾರದ

ವೈಶಿಷ್ಟ್ಯ ಗುಣಮಟ್ಟದ ಆರೈಕೆಯನ್ನು ಪೂರೈಸುವಲ್ಲಿ ವೈಫಲ್ಯ

ಸಂವಹನದ ಕೊರತೆ ಆರೈಕೆಯ ಕೊರತೆ ಸ್ವಾಯತ್ತತೆಯ ನಷ್ಟ

ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಯ ಪರಿಸ್ಥಿತಿಗಳು ಮತ್ತು ನಿರ್ಬಂಧಗಳು

ಇದನ್ನು ಪಡೆಯುವ ಹಕ್ಕು ನನಗಿದೆ

ಗೌರವ

ಸಮಾನತೆ

ಪ್ರತಿಭಟನೆ

ಗೌಪ್ಯತೆ

ಸುರಕ್ಷತೆ

ಬಾಳುವಹಿತವಿಕೆ

ಗೌರವ

ಸಮಾನತೆ

ಪ್ರತಿಭಟನೆ

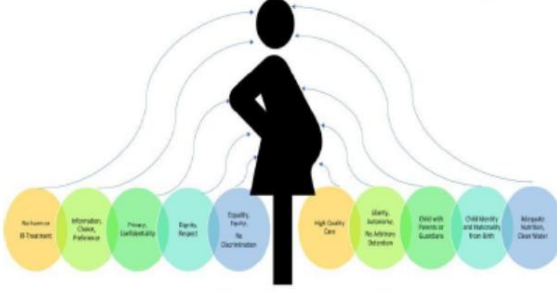
ಗೌಪ್ಯತೆ

ಸುರಕ್ಷತೆ

ಬಾಳುವಹಿತವಿಕೆ

10 आदरयुक्त प्रसूतीच्या देखभालीचे महत्त्व

जेव्हा महिलांना आदर आणि पाठबळ मिळते तेव्हा त्यांना सकारात्मक अनुभव येण्याची शक्यता जास्त असते.



Respectful Maternity Care

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आदरयुक्त मातृत्वाची काळजी



प्रसूती आणि प्रसूतीदरम्यान महिलांची सुरक्षा आणि हक्क सुनिश्चित करणारा करणारा मूलभूत मानवी हक्क म्हणून आदरयुक्त प्रसूती काळजी (आर. एम. एम. सी.). आर. एम. सी. हे अधिकार-आधारित दृष्टिकोनावर आधारित आहे आहे आणि प्रसूती सेवेची गुणवत्ता आणि वापर सुधारण्याचे उद्दिष्ट आहे.

प्रसूतीशास्त्र हिंसा खालील गोष्टींद्वारे प्रकट केली जाऊ शकते

बळाचा वापर, शारीरिक निर्बंध

शारीरिक शोषण

तोंडी गैरवर्तन

कठोर भाषा, धमक्या आणि दोषारोप

लैंगिक शोषण

कलक आणि भेदभाव

सामाजिक-जनसांख्यिकीय वैशिष्ट्ये आणि वैद्यकीय स्थितीवर आधारित

माहितीपूर्ण संमतीचा अभाव, अभाव, गोपनीयता, दुर्लक्ष आणि त्याग

देखभालीच्या व्यावसायिक मानकांची पूर्तता

खराब संबंध

संवादाचा अभाव सहाय्यक काळजीचा अभाव स्वायत्तता गैरमावणे

साधनसंपत्तीची कमतरता धोरणांचा अभाव सुविधा संस्कृतीचा अभाव

आरोग्य व्यवस्थेच्या व्यवस्थेच्या अटी आणि प्रवृत्ती



ANNEXURE VII

PUBLICATION



<https://africanjournalofbiomedicalresearch.com/index.php/AJBR>

Afr. J. Biomed. Res. Vol. 27 (September 2024); 622-625

Research Article

The satisfaction levels of post-natal mothers with the respectful maternity care (RMC) at a tertiary care hospital, Belagavi.

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ABSTRACT

Respectful maternity care (RMC) is a personalised strategy that places a strong focus on moral principles and respect for human rights. It also promotes actions that consider women's preferences and the needs of both expectant mother and new mothers. The Indian government recently launched RMC under LaQshya to provide appropriate attention and care to pregnant patients in medical facilities.

