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Assessment of knowledge, practice and challenges regarding respectful maternity care (RMC) among midwives posted at labor room of selected public health care facilities, West Bengal

Umme Salma, Mousumi Samanta and Anupama Jash

Abstract
Aim: To assess the knowledge regarding respectful maternity care (RMC) among midwives; identify the practice of respectful maternity care (RMC) among midwives; find out the challenges faced by midwives to provide respectful maternity care (RMC) to the laboring woman; and find out the correlation between knowledge and practices regarding respectful maternity care (RMC) among midwives.
Design: Descriptive survey research design.
Methods: Health Promotion Model as conceptual framework was adopted. 106 respondents were selected through non-probability purposive sampling technique. Structured knowledge questionnaire, observation checklist and 4 point rating scale were used for collection of data.
Results: 35.85% midwives had excellent knowledge, 74.53% had partial satisfactory practice and 73.59% midwives faced midrange reported challenges to provide RMC. Significant correlation between knowledge and practice (r=0.48 and t=5.61) of RMC at 0.01 level of significance was found.
Conclusion: Midwives were found to have good knowledge of RMC. But in actual scenario they failed to implement their knowledge into practice. There was scope for improvement in practice of midwives' knowledge of RMC through the elimination of identified challenges.
Implication for the profession: The ground reality reported in the study will help identify knowledge-practice gap in RMC service and provide insights into the factors contributing to it.
Implication for practice/policy: It will help the government take the most appropriate decisions to frame policy for tackling the obstacles in providing RMC in public health care facilities to provide due human rights to the laboring mothers.
Impact: What is already known: Midwives in the study area were distributed in terms of their knowledge of RMC.
What this paper adds: Midwives failed to implement their knowledge of RMC into practice because majority (71.71%) of them faced various challenges. There are scopes for improvement in practice of midwives' knowledge of RMC through the elimination of identified challenges in providing RMC.

Keywords: Respectful maternity care, midwives, mistreatment, knowledge, practice, challenges

1. Introduction
Women deserve a quality maternity care which includes antenatal, intrapartum, and postnatal care because they greatly serve the family, the society and the nation as a whole. Besides this, maternal health significantly impacts a country's economy. Maternal morbidity places substantial economic burdens on households and countries (Kes, Ogwang *et al*., 2015) [12]. Not only that, it can also have negative impact on country's Global Health Security Index (GHSI) which measures country's capacities to detect, respond to and recover from serious health issues (Grant, 2022) [9].
But it is very unfortunate that women during this period of intense vulnerability face disrespect and abuse in health facilities while they deserve a safe motherhood and respectful care. This mistreatment or abuse is one of the major reasons that women delay or avoid maternity services available to them in their communities. This avoidance and delay to access maternal health care services in public health care facilities leads to increased rate of maternal, fetal and infant mortality and morbidity (Mweemba, Mapulanga *et al*., 2021) [18].

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The unethical treatment extended to women in public healthcare facilities during prenatal care and its resultant contribution in increased maternal, foetal and infant mortality have become a global issue (Clark, 2019) [4]. Browser and Hill (2010) [3] identified "physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination based on socio-economic attributes, abandonment during care, and detention in facilities" as the seven major types of mistreatments that laboring women face at the time of childbirth (Browser, Hill, 2010) [3].

Since 2015, UNICEF and WHO use to maintain a joint database on skilled attendant at birth. According to this database, as on May 2021, globally approximately 73 percent of rural mothers accessed the service of skilled health personnel while 91 percent of urban mothers used such service (UNICEF, 2022) [23]. This means a significant portion of people still give births without any assistance from skilled personnel in facilities. On the other hand, there are increasing cases of mistreatment, abuse and disrespect to women when attending the facilities for childbirth. This is very unfortunate that much of these disrespects and abuse are from the clinicians providing the maternal care. These disrespects and abuse deter the global effort to decrease the rate of mortality and morbidity of laboring women through the access to and use of the service of skilled health personnel in public health facilities (Schuiling, 2016) [21].

International bodies like the White Ribbon Alliance for Safe Motherhood (WRA) and the World Health Organization (WHO) have come forward to publish and provide charter of rights of laboring woman and quality care guidelines for maternity care. White Ribbon Alliance, since its foundation in 1999, has been functional to transform the world where in every woman has rights to quality healthcare and wellbeing (Ateva, 2018) [1]. WRA advocates for quality health, rights and gender equality for women and girls. It recognizes gender inequality and gender violence as the major issues of maternity care and expands the concept of 'safe motherhood' beyond the scope of prevention of maternal mortality only encompassing respect for laboring women's fundamental human rights including "respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care" (Respectful Maternity Care- Health Policy Project, 2012) [20]. WHO, the premiere organization in the field of health and medicine defined RMC as the care given to laboring women which protects their dignity and honour, privacy and confidentiality; guarantees no harm and maltreatment, and permits informed decision-making and ongoing help and assistance throughout labor and delivery (WHO, 2018) [24].

2. Background
When RMC first came into existence in the early 2000s, its primary goal was to stop women from being mistreated or harmed while giving birth. WHO's recommendation on "Prevention and Elimination of Disrespect and Abuse During Facility-Based Delivery" played a vital role in bringing this issue to light and emphasized how crucial it was to treat women with respect during childbirth (WHO, 2015).

Reduction of maternal mortality rate (MMR) has always been an important agenda for every nation. SDG 2030 aims to reduce MMR <70/100,000. Every country has been trying hard to achieve this target and accordingly implementing different plans and programmes in the national health system. Emphasis has been given to motivate mothers to deliver in public health facilities where skilled birth attendants will take care of the mothers during labor. Despite this, low-income countries are still very far from the target set by SDG 2030. Disrespectful and abusive care is one of the main reasons that women tend to deny access public health care facilities and consequently MMR <70/100,000 by 2030 seems unachievable (Lee, Kjaerulf et al., 2016) [13].

