BRIEF RESEARCH COMMUNICATION

Improving the Knowledge and Awareness of Labor Care Providers on Respectful Maternal Care in Sri Lanka: An Intervention Using Spiritual Principles

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Abstract

Respectful care during labor can improve obstetric outcomes in many ways, while abusive and disrespectful care may lead to poor obstetric outcomes. Many factors, including lack of knowledge, poor attitude toward supportive care, and subjective norms, influence the behavior of healthcare providers, leading to abusive and disrespectful care. We developed and implemented a workshop on respectful maternity care (RMC) for healthcare providers, highlighting spiritual principles that closely resonated with the cultural background of the participants. This workshop included a presentation by a Buddhist priest who emphasized the importance of compassionate and RMC according to four Buddhist principles known as the *Brahma-vihāras*: *Metta, Karuna, Muditha,* and *Upekkha.* Core Buddhist principles were connected with domains of RMC in a culturally appropriate manner to improve the knowledge, awareness, and attitudes toward compassionate, supportive, and respectful care among labor care providers in Sri Lanka. A total of 116 labor care providers participated in the workshop, and feedback was received from 115 (99.1%). One hundred seven (93.0%) reported improvement in their knowledge of RMC, and 109 (94.8%) reported improvement in attitudes toward RMC after attending this program. 110 (95.6%) agreed that the inclusion of this approach to the standard scientific program was thought-provoking. The results suggest that the inclusion of spiritual principles would resonate with the majority of labor care providers, and further studies are warranted to explore the impact.

Keywords: Attitudes, Low middle-income country, Midwife, Quality improvement, Respectful maternity care, Supportive care.

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Introduction

The provision of respectful care during labor can improve obstetric outcomes in many ways, while abusive and disrespectful care may lead to poor obstetric outcomes.[1] Respectful maternity care (RMC) or compassionate care includes maintaining the dignity, confidentiality, and privacy of clients while ensuring continuous support and informed choices during childbirth.[2] Increased intervention rates, emotional, verbal, and sexual violence, abandonment of care, lack of provider empathy, and lack of consent for interventions are reported in many settings.[1] Lack of respectful care has been reported in Sri Lanka as well, with researchers emphasizing the need to incorporate ethics of care into the professional training of obstetric health providers to minimize abusive and disrespectful care.[3]

Lack of knowledge, poor attitudes toward supportive care, and subjective norms are key factors that influence the behavior of obstetric care providers.[4] Furthermore, caregivers may have a misguided belief that physical or verbal mistreatment is sometimes necessary to improve outcomes or minimize clinical harm, even at the cost of emotional and psychological trauma.[1,3] Interventions aiming at caregivers' knowledge and attitudes are known to improve RMC. However, these interventions should be context-specific and modified to suit the settings to make it more meaningful and productive.[5]

Improving caregiver knowledge of RMC is often addressed through standard pedagogy, such as didactic lectures, problem-based learning, and active self-directed learning. In contrast, attitudinal change toward RMC has received relatively less attention. The latter consists of cognitive, affective, and behavioral components, and psychological theories explain how a persuasive communicator can modify these components. Persuasion is more likely to succeed when the audience is already knowledgeable of the content.[6]

Religion and spirituality have been applied to change attitudes as part of the treatment of many clinical conditions, and spiritual care has become an integral part of health care in a range of settings.[7] However, there is relatively scarce evidence on using religion or spirituality in the training of caregivers.

Sri Lanka is a multireligious society, with Buddhists (~70%) comprising the religious majority. Allopathic medicine is the

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Conflict of interest: None

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predominant health system, along with several other traditional ethnomedical practices.[8] Unlike the traditional medical systems, allopathic medicine rarely integrates spiritual aspects into the care process. We aimed to incorporate this neglected area into a caregiver training program and describe the attitudes and perceptions of the participants.

The training program was planned following stakeholder recommendations obtained as part of a quality improvement project conducted at the De Soysa Hospital for Women (DSMH), a tertiary care hospital in Colombo, Sri Lanka. Research done at the initial stage of this project identified gaps in the provision of care, person-centered maternity care, and women's satisfaction.[9]

Materials and Methods

We designed a training program to address the gaps in knowledge and attitudes of labor care providers (i.e., doctors, nurses, and midwives) on RMC. A total of 75 nurses, 32 midwives, and 9 specialist and non-specialist doctors attended the in-service activity in September 2022.