Objectives: To assess the level of postnatal mothers satisfaction with respectful maternity care.

Methods and materials: A descriptive study design was used to obtain data from 370 respondents. Prior to data collection, participants' satisfaction levels with RMC were assessed. The information was obtained using a modified Person-Centered Maternity Care Scale.

Result: The total satisfaction level of post-natal mother with RMC was 63.50%. Level of satisfaction with RMC domain, Dignity and Respect (52.89%), Communication and Autonomy (75.71%), Supportive care (48.05%), Privacy and confidentiality (64.32%), Trust (94.72%), Facility and environment (64.70%), Predictability and transparency of payment (44.14%).

Conclusion: Overall mother satisfaction with RMC care services offered in the tertiary care hospital was excellent. Dignity and Respect, Supportive care, Privacy and confidentiality, Communication and Autonomy, Facility and environment, Predictability and transparency of payment domains were associated with post-natal mother's satisfaction with RMC. Therefore, Health care professionals should collaborate on identified factors for better maternal satisfaction.

Key words: Post-natal, RMC, Tertiary care hospital.

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INTRODUCTION

Satisfaction is defined as an individual's emotions of happiness or sadness when comparing the outcome of a product to his or her expectations. Client satisfaction has become an essential component of hospital and clinic management practices around the world.

In the last 20 years, client-centered or patient-centered care has gained international recognition as an aspect of high-quality healthcare as a whole. According to the Institute of Medicine (IOM), high-quality healthcare should be prompt, efficient, patient- or client-centered, safe, and equitable. "Care that is respectful of and responsive to individual client or

patient preferences, needs, and values, and ensuring that client's or patient's values guide all clinical decisions" is how client- or patient-centered care was described. (Babure ZK, et al-2019)

One of the most significant and unforgettable moments in a woman's life is giving birth, and she should have the support of her chosen companion and caregivers. It is important that women are treated with dignity and respect during this time. Disrespectful maternity care is still a major issue in both developing and developed nations, though. Abuse and disrespect are two of the biggest obstacles that prevent women from accessing healthcare, particularly in developing nations,

The satisfaction levels of post-natal mothers with the respectful maternity care (RMC) at a tertiary care hospital, Belagavi.

which makes it difficult to bring down maternal morbidity and mortality rates. (Bohren MA et al-2017, whiteribbonalliance.org)

Maternal satisfaction with the delivery service may have both immediate and long-term impacts on the health of both the mother and the newborn. Negative feedback on the childbirth experience instantly increases the chance of postpartum depression and unhappiness, while also changing maternal views towards future pregnancies and manner of delivery. However, several of the reported detrimental effects were mirrored in a variety of health outcomes, including maternal and infant mortality, perinatal infections, perceived health status, and hygiene compliance. Feelings of satisfaction are vital to preserving maternal health and providing continuing excellent care for mother and child health. (Babure ZK, et al-2019)

The World Health Organisation (WHO) issued a consensus statement on preventing disrespect and abuse during childbirth, highlighting the need of women's participation in increasing quality of care and abolishing disrespectful practices. The statement was then extended into the core recommendations, Respectful Maternity Care (RMC) methods, which are based on human rights and are expected to result in better birth and labour experiences for women, as well as equity in the health-care system. (Downe S, et al-2018, Bowser and Hill, 2010, WHO)

Respectful maternity care (RMC) is an innovative concept developed by LaQshya to ensure pregnant women receive respectful care in health facilities. Some of its components are visual privacy, choices, freedom from ill treatment, and birth companion. The RMC aims to prevent and eliminate disrespect and abuse during childbirth in healthcare settings. This broader approach aims to improve women's satisfaction with their birth experience. (Venkatesh Reddy B-2019)

As a result, many countries strive to improve RMC in an effort to enhance the standard of childbirth care in maternity services. The first stage in such initiatives is to evaluate the current situation and the goal of this study is to assess the mother's level of satisfaction.

MATERIALS AND METHODS:

In the present study, researcher adapted Descriptive research design. The study was carried out on 370 samples. Convenient sampling technique was used to select samples for postnatal mothers admitted in tertiary care hospital. Basic demographic profile and modified Person-Centered Maternity Care Scale were used. Institutional ethics committee approved the ethical clearance. Analysis of data was calculated by using descriptive and inferential statistics.