Maternal Mortality Ratio (MMR) in India was terrifying with 556 deaths of woman during child birth while the global MMR was much lower at 356 in 1990 (GoI, 2018). But India successfully managed to bring down the MMR to a significant 97 per 1,00,000 live births in 2018-20. This substantial gain was largely due to the massive and strategic investment made under National Health Mission, Govt. of India. Ministry of Health & Family Welfare, Govt. of India has started a number of initiatives like Janani Suraksha Yojana (JSY), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), Janani Shishu Suraksha Karyakaram (JSSK), Rashtriya Kishor Swasthya Karyakram (RKSK), SUMAIV-Surakshit Matritva Aashwasan, and LaQshya etc for the elimination of the major factors of mortality and morbidity among women and children. The government aimed to prevent maternal and newborn deaths caused by preventable reasons. The most important reasons behind these initiatives was to provide a positive birthing experience among the laboring women so that they do not hesitate to access the public health facilities in future labor (GoI, 2013).

Nurse midwives are the most important stake holder in health care service. In maternal healthcare service they can make the birth experience of a woman a happy one and consequently empower and comfort them. They can contribute to the global effort to reduce the maternal mortality. But at times they may also inflict damage and feel them devastated emotionally with disrespectful care which is an important barrier to the use of skilled care given in facilities during child birth. Respectful care or disrespectful care largely depends on knowledge and challenges in practice of respectful maternity care that protects women from mistreatments including verbal abuse, physical abuse, disrespect, discrimination based on cast, creed and socio-economic status; and give them their rights to have complete information to empower them making an informed choice about her pregnancy and delivery (UNICEF, 2022) [23].

3. The Study
3.1 Aims
This study aims to
i)   Assess the knowledge regarding respectful maternity care (RMC) among midwives,
ii) identify the practice of respectful maternity care (RMC) among midwives,
iii) find out the challenges faced by midwives to provide respectful maternity care (RMC) to the laboring woman,
iv) find out the correlation between knowledge and practices regarding respectful maternity care (RMC) among midwives.

4. Methods
4.1 Research Design
This descriptive survey research design with Health Promotion Model as conceptual framework was conducted between 30 January 2023 to 18 march 2023.

4.2 Research Approach
Nonexperimental quantitative research approach was adopted for the present study in order to accomplish the objectives of the study.

4.3 Variables under study
4.3.1 Research variable
The research variable included
- Knowledge regarding RMC
- Practice regarding RMC
- Challenges to provide RMC

4.3.2 Demographic variables
The demographic variables composed of age in years, level of public health care facility of posting, professional qualification, total working experience (in years), year of work experience in labor room, in-service training regarding maternity service.

4.4 Population
In this study population referred to all midwives working at labor room of public health care facilities in West Bengal.

4.5 Sample
In this study samples were midwives working at labor room of selected public health care facilities under Murshidabad District, Birbhum District and Rampurhat Health District in West Bengal**.**

4.6 Setting and Sampling
The pilot study was conducted with 11 participants during 30th January, 2023 to 05th February, 2023 at labor room of Jangipur SD Hospital and the final study was conducted from 19.02.2023 to 18.03.2023 at Nashipur BPHC, Krishnapur RH, Kanapukur RH, and Murshidabad Govt. Medical College & Hospital under Murshidabad District, Bolpur SD Hospital and Suri District Hospital under Birbhum district and Rampurhat Govt. Medical College and Hospital under Rampurhat Health District.
106 respondents were selected through non-probability purposive sampling technique. The sample size was calculated on the basis of 50% awareness of midwives regarding Respectful Maternity Care, 95% confidence interval and 10% margin of error. The formula used for sample size calculation is as below.
$n = z^2 * p(1-p)/m^2$
n = Required sample size
z = Confidence level at 95% (Standard value = 1.96)
P = Estimated prevalence of adequate knowledge of RMC among midwives (considering 50% =0.5),
m = Margin of error at 10% = 0.1
$n = z^2 * p(1-p)/m^2$
$n = (1.96)^2 * 0.5 (1- 0.5)/ (0.1)^2$
$n = 3.84 * (0.5 \times 0.5)/ 0.01$
n = 96

By adding 10% mortality
Required sample size (n) = 96+9.6
n = 105.64
n = 106

4.7 Inclusion criteria
- Midwives who had working experience equal or more than 1 year.
- Only Female midwives were included.
- Midwives who were present at the time of data collection.

4.8 Exclusion criteria
- Midwives who were chronically ill.
- Midwives who did not give consent.

4.9 Data collection tools
A semi-structured questionnaire (Tool I) was developed to measure the demographic variable while the knowledge of the midwives regarding RMC was measured using a structured questionnaire (Tool II). Practice of RMC by the midwives at public health facilities was measured by a observational checklist (Tool III). A 4 point rating scale (Tool IV) was developed to measure the challenge faced by the midwives in providing RMC. Content and construction validity of the tools were established by 9 experts from Department of Obstetrics and Gynecology. The reliability of the tool II, III and IV was established by using Split half method, Interrater method and Cronbach's Alpha respectively.

4.10 Ethical and Administrative Permission
Ethical permission was taken from Institutional Ethics Committee of Burdwan Medical College, Burdwan and required administrative permissions were received from every single authority wherever necessary. Informed consent from the respondents was collected before the interview took place.