The training program was designed as a four-hour interactive workshop, including both lectures and discussions on evidence-based findings related to the importance of supportive care. In addition to standard academic content, we included a presentation by a Buddhist monk (Venerable Reverend: Aludeniye Subodhi Thero) who emphasized the relevance and importance of supportive and RMC according to the four Buddhist principles known as the *Brahma-vihāras*: *Metta, Karuna, Muditha,* and *Upekkha* (Table 1).[10] In this persuasive speech, which lasted ~1 hour, all four principles were connected with domains of RMC in a culturally sensitive manner to improve the knowledge, awareness, and attitudes toward compassionate, supportive, and respectful care among labor care providers in Sri Lanka. A vibrant discussion with the participants followed this. The above core principles were selected as Buddhism, which is the majority religion in Sri Lanka. However, these core principles are reflected in the teachings and values of other religions and were considered to be acceptable to non-Buddhists as well. Written feedback was obtained from the participants at the end of the workshop.

Results

There were 116 participants, of which 112 (96.6%) were female. There were 75 nurses (64.7%) and 32 (27.6%) midwives, while 9 (7.8%) were medical officers and consultants. The mean age was 36.91 ± 1.87 years (95% CI) and ranged from 24 to 63 years. The proportion of Buddhists was 84 (72.4%), which was reflective of national statistics. Other sociodemographic characteristics are summarized in Table 2.

We received feedback from 115 (99.1%) midwives, nurses and doctors. A majority (85%) were staff involved in providing labor care in hospital settings. The majority, 109 (94.8%) agreed that workshop objectives were clear and that there was a logical flow to the program. There were 109 (94.8%) who reported that the program improved their attitudes toward RMC, and 107 (93.0%) stated that the program improved their knowledge. Further, 110 (95.6%) agreed that the inclusion of a spiritual approach to the standard academic program was thought-provoking. The majority (n = 106, 92.2%) stated being determined to follow these principles at the workplace.

Discussion

The training program on RMC received very favorable feedback from participants. The results suggest that applying and showing the relevance of spiritual principles may be an effective complementary approach to promoting RMC. The inclusion of Buddhist principles was done in the context where the majority is of the Buddhist faith. It would need modification in instances of a more diverse group of participants. Adding a contextualized faith-based component appears to be an effective way to promote RMC in similar settings where healthcare worker's attitudes and behaviors need to change.

Our workshop was designed based on the theory of planned behavior, in which attitudes and beliefs are linked to an individual's behaviors.[11] This psychological theory was modified to influence behavior related to RMC in a culturally appropriate way.

Evaluation at the first level of Kirkpatrick's model[12] demonstrated the acceptability of this novel approach through participants' immediate responses, perceptions, and feelings about the quality, relevance, and presentation. However, more detailed evaluations should be conducted to assess whether this approach can result in some desirable outcomes in our setting.

The lack of a control group limits this study. We plan to conduct further research, including controlled educational interventions and evaluation of the impact on RMC and patient satisfaction. We also hope to modify and replicate this intervention in other cultural-religious settings.

Availability of Data and Materials

All data generated or analyzed during this study are included in this published article.

Table 1: Buddhist principles[10]

Metta is defined as loving-kindness or goodwill. When acted on, it is true benevolence and not dependent on one's own happiness. It is mirrored in the benevolence shown during labor care, which is aimed at achieving good maternal and neonatal outcomes, regardless of the carer's fatigue or personal feelings. The other principles are embedded in *Metta*.
Karuna is compassion. It is the empathetic recognition of suffering together with the desire to remove suffering. This concept is most intuitively mirrored when providing pain relief during labor care and can be applied to other aspects as well.
Mudita is sympathetic joy or the selfless joy that is felt at the well-being of others. During labor care, it is mirrored in the joy (devoid of self-interest) experienced by the caregivers when challenges are overcome and good outcomes are achieved. It can also be seen in the satisfaction felt by the carer when maternal autonomy and empowerment are assured.
Upekkha translates as equanimity, or having a nonreactive mind despite loss or gain. It is neutrality, not indifference. Equanimity enables labor care providers to maintain a clear and undistracted mind that can respond to rapidly changing clinical situations.