RESULT:

The analysis and interpretation of the data collected to determine the satisfaction levels of post-natal mothers with the respectful maternity care (RMC) is carried out based on the objective set by the researcher.

I. Socio- demographic information

Table 1: Demographic characteristics of postnatal mother

Factors		No of postnatal mother	% of postnatal mother
Age groups	21-25	118	31.89
	26-30	126	34.05
	31-35	97	26.22
	36 - 40	29	7.84
Educational Status	Primary	70	18.92
	Secondary	92	24.86
	Graduate	123	33.24
	PG	85	22.97
Occupation	Sedentary	73	19.73
	Moderate	114	30.81
	House Wife	148	40.00
	Others	35	9.46
Obstetrical score	Primi	201	54.32
	Second	163	44.05
	Multi	6	1.62
	Primi	201	54.32
Religion	Hindu	208	56.22
	Christian	66	17.84
	Muslim	89	24.05
	Others	7	1.89
Type of family	Nuclear	250	67.57
	Joint	120	32.43
Type of resident	Rural	95	25.68
	Urban	275	74.32
Total		370	100.00

Table 1 shows the demographic features of postnatal mothers. 34.05% of the samples were between the ages of 26 and 30, 33.24% were graduates, 40% were homemakers, 54.32% were

primi mothers, 56.22% practiced Hinduism, 67.57% were from nuclear families, and 74.32% were from urban areas.

The satisfaction levels of post-natal mothers with the respectful maternity care (RMC) at a tertiary care hospital, Belagavi.

II. Domain wise mother's satisfaction level.

Table 2: Percent of post-natal mother responding to items in the Person-Centered maternity care scale "yes, most of the time" N=370

Dignity and Respect :		
Feel about the amount of time you waited	305	(82.43)
Short : () Long ()		
Did the doctors, nurses, or other health-care providers introduce themselves to you when they first came to see you	187	(50.54)
Did the doctors, nurses, or other health-care providers call you by your name	348	(94.05)
Did the doctors, nurses, or other staff at the facility treat you with respect	275	(74.32)
Did the doctors, nurses, and other staff at the facility treat you in a friendly manner	249	(67.30)
Did you feel the doctors, nurses, or other health providers shouted at you, scolded, insulted, threatened, or talked to you rudely	06	(1.62)
Did you feel like you were treated roughly like pushed, beaten, slapped, pinched, physically restrained, or gagged	00	(00)
Communication and autonomy:		
Did you feel like the doctors, nurses, or a staff at the facility involved you in decisions about your care	278	(75.14)
During the delivery, do you feel like you were able to be in the position of your choice	95	(25.68)
Did the doctors, nurses or other staff at the facility speak to you in a language you could understand	370	(100.00)
Did they ask your permission/consent before doing procedures on you	362	(97.83)
Explain to you why they were doing examinations or procedures on you	282	(76.22)
Did they explain to you why they were giving you any medicine	236	(63.78)
Did you feel you could ask the doctors, nurses, or other staff at the facility any questions you had	338	(91.35)
Supportive care:		
Did the doctors and nurses at the facility talk to you about how you were feeling	339	(91.62)
Did the doctors, nurses, or other staff at the facility try to understand your anxieties	144	(38.92)
When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention	167	(45.14)
Do you feel the doctors or nurses did everything they could to help control your pain	239	(64.59)
Were you allowed to have someone you wanted to stay with you during labour	0	(0.00)
Privacy and Confidentiality:		
During examinations in the labour room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed	124	(33.51)
Do you feel like your health information was or will be kept confidential at this facility	352	(95.13)
Trust:		
Did you feel the doctors, nurses, or other staff at the facility took the best care of you	349	(94.32)
Did you feel you could completely trust the doctors, nurses, or other staff at the facility with regard to your care	352	95.13
Facility and Environment:		
Do you think there was enough health staff in the facility to care for you	256	(69.19)
Thinking about the labour and postnatal wards, did you feel the health facility was crowded	153	(41.35)
Thinking about the wards, washrooms, and the general environment of the health facility, will you say the facility was clean	48	(12.97)
Was there water in the facility	370	(100.00)
Was there electricity in the facility	370	(100.00)
Predictability and transparency of payment:		
In general, did you feel safe in the health facility	356	(96.21)
Did the doctors, nurses, or other staff at the facility ask you or your family for money other than the official cost	0	(0.00)
Were you or your family asked to buy anything from outside the health facility for your care	134	(36.22)

Note: all the domain scores are significant at $p < 0.001$.