4.11 Data analysis and interpretation
Based on the objectives of study data analysis were planned with the help of both descriptive and inferential statistics. After data collection from 106 midwives, data were coded and tallied. Master data sheet was prepared according to the responses of the subjects. Data were planned to be analysed as follows
- To describe demographic characteristics of midwives by frequency and percentage.
- To assess midwives' knowledge and practice of RMC and challenges to provide RMC by midwives through frequency, percentage, mean, median, standard deviation and mean percentage.
- To find out correlation between knowledge and practice of RMC through calculation of Pearson's correlation coefficient.
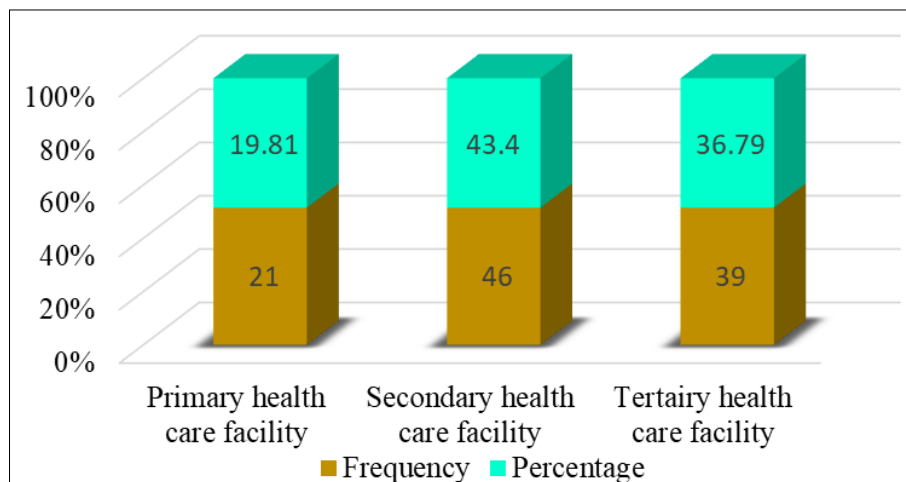
5. Results

5.1 Demographic characteristics of midwives at labor room of public health care facilities
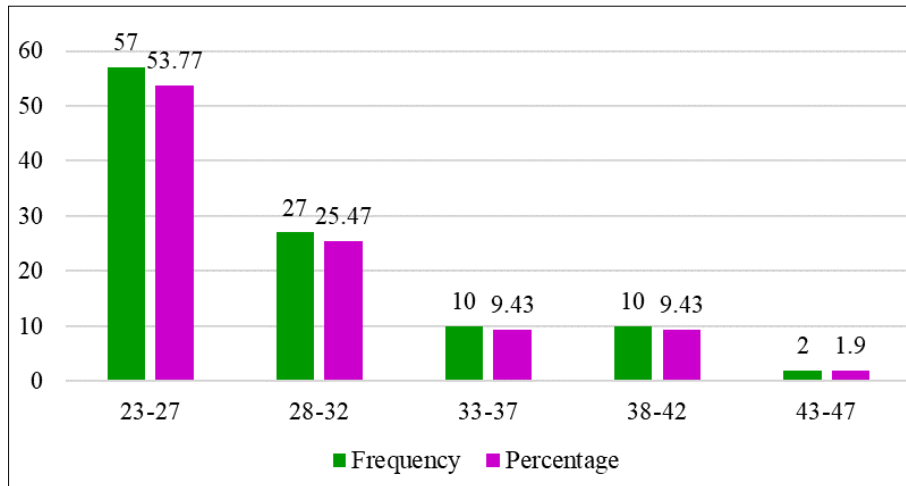
Fig 1: Frequency and percentage distribution of midwives according to their age n= 106

Figure1 reports that 53.77% respondents were in the age group of 23 to 27 years; 25.47% were in the age group of 28 to 32 years; 9.43% belonged to the age groups of 33 to 37 and 38 to 42 years equally and 1.90% respondents were in the age group of 43 to 47 years.

Fig 2: Frequency and percentage distribution of midwives according to levels of public health care facility of their posting n=106

Figure 2 shows that 43.40% respondents were posted in secondary level of public health-care facilities. 36.79% respondents were in tertiary level of public health care facilities and 19.81% respondents were in primary health care facilities.
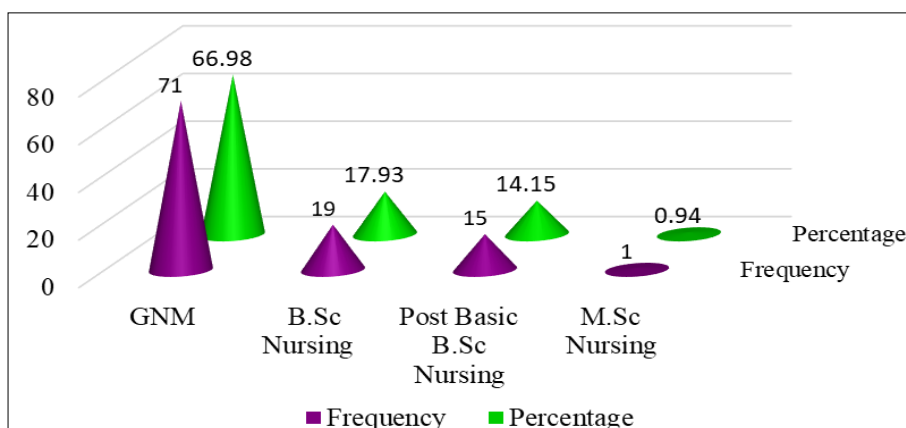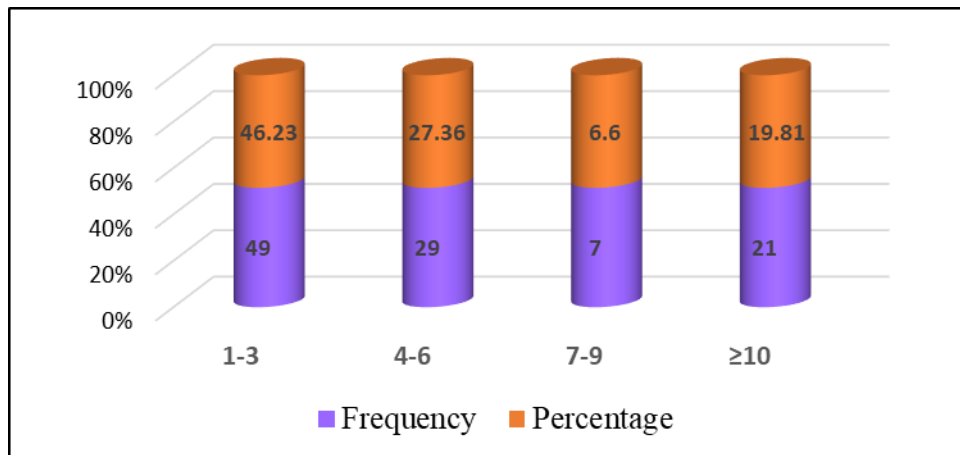

Fig 3: Frequency and percentage distribution of midwives by professional qualification n=106

Data represented in Figure 3 reveals that 66.98% respondents had GNM degree. 17.93% respondents had B.Sc Nursing degree. 14.15% respondents were Post Basic B.Sc Nursing degree holder. Only 0.94% respondents were M. Sc Nursing degree holder.

Fig 4: Frequency and percentage distribution of midwives according to their total working experience (in years) n= 106

Data represented in figure 4 shows that 46.23% respondents had 1 to 3years of work experience in nursing. 27.36% respondents had 4 to 6years. 19.81% respondents had equal or more than 10 years of work experience. Only 6.60% respondents had 7 to 9 years of work experience in nursing.
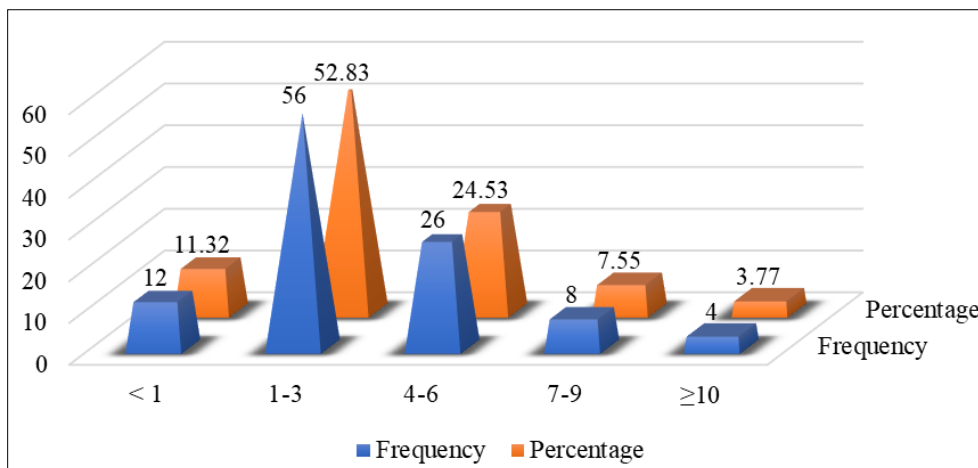
Fig 5: Frequency and percentage distribution of midwives according to their year of work experience in labor room n= 106

Data represented in Figure 5 expresses that 52.83% respondents had 1 to 3 years of work experience in the labor room. 24.53% respondents had 4 to 6 years of work experience in labor room. 11.32% respondents had less than 1 year of work experience. 7.55% respondents had 7 to 9 years work experience in labor room and only 3.77% respondent had equal or more than 10 years of work experience in labor room.
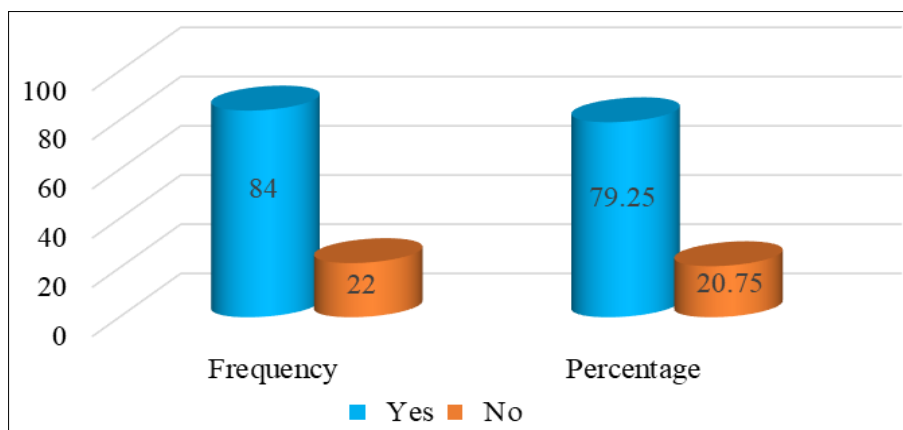
Fig 6: Frequency and percentage distribution of midwives according to their in-service training regarding maternity service n= 106

Data presented in figure 6 reveals that 79.25% respondents had undergone in-service training regarding maternity service. 20.75% respondents had no in-service training regarding maternity service.

5.2 Findings related to Knowledge of RMC among midwives working at labor room of public health care facilities

Table 1: Frequency and percentage distribution of midwives according to knowledge regarding RMC n= 106

Knowledge	Score	Frequency	Percentage
Excellent	≥21 (≥ 80%)	38	35.85
Very good	18-20 (70% - < 80%)	31	29.25
Good	16-17 (60% - < 70%)	19	17.92
Average	13-15 (50% - < 60%)	7	6.60
Poor	<13 (<50%)	11	10.38

Maximum possible score 26 Minimum possible Score 0

Table 1 reports that 35.85% respondents had excellent knowledge, 29.25% respondents had very good knowledge and 17.92% respondents had good knowledge. There were 10.38% respondents with poor knowledge and 6.60% respondents with average knowledge regarding RMC.

Table 2: Range, Mean, Median and Standard Deviation of knowledge score of midwives regarding RMC n= 106

Variable	Obtained Range	Mean	Median	SD
Knowledge	12-26	19.33	20	±3.74

Maximum possible score 26 Minimum possible Score 0

Table 2 reveals that the knowledge score of midwives regarding RMC was ranging from 12-26, mean knowledge score was 19.33 with a calculated median 20 and standard deviation was ±3.74.

So, it can be inferred that knowledge of midwives regarding RMC was almost normally distributed with mild negative skewness (-0.54). It also depicts that the obtained score was mildly dispersed as evident by SD value of ±3.74.