DISCUSSION:

In the present study satisfaction level of post-natal mother with respectful maternity care as follows: out of all 52.89% of postpartum mothers were satisfied with dignity and respect; 75.71% were satisfied with autonomy and communication;

48.05% were satisfied with supportive care; 64.32% were satisfied with privacy and confidentiality; 94.72% of mothers felt trusted; 64.70% were satisfied with the facilities and surroundings; and 44.14% were satisfied with payment predictability and transparency. A similar study was conducted

The satisfaction levels of post-natal mothers with the respectful maternity care (RMC) at a tertiary care hospital, Belagavi.

by the Patience Afulani et. al (2019) reported that the average person-centered maternity care score was 50%. Another similar study conducted by Merette Khalil, Kashi Barbara Carasso and Tamar Kabakian-Khasholian (2022) reported Women's Narratives of Disrespect and Abuse in Childbirth.

CONCLUSION:

A paradigm shift involving infrastructure modifications, advocacy, education, empowerment, and a women-centered and gender-sensitive approach to strengthening the health system are all necessary to eradicate obstetric violence. In order to guarantee that every woman attains her right to health and gives birth in a dignified, respected, and empowered manner, recommendations are made at the individual, community, health systems, and policy levels.

ACKNOWLEDGEMENT:

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Nil

CONFLICTS OF INTEREST:

Nil

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African Journal of Biological Sciences



A Step Towards "Respectful Maternity Care": Descriptive Survey To Assess Knowledge Among Health Care Providers.

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ABSTRACT

Maternal health care is not merely about medical interventions; it encompasses the entirety of a woman's experience during childbirth, including her rights to dignity, respect, and autonomy. Respectful Maternity Care (RMC) has emerged as a critical framework aimed at ensuring that every woman receives care that is not only medically appropriate but also respectful of her basic human rights.

Objective: To assess the existing knowledge on RMC among Care providers working in the maternity units.

Methods and materials: A non-experimental descriptive survey design was used to assess the knowledge on Respectful Maternity Care among Care providers working in the maternity units. The sample size of 370 were selected by using Non-Probability; purposive sampling technique. Basic demographic profile and structured knowledge questionnaire were administered to collect the data.

Result: The survey found that 34.59% of participants had an average knowledge of Respectful Maternity Care. The mean knowledge score was 47.10, with a mean percentage of 12.72 and a standard deviation of 12.92.

Conclusion: The researcher concluded that care providers awareness of respectful maternity care was average. Knowledge levels and demographic characteristics are associated with gender, education, and work experience.

Key words: Knowledge, Maternity units, RMC, care provider.

INTRODUCTION

Pregnancy is a unique, exciting, and often happy time in a woman's life, emphasising the incredible creative and caring process. Pregnancy begins on the first day of the last menstrual period and normally ends in birthing at 38-40 weeks gestation. During pregnancy, a woman's physiological changes occur; yet, her systems may fail to accommodate these changes. Complications can occur at any stage of pregnancy. So, timely obstetric care services are vital for addressing difficulties during pregnancy, labour, and the immediate postpartum period. (Dhanya Devassy, Sangeetha X-2023)

The National Health Mission (NHM) has implemented numerous measures to reduce maternal and new-born mortality in India. One of the key initiatives is LaQshya, Labour Room Quality Improvement Initiative Guideline, is an essential initiative that offers recommendations for enhancing the intrapartum and immediate postpartum care provided in the labour room and

maternity operation theatre (Ministry of Health and Family Welfare, LaQshya Programme- 24 MAR 2023.) This is a new, revolutionary initiative in the area of maternal health care that respect both the physiological and psychological needs of the pregnant mother and her family during childbirth. (Venkatashiva Reddy B-2019)