Table 3: Area wise Mean, Median, Standard Deviation and Mean Percentage of knowledge score of midwives regarding RMC n= 106

Area of knowledge	Maximum possible score	Mean	Median	SD	Mean Percentage	Rank
Concept of RMC	4	3.23	3	±0.68	80.75	1st
Dignity and respect	3	2.25	2	±0.73	75	3rd
Privacy and confidentiality	3	2.18	2	±0.74	72.67	6th
Right to information, informed consent and respect for choice and preference	4	2.81	3	±0.99	70.25	8th
Equitable care, free from discrimination	2	1.46	2	±0.65	73	5th
Free from harm and ill treatment	6	4.51	5	±1.30	75.17	2nd
Never left without care	2	1.42	1	±0.62	71	7th
Never detained/ confined against will	2	1.47	2	±0.60	73.5	4th

Table 3 shows that that in the area of 'concept of RMC' the obtained mean was 3.23 with a calculated median of 3. It shows that the responses were almost normally distributed. The calculated SD was ±0.68 indicating that there had been mild variation in responses with a mean percentage of 80.75 and ranked as 1st.

It also expresses that in area of 'free from harm and ill-treatment' the obtained mean was 4.51 with a calculated median of 5 showing that the responses were normally distributed. The calculated SD was ±1.30 which indicated that there had been mild variation in responses with a mean percentage of 75.17 and ranked as 2nd.

It also depicts that in the area of 'dignity and respect' the obtained mean was 2.25 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±0.73 which indicated that there had been mild dispersion in responses with a mean percentage of 75 and ranked as 3rd.

It was also observed that in the area of 'never detained or confined against will' the obtained mean was 1.47 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±0.60 which indicated that there had been mild dispersion in responses with a mean percentage of 73.5 and ranked as 4th.

It presents that in area of 'equitable care, free from discrimination' the obtained mean was 1.46 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±0.65 which indicated that there had been mild dispersion in responses with a mean percentage of 73 and ranked as 5th.

It also shows that the obtained mean in the area of 'privacy and confidentiality' was 2.18 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±0.74 which indicated that there had been mild dispersion in responses with a mean percentage of 72.67 and ranked as 6th.

It also explores that in the area of 'never left without care' the obtained mean was 1.42 with a calculated median of 1 showing that the responses were almost normally distributed. The calculated SD was ±0.62 which indicated that there had been mild dispersion in responses with a mean percentage of 71 and ranked as 7th.

It also depicts that in area of 'right to information, informed consent and respect for choice and preference' the obtained mean was 2.81 with a calculated median of 3 showing that the responses were almost normally distributed. The calculated SD was ±0.99 which indicated that there had been mild dispersion in responses with a mean percentage of 70.25 and ranked as 8th.

5.3 Findings related to Practice of RMC among midwives working at labor room of public health care facilities

Table 4: Frequency and percentage distribution of midwives according to practice regarding RMC n=106

Practice	Score	Frequency	Percentage
Fully satisfactory	> 21 (>Mean+1SD)	12	11.32
Partially satisfactory	18-21(≥ Mean-1SD to ≤Mean+1SD)	79	74.53
Unsatisfactory	< 18 (<Mean-1SD)	15	14.15

Maximum possible score 27 Minimum possible Score 0

Data presented in table 4 explores that 74.53% respondents had partial satisfactory practice. 14.15% respondents had unsatisfactory practice, while only 11.32% respondent had fully satisfactory practice in respect of RMC.

Table 5: Range, Mean, Median and Standard Deviation of practice score of midwives regarding RMC n=106

Variable	Obtained Range	Mean	Median	SD
Practice	15-23	19.23	19	±1.72

Maximum possible score 27 Minimum possible Score 0

Data presented in table 5 reveals that the practice score of midwives regarding RMC was ranging from 15-23, mean practice score was 19.23 with a calculated median 19 and Standard deviation was ±1.72.

So, it can be inferred that practice of midwives regarding RMC was almost normally distributed with mild positive skewness (0.40). It also depicts that the practice score was mildly dispersed as evident by SD value of ± 1.72.

Table 6: Area wise Mean, Median, Standard Deviation and Mean Percentage of practice score of midwives regarding RMC n=106

Area of practice	Maximum possible score	Mean	Median	SD	Mean Percentage	Rank
Dignity and respect	5	3.05	3	±0.74	61	6th
Privacy and confidentiality	4	2.86	3	±0.76	71.5	5th
Right to information, informed consent, respect for choice and preference	6	3.32	3	±0.92	55.33	7th
Equitable care, free from discrimination	2	1.97	2	±0.17	98.5	2nd
Free from harm and ill treatment	8	6.12	6	±1.07	76.5	4th
Never left without care	1	0.91	1	±0.29	91	3rd
Never detained/ confined against will	1	1	1	±0	100	1st

Data presented in Table 6 shows that in area of 'never detained or confined against will' the obtained mean was 1 with a calculated median of 1 showing that the responses were normally distributed. The calculated SD was ±0 which indicated that there had been no dispersion in responses with a mean percentage of 100 and ranked as 1st.

It also reveals that in area of 'equitable care, free from discrimination' the obtained mean was 1.97 with a calculated median of 2 showing that the responses were almost normally distributed.

The calculated SD was ±0.17 Which indicated that there had been mild dispersion in responses to a mean percentage of 98.5 and ranked as 2nd.

It also explores that in the area of 'never left without care' the obtained mean was 0.91 with a calculated median of 1 showing that the responses were almost normally distributed. The calculated SD was ±0.29 which indicated that there had been mild dispersion in responses with a mean percentage of 91 and ranked as 3rd.

It depicts that in area of 'free from harm and ill-treatment' the obtained mean was 6.12 with a calculated median of 6 showing that the responses were almost normally distributed. The calculated SD was ±1.07 which indicated that there had been mild dispersion in responses with a mean percentage of 76.5 and ranked as 4th.

It shows that in area of 'privacy and confidentiality' the obtained mean was 2.86 with a calculated median of 3 showing that the responses were almost normally distributed. The calculated SD was ±0.76 which indicated that there had been mild dispersion in responses with a mean percentage of 71.5 and ranked as 5th.

It also shows that in the area of 'dignity and respect' the obtained mean was 3.05 with a calculated median of 3 showing that the responses were almost normally distributed. The calculated SD was ±0.74 which indicated that there was mild dispersion in responses with a mean percentage of 61 and ranked as 6th.

It also expresses that the obtained mean in the area of 'right to information, informed consent and respect for choice and preference' was 3.32 with a calculated median of 3 showing that the responses were almost normally distributed. The calculated SD was ±0.92 which indicated that there had been mild dispersion in responses to a mean percentage of 55.33 and ranked as 7th.

5.4 Findings related to challenges faced by midwives to provide RMC at labor room of public health care facilities

Table 7: Frequency and percentage distribution of midwives according to the challenges faced to provide RMC n= 106

Challenges	Score	Frequency	Percentage
High reported Challenge	> 33 (>Mean+1SD)	16	15.09
Midrange reported Challenges	20-33 (≥ Mean-1SD to ≤ Mean+1SD)	78	73.59
Low reported Challenges	< 20 (<Mean-1SD)	12	11.32

Maximum possible score 90 Minimum possible Score 0

In providing RMC at labor room of public health care facilities in West Bengal 73.59% respondents had midrange reported challenges, 15.09% respondents had high reported challenge and 11.32% respondent had low reported challenges. The following table depicts the findings.

Table 8: Range, Mean, Median and Standard Deviation of challenges score faced by midwives regarding RMC n=106

Variable	Obtained Range	Mean	Median	SD
Challenges	13-43	26.36	26	±6.24

Maximum possible score 90 Minimum possible Score 0

Research findings in table 8 reveals that the challenges score of midwives regarding RMC was ranging from 13-43, mean challenge score was 26.36 with a calculated median 26 and Standard deviation was ±6.24.

So, it can be inferred that challenges of midwives regarding RMC was almost normally distributed with mild positive skewness (0.17). It also depicts that the challenged score was moderately dispersed as evident by SD value of ±6.24.

Table 9: Area wise Mean, Median, Standard Deviation and Mean Percentage of challenge score of midwives regarding RMC n= 106

Area of challenges	Maximum possible score	Mean	Median	SD	Mean Percentage	Rank
Physical facilities	12	5.91	6	±2.40	49.25	2nd
Resources and Logistics	24	2.31	2	±2.44	9.63	9th
Institutional policy	9	5.53	6	±1.20	61.44	1st
Lack of time to attend every laboring woman equally	6	2.64	2	±1.56	44	3rd
Collaboration among professional	6	0.84	1	±0.92	14	8th
Lack of training	6	1.75	1.50	±1.17	29.17	6th
Language barrier	12	1.81	1	±1.87	15.08	7th
Non-cooperation from laboring woman in providing emotional support	6	1.87	2	±1.10	31.17	5th
Problem in allowing birth companion for emotional support	9	3.71	4	±1.82	41.22	4th

Research data presented in Table 9 expresses that in the area of 'Institutional policy' the obtained mean was 5.53 with a calculated median of 6 showing that the responses were almost normally distributed. The calculated SD was ±1.20 which indicated that there had been mild dispersion in responses with a mean percentage of 61.44 and ranked as 1st.

It also shows that in the area of 'Physical facilities' the obtained mean was 5.91 with a calculated median of 6 showing that the responses were almost normally distributed. The calculated SD was ±2.40 which indicated that there had been mild dispersion in responses with a mean percentage of 49.25 and ranked as 2nd.

It also expresses that in the area of 'Lack of time to attend every laboring woman equally' the obtained mean was 2.64 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±1.56 which indicated that there had been mild dispersion in responses with a mean percentage of 44 and ranked as 3rd.

It also shows that in area of 'Problem in allowing birth companion for emotional support' the obtained mean was 3.71 with a calculated median of 4 showing that the responses were almost normally distributed. The calculated SD was ±1.82 which indicated that there had been mild dispersion in responses with a mean percentage of 41.22 and ranked as 4th.

It explores that in the area of 'Non-cooperation of laboring woman in providing emotional support' the obtained mean was 1.87 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±1.10 which indicated that there had been mild dispersion in responses with a mean percentage of 31.17 and ranked as 5th.

It also reveals that the obtained mean in the area of 'Lack of training' was 1.75 with a calculated median of 1.50 showing that the responses were almost normally distributed. The calculated SD was ±1.17 which indicated that there had been mild dispersion in responses with a mean percentage of 29.17 and ranked as 6th.

It also depicts that the obtained mean in the area of 'Language barrier' was 1.81 with a calculated median of 1 showing that the responses were almost normally

distributed. The calculated SD was ±1.87 which indicated that there had been mild dispersion in responses with a mean percentage of 15.08 and ranked as 7th.

It also explores that in area of 'Collaboration among professional' the obtained mean was 0.84 with a calculated median of 1 showing that the responses were almost normally distributed. The calculated SD was ±0.92 which indicated that there had been mild dispersion in responses with a mean percentage of 14 and ranked as 8th.

It also depicts that in area of 'Resources and logistics' the obtained mean was 2.31 with a calculated median of 2 showing that the responses were almost normally distributed. The calculated SD was ±2.44 which indicated that there had been mild dispersion in responses with a mean percentage of 9.63 and ranked as 9th.

5.5 Findings related to correlation between knowledge and practice regarding RMC among midwives working at labor room of public health care facilities.

Table 10: Correlation coefficient between knowledge and practice of midwives regarding RMC n=106

Variable	Mean	'r'	't' value
Knowledge	19.33	0.48	5.61**
Practice	19.23		

't' (df 104) = 2.62, p <0.01

The data presented in table 10 shows that mean knowledge score of midwives were 19.33 and mean practice score of midwives were 19.23.

Calculated 'r' value between knowledge and practice score was 0.48 which shows that there was positive correlation between knowledge and practice of midwives regarding RMC and it was significant correlation at 0.01 level of significance as evident by calculated 't' value 5.61 which was more than table value at df 104 at 0.01 level of significance. So it can be concluded that knowledge of midwives was significantly correlated with practice. The relationship was true relationship, not by chance. That means as knowledge of RMC increases the practice of RMC also increases.