Childbirth is a challenging and exhausting procedure, yet women's bodies were intended to give birth. Respecting and understanding women can assist new-borns, who also have rights and deserve to be respected and recognised. Respectful Maternity Care (RMC) is an individual-focused approach that promotes strategies that respect human rights and are founded on ethical values. The components of the RMC are: "Respect for Autonomy, Dignity, Empathy, Privacy, Confidentiality, Feelings, choices and preferences, and expectations of mothers and new-borns. Including companionship during maternity and continuing care during labour and delivery and to prevent injury and abuse." Improving the physical environment and resources; inflict lasting harm and emotional suffering; offering equitable maternity care. (Ms. Ayushi Sharma, Dr. Priyanka A. Masih-2022)

MATERIALS AND METHODS:

The current study used a non-experimental descriptive study methodology and included 370 samples. The non-probability purposive selection technique was used to choose samples for healthcare providers working in maternity units at a tertiary care hospital. Data were collected using demographic characteristics of health care providers and a structured knowledge questionnaire (based on RMC components). The institutional ethics committee approved the ethical clearance. The data was analysed using descriptive and inferential statistics.

Inclusion criteria

All health care providers (OBG PG -MS, Registered Nurse, health assistance) who are working in maternity units of Selected Tertiary Care Hospital, Belagavi.

Exclusion criteria

Health care provider who undergone any training / in-service education programme on RMC

RESULT:

Based on the objectives set by the researcher, the data is analysed and interpreted in order to evaluate the health care provides level of knowledge regarding respectful maternity care.

Socio-demographic characteristics of health care providers

Among 370 health care providers, more than half (79.46%) remained between the ages of 21-25. Only 4.86% of the participants were 35 and older.

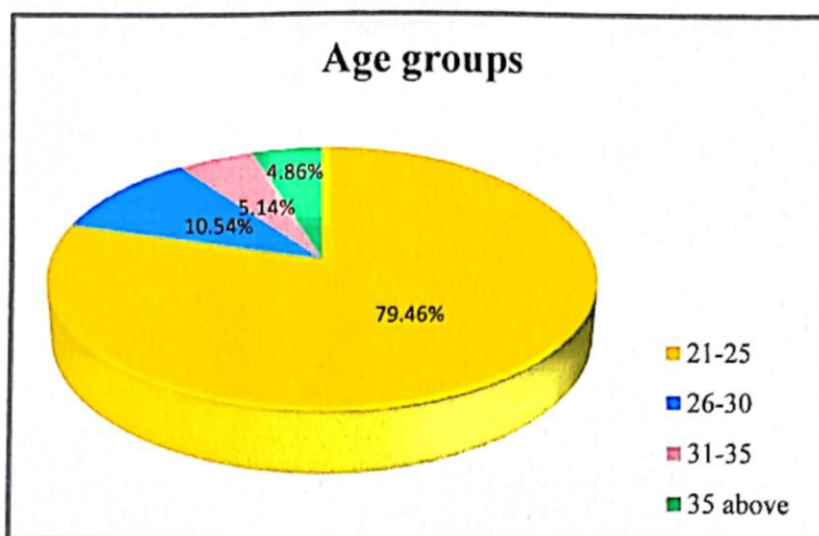


Figure 1: Percentage distribution of participants with regards to age group (n=370)

The majority of the participants were female 90.27%

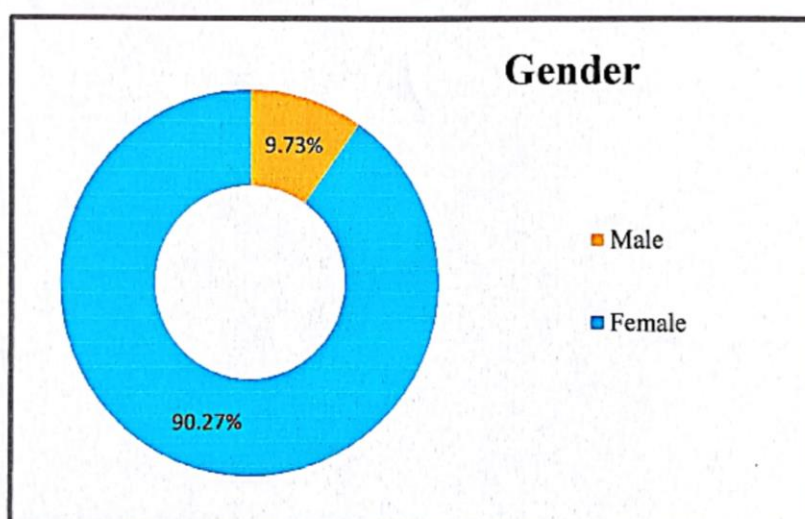


Figure 2: Percentage distribution of participants with regards to Gender (n=370)

Table 1: Frequency and percentage distribution of participants with regards to educational status (n=370).