So, research hypothesis (H$_1$) can be developed as there is

significant correlation between knowledge and practice of midwives regarding RMC at 0.01 level of significance.

6. Discussion
6.1 Knowledge score of midwives regarding RMC
The results of the present study depicted that 35.85% respondents had excellent knowledge, 29.25% respondents had very good knowledge and 17.92% respondents had good knowledge. There were 10.38% respondents with poor knowledge and 6.60% respondents with average knowledge regarding RMC.

The findings of present study is supported by study findings of a correlational study "Midwives perception and practice of Respectful Maternity Care during pregnancy and childbirth in selected heath facilities in Nigeria" by Ojong IN et al. (2022) [19]. The findings revealed that in UCTH hospital 52.6% respondents had high knowledge, 40% respondents had moderate knowledge and 7.4% respondents had low knowledge. The findings also showed that in GHC hospital 48.4% respondents had high knowledge, 38.7% had moderate knowledge and 12.9% had low knowledge (Ojong, Chukwudozie, et al., 2022) [19].

The findings of the present study are quite similar to the cross-sectional study "Iranian midwives awareness and performance of respectful maternity care during labor and childbirth" conducted by Haghdost S et al. (2021). The findings expressed that among all midwives 49.2% had good awareness, 40% had fair awareness and 10.8% had weak awareness (Haghdoost, Abdi et al., 2021) [10].

The findings of the present study are quite similar to the study findings of Mathew B (2021) [16] on "A study to assess the knowledge on respectful maternity care among health workers working in selected hospital/health centre at Meerut". This descriptive study was conducted among 30 staff nurses who were selected by using convenient sampling technique. The results revealed that 50% respondents possessed moderate knowledge, 40% respondents possessed adequate knowledge and 3% respondents possessed inadequate knowledge about Respectful Maternity Care (Mathew, 2021) [16].

In contrast, in the descriptive cross-sectional study on "A study to assess knowledge and practice regarding respectful maternity care among staff nurses in labor room at selected hospitals of the city with a view to develop an information booklet" by Bobade AS, Shinde M (2022) [2]. The study findings expressed that majority of sample (65%) possessed inadequate level of knowledge on respectful maternity care whereas 29% samples possessed moderate knowledge and 6% samples possessed adequate knowledge level on respectful maternity care (Bobade, Shinde, 2022) [2].

The findings of another study titled "To assess the knowledge and attitude regarding respectful maternity care among staff nurses in selected hospitals of Pune city" conducted by Lilileima DL et al. (2021) [14] revealed a contrasted result. In this study among the respondents 61% staff nurses had average knowledge, 39% staff nurse had good knowledge and 0% staff nurse had poor knowledge (Lilileima, 2021) [14].

6.2 Practice of midwives regarding RMC
The results of the present study depicted 74.53% respondents had partial satisfactory practice, 14.15% had unsatisfactory practice and 11.32% had fully satisfactory practice in respect of RMC.

This findings of present study are supported by study findings of a correlational study "Midwives perception and practice of Respectful Maternity Care during pregnancy and childbirth in selected heath facilities in Nigeria" by Ojong IN et al. (2022) [19]. The findings revealed that 73% respondents practiced respectful maternity care and 27% did not practice respectful maternity care (Lusambili, Wisofschi, 2023) [15].

The findings of the present study are quite similar to the findings of a cross-sectional study "Iranian midwives awareness and performance of respectful maternity care during labor and childbirth" conducted by Haghdost S et al. (2021). The findings expressed that among all midwives 51.5% midwives had fair performance, 30.8% had good performance and 17.7% weak performance (Haghdoost, Abdi et al., 2021) [10]. In contrast, in the descriptive cross-sectional study "A study to assess knowledge and practice regarding respectful maternity care among staff nurses in labor room at selected hospitals of the Mumbai city with a view to develop an information booklet" by Bobade AS, Shinde M (2022) [2], the study findings expressed that majority of sample (71%) had inadequate level of practice on respectful maternity care whereas 29% samples had moderate level of practice and none of samples had adequate level practice on respectful maternity care (Bobade, Shinde, 2022) [2].

In the present study midwives were found to practice with the greatest rate (100%) in the area of 'never detained/confined against will' followed by 'equitable care, free from discrimination' (98.5%), 'never left without care' (91%), 'free from harm and ill-treatment' (76.5%). 'Privacy and confidentiality' (71.5%), 'dignity and respect' (61%), and 'right to information, informed consent and respect for choice and preference' (55.33%).

The findings of present study is supported by the study findings of a descriptive study "A study to assess the level of adherence to respectful maternity care (RMC) and reasons of non-adherence among health personnel in the maternity department of selected Hospitals, West Bengal" by Ghosh A, Mani S (2018) [6]. This study was conducted among 92 samples of which nursing personnel were 40. The adherence among nursing personnel was highest in 'detained or confined against will' (100%) and 'equitable care, free of discrimination' followed by 'abandonment or denial of care' (95.9%), 'physical harm and ill treatment' (91.6%), 'dignity and respect' (81.6%), 'confidentiality and privacy' (66.7%), 'informed consent' (61.1%) and 'choice/preference' (0%) (Ghosh, Mani, 2019) [6].

6.3 Challenges in providing RMC
The findings of the present study explored that majority of the respondents (71.70%) had midrange reported challenges in providing RMC. Rest of the respondents almost equally (16.04% and 12.26%) divided to report high range reported challenge and low range reported challenge respectively.

According to the research findings midwives reported that 'Institutional policy' (61.44%) had been major challenge followed by 'Physical facilities' (49.25%), 'Time to attend every laboring woman equally' (44%), 'Problem for allow birth companion for emotional support' (41.22%), 'Non-cooperation of laboring woman in providing emotional support' (31.17%), 'Lack of training' (29.17%), 'Language barrier' (15.08%), 'Collaboration among professional' (14%), and 'Resources and logistics' (9.63%).

Ige WB, Cele WB (2022) [11] in their study "Barriers to the

provision of respectful maternity care during childbirth by midwives in South-West, Nigeria: Findings from semi-structured interviews with midwives" explored that 'Hospital policy', 'Shortage of staff', 'Shortage of resources' and 'poor collaboration among professional' as challenges to provide RMC. They collected the data for their research through semi-structured interviews of individual respondents.

The findings of this study is consistent with that of the current study (Ige, Cele, 2022). Singh S (2021) [22] explored in their cross-sectional study "Presence of birth companion—a deterrent to disrespectful behaviours towards women during delivery: an exploratory mixed-method study in 18 public hospitals of India" that the lack of hospital policy, overcrowding and privacy concerns for other patients were the barriers for allowing birth companions in labor rooms. So, the findings of this study are quite similar and support the research findings of the current study (Singh *et al.*, 2021) [22]. In the present study midwives reported that 'Institutional policy' (61.33%) as the major challenge in providing RMC. This is in line with the results of Mselle LT *et al.* (2018) [17]. They explored in their qualitative study "Barriers and facilitators to humanizing birth care in Tanzania: findings from semi-structured interviews with midwives and obstetricians" that institutional norms and practices acted as the barriers by not allowing family members in birthing process in the labor room. In the same study they found 'Physical facilities, 'lack of trainings', 'Time to attend every laboring woman equally', 'Collaboration among professional', and lack of 'Resources and logistics' as the other major barriers (Mselle, kohi *et al.*, 2018) [17].

6.4 Correlation between knowledge and practice of midwives regarding RMC

The results of the present research study explored that mean knowledge score of midwives were 19.33 and mean practice score of midwives were 19.23. There was significant positive correlation coefficient (r=0.48) between knowledge and practice of midwives regarding Respectful Maternity Care (RMC) at 0.01 level of significance.

This findings of the present study are supported by study findings of a correlational study "Midwives perception and practice of Respectful Maternity Care during pregnancy and childbirth in selected heath facilities in Nigeria" by Ojong IN *et al.* (2022) [19].

The findings revealed that mean knowledge score of respondents was 27.68 whereas mean practice score of respondents was 24.48 with SD value of 2.98. The correlation between knowledge of respectful maternity care and its practice in labor was examined using a Pearson Product Moment Correlation Coefficient test. The result indicated that there was a statistically significant relationship (r=0.697 p<0.05) between knowledge and practice of respectful maternity care. The null hypothesis was rejected (Lusambili, Wisofschi, 2023) [15].

The findings of present study is not supported by the study findings of a descriptive cross- sectional study "A study to assess knowledge and practice regarding respectful maternity care among staff nurses in labor room at selected hospitals of the city with a view to develop an information booklet" by Bobade AS, Shinde M (2022) [2].

The result of this study presented that mean knowledge score was 13.86 with SD value ±4.43 and mean practice score was 35.69 ±6.62. A Karl Pearson Correlation

Coefficient test was done to examine the relationship between knowledge and practice of respectful maternity care. The result of test depicted that there was negative correlation between knowledge and practice score (r = - 0.018, P=0.856) and it was not significant at 0.05 level of significance (D-zomeku, 2020) [5].

7. Conclusion

In conclusion it may be said that midwives in the study area were distributed in terms of their knowledge of RMC. But in actual scenario they failed to implement their knowledge into practice because majority (71.71%) of them faced various challenges like lack of institutional policy etc. Though the midwives had excellent (35.85%) to very good knowledge (29.25%) and good knowledge (17.92%), 74.53% women was only partially satisfied with their practice of RMC knowledge. There was scope for improvement in practice of midwives' knowledge of RMC through the elimination of identified challenges in providing RMC.

8. Recommendation

Research results motivated the researcher to recommend the following

8.1 Improving knowledge, practices and challenges related to RMC

- Midwives' knowledge and practice at every level of health care facilities should be improved through continuous trainings, workshops and seminars. The sister-in-charge should play pro-active roles in this regard. She may lead and motivate the midwives to follow the RMC guidelines to the highest possible level. Posters on RMC demonstrating the do's and don'ts for the midwives and posters displaying the rights of pregnant/laboring woman, national guidelines should be displayed.

- It should be ensured that every midwife undergoes timely and adequate training especially on RMC, if there is one, or the LaQshya training should a mandatory one for the midwives. Available other training related to maternity service should be made mandatory for every midwife before they are posted at labor room.

- Training for the midwives is not enough if there is no continuous supervision from the higher authority to check whether the training is being properly implemented by the midwives. Concerned officers or officer in charge in the respective organization should be responsible for the supervision of the staff training.

- Onsite mentoring is needed to motivate the midwives for proper implementation of RMC knowledge into practice such as taking verbal or written consent before giving episiotomy or PV examination, giving proper explanation before any procedure, giving information about the findings of progress of labor, use of curtain to ensure privacy. The preferences of the laboring woman should be kept in mind regarding the birthing position, consumption of fluid or food during childbirth.

- Authority concerned in public health care facilities should clearly instruct the midwives to allow birth companion during labor.

- It is to be ensured that there is a mix of midwives having more years of experience and those with fewer

years of experience at the public healthcare facilities. In such a way the newly appointed midwives will be guided by their seniors.

8.2 Recommendation of future research study

- Another study may be conducted on a sample larger than that of the current study and also at other research settings.
- A comparative study may be carried out for the assessment of the knowledge and practice of staff nurse regarding respectful maternity care in different level of public health care facilities in West Bengal.
- A qualitative or quantitative study may be conducted to assess the barriers for midwives to provide RMC in different health care facilities in West Bengal.
- A similar study may be undertaken to assess perception of RMC among the laboring mothers and their satisfaction regarding RMC in public health care facilities in West Bengal.
- A comparative analysis of respectful maternity care among the midwives working at government health facilities and private health facilities may be undertaken.

9. Conflict of Interest
Not available

10. Financial Support
Not available

11. References

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