Category	Frequency	Percentage
Educational status:		
M.S OBG	21	5.68
MSC (N)	36	9.73
BSc/PBBSc	150	40.54
GNM	139	37.57
Others	24	6.49

The majority of participants (40.54%) had an educational status of BSc/PBBSc.

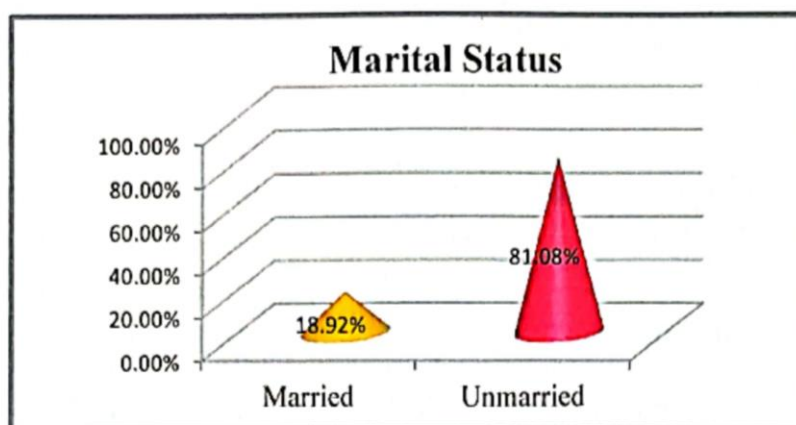


Figure 3: Percentage distribution of participants with regards to Marital Status (n=370)

The vast majority of participants (81.08) were unmarried.

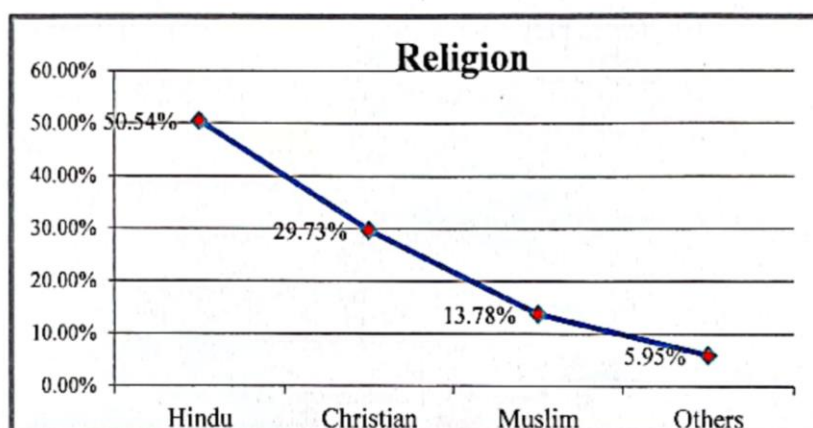


Figure 4: Percentage distribution of participants with regards to Religion (n=370)

The greater part of participants (50.54%) follows Hinduism.

Table 2: Participants' frequency and percentage distribution with respect to work experience (n=370).

Category	Frequency	Percentage
Work experience:		
1 year	112	30.27
2-5 years	158	42.70
5-10 years	66	17.84
>10years	34	9.19

A large proportion of the participants (42.70%) had 2-5 years of experience.

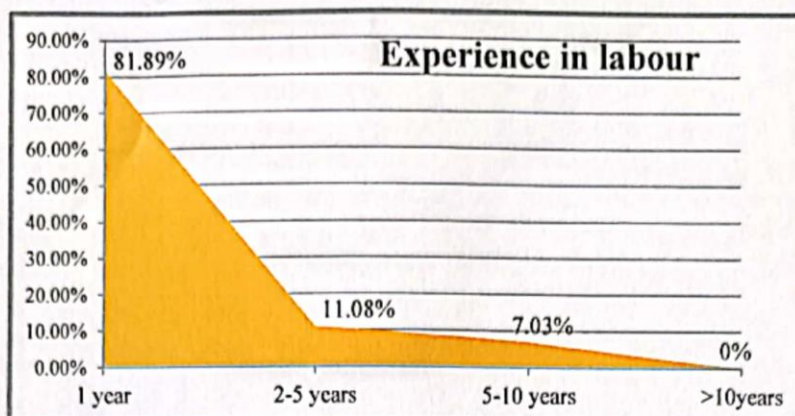


Figure 5: Percentage distribution of participants based on experience in labour (n=370)

The greater part of participants (81.89%) had 2-5 year of experience in labour.

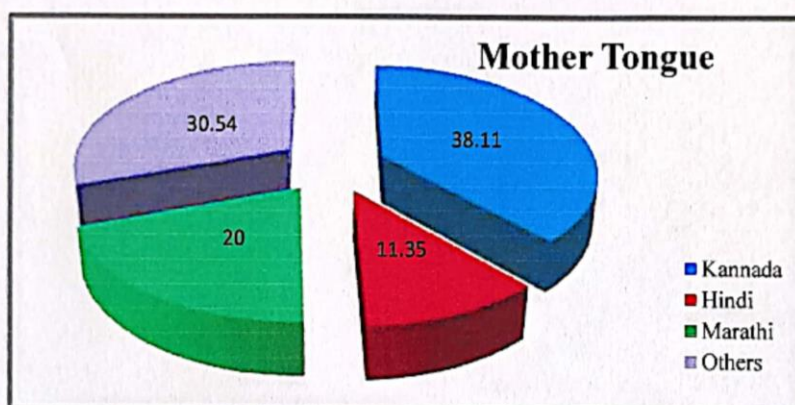


Figure 6: Participants' percentage distribution according to mother tongue (n=370)

The majority of Participants (38.11%) speak kannada as their mother tongue.

Figure 7: Depicts the mean, mean percentage and standard deviation of participants' knowledge scores on respectful maternity care (n=370).

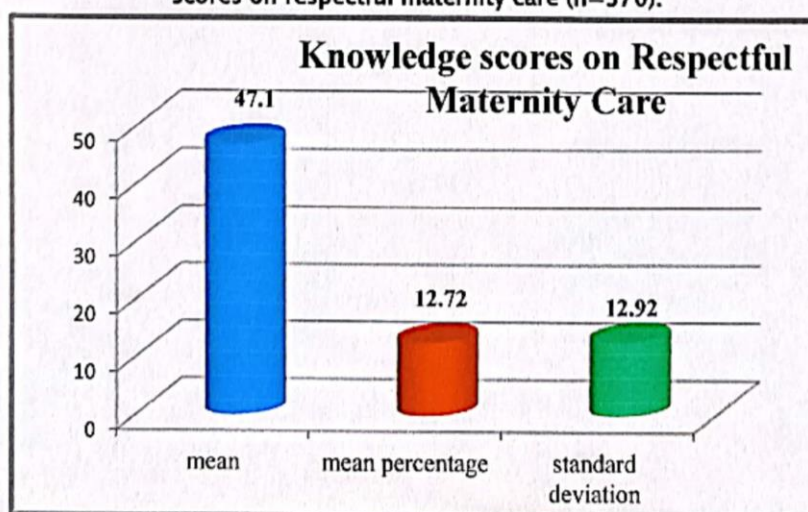


Table 3: Frequency and percentage distribution of knowledge score on respectful maternity care. (n=370)

Levels	Numbers	Percentage
Inadequate ($\leq 50\%$)	237	64.05
Moderately adequate (51–75%)	128	34.59
Adequate ($\geq 76\%$)	5	1.35
Total	370	100.00

Table 4: Association between knowledge on respectful maternity care with socio-demographic characteristics. (n=370)

Profile	Levels of knowledge on RMC				Total	%	Chi-square	p-value
	Low	%	High	%				
Age groups								
21-25	190	64.63	104	35.37	294	79.46	3.9190	0.2700
26-30	28	71.79	11	28.21	39	10.54		
31-35	9	47.37	10	52.63	19	5.14		
35 above	10	55.56	8	44.44	18	4.86		
Gender								
Male	33	91.67	3	8.33	36	9.73	13.2060	0.0001*
Female	204	61.08	130	38.92	334	90.27		
Educations								
M.S OBG	0	0.00	21	100.00	21	5.68	105.0710	0.0001*
MSC (N)	3	8.33	33	91.67	36	9.73		
BSc/PBBSc	119	79.33	31	20.67	150	40.54		
GNM	96	69.06	43	30.94	139	37.57		
Others	19	79.17	5	20.83	24	6.49		
Marital Status								
Married	42	60.00	28	40.00	70	18.92	0.6160	0.4320
Unmarried	195	65.00	105	35.00	300	81.08		
Religion								
Hindu	127	67.91	60	32.09	187	50.54	7.5770	0.0560
Christian	59	53.64	51	46.36	110	29.73		
Muslim	35	68.63	16	31.37	51	13.78		
Others	16	72.73	6	27.27	22	5.95		
Work experience								
1 year	83	74.11	29	25.89	112	30.27	44.8500	0.0001*
2-5 years	117	74.05	41	25.95	158	42.70		
5-10 years	27	40.91	39	59.09	66	17.84		
>10years	10	29.41	24	70.59	34	9.19		
Experience in labour								
1 year	196	64.69	107	35.31	303	81.89	0.5170	0.7720
2-5 years	26	63.41	15	36.59	41	11.08		
5-10 years	15	57.69	11	42.31	26	7.03		
Mother Tongue								

Kannada	95	67.38	46	32.62	141	38.11	2.5720	0.4620
Hindi	26	61.90	16	38.10	42	11.35		
Marathi	42	56.76	32	43.24	74	20.00		
Others	74	65.49	39	34.51	113	30.54		
Total	237	64.05	133	35.95	370	100.00		

*p<0.05

Table 4: Indicates that socio-demographic characteristics such as gender, educational status and work experience are associated with knowledge on respectful maternity care.

DISCUSSION:

The study shows that among 370 health care providers from maternity units, 34.59% were having moderately adequate knowledge, 64.05% were having inadequate knowledge and 1.35% of health care providers had adequate knowledge. This study is largely dependable with a study led by Ms. Ayushi Sharma, Dr. Priyanka A. Masih in obstetrics and gynecology ward and medical college Bareilly, U. P shows that 66.6% of poor knowledge, 33.3% of average knowledge and 0.0% of good knowledge. The similar study led by Dhanya Devassy, Sangeetha X in Medical College Hospital, Bengaluru, India revealed that 65.2% nurse were having moderately adequate knowledge, 14.5% of nurses had inadequate knowledge, and 14% nurses had adequate knowledge. These study findings suggest that there is a widespread need for healthcare providers to improve their knowledge of respectful maternity care.

The study findings revealed that there is a significant association with gender ($p=0.0001$), educational status ($p=0.0001$) and work experience ($p=0.0001$), whereas no significant association with age group ($p=0.2700$), marital status ($p=0.4320$), religion ($p=0.0560$) and experience in labour room ($p=0.7720$), mother tongue ($p=0.4620$).

The results of the study are supported by a descriptive study conducted on knowledge on Respectful Maternal Care among the health workers working in Selected Hospital/Health Centers at Meerut by Ms. Blessy Mathew, results founds that there was significant association with number of deliveries where as there is no significant association between age, sex, education, years of experience, area of working and attending any midwifery related training.

The similar study on Knowledge and Attitude Regarding Respectful Maternity Care among Staff Nurses in Selected Hospitals of Pune City, led by Ms. Laishram Lilileima Devi, results found that there is no significant association between knowledge of staff nurses regarding respectful maternity care and demographic variable Age in years, Educational qualification, Experience in clinical areas, Experience in Obstetrics Gynecology Department and Marital Status. The variation in the research findings might be attributed to variations in the sample size and the region of investigation.

Conclusion:

Every woman has the right to be treated with respect as a mother, regardless of her age, gender, or colour. Healthcare professionals and administrators must encourage dignified treatment for expectant mothers in order to make their journey to parenthood memorable and enjoyable.

Although the 34.59% of health care providers had moderately adequate knowledge of respectful maternity care, most were unfamiliar with the concept of RMC. This could be due to a lack of up-to-date knowledge and busy job schedules, which restrict health care professionals to provide high level of satisfaction to women in labour. These study findings indicate that in-depth awareness initiatives focusing on respectful maternity care should be provided to nurses and other healthcare

providers, and the nurse administrators should be responsible for obtaining feedback from women in labour.

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