Table 2: Sociodemographic details of the participants

Sociodemographic feature	*Number of patients (%)*
Gender of the participants	
Male	4 (3.4%)
Female	112 (96.6%)
Age distribution: Mean age 36.91 ± 1.87 years (95% CI)	
25 and less	7 (6.0%)
26–35	54 (46.6%)
36–45	24 (20.7%)
46 and more	31 (26.7%)
Religion	
Buddhism	84 (72.4%)
Christianity	29 (25.0%)
Islam	2 (1.7%)
Hinduism	1 (0.9%)
Healthcare profession	
Medical officers and consultants	9 (7.8%)
Midwives	32 (27.6%)
Nurses	75 (64.7%)

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Authors' Contributions

MR, HS, ML, and AA conceptualized the study. MR and AA developed the study instruments, compiled data, and wrote the paper. SJ, HS, and ML revised the paper. All authors read and approved the final manuscript.

Ethics Approval and Consent to Participate

The study was approved by the Ethics Review Committee of the Faculty of Medicine, University of Colombo (Reference number EC-18-128).

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References

1. Amathullah AS, Rishard M, Walpita Y. Impacts of disrespectful care and abusive care practices in maternity units and potential interventions to improve the quality of care in low- and middle-income countries: A narrative review. Int J Gynecol Obstet 2023;1–13. DOI: 10.1002/ijgo.14811.
2. Dhakal P, Creedy DK, Gamble J, et al. Educational interventions to promote respectful maternity care: A mixed-methods systematic review. Nurse Educ Pract 2022;60:103317. DOI: 10.1016/j.nepr.2022.103317.
3. Perera D, Lund R, Swahnberg K, et al. 'When helpers hurt': Women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka. BMC Pregnancy Childbirth 2018;18(1):211. DOI: 10.1186/s12884-018-1869-z.
4. Downe S, Nowland R, Clegg A, et al. Theories for interventions to reduce physical and verbal abuse: A mixed methods review of the health and social care literature to inform future maternity care. PLOS Glob Public Health 2023;3(4):e0001594. DOI: 10.1371/journal.pgph.0001594.
5. Kasaye H, Sheehy A, Scarf V, et al. The roles of multi-component interventions in reducing mistreatment of women and enhancing respectful maternity care: A systematic review. BMC Pregnancy Childbirth 2023;23(1):305. DOI: 10.1186/s12884-023-05640-3.
6. Jonas K, Crutzen R, van den Borne B, et al. Healthcare workers' behaviors and personal determinants associated with providing adequate sexual and reproductive healthcare services in sub-Saharan Africa: A systematic review. BMC Pregnancy Childbirth 2017;17(1):86. DOI: 10.1186/s12884-017-1268-x.
7. Rykkje L, Søvik MB, Ross L, et al. Educational interventions and strategies for spiritual care in nursing and healthcare students and staff: A scoping review. J Clin Nurs 2022;31(11–12):1440–1464. DOI: 10.1111/jocn.16067.
8. Udayanga S. Cultural understanding of 'spiritual well-being' and 'psychological well-being' among Sinhalese Buddhists in Sri Lanka. Sri Lanka Journal of Social Sciences 2021;44(1):33–53. DOI: 10.4038/sljss.v44i1.7990.
9. Rishard M, Fahmy FF, Senanayake H, et al. Correlation among experience of person-centered maternity care, provision of care and women's satisfaction: Cross sectional study in Colombo, Sri Lanka. PLoS One 2021;16(4):e0249265. DOI: 10.1371/journal.pone.0249265.
10. Bhikku T. Metta sutta: Good will (SN 46-54). Translated from the Pali. Access to Insight (BCBS edition), 2012. Available from: http://www.accesstoinsight.org/tipitaka/ sn/sn46/sn46.054.than.html. (Accessed on March 10, 2023).
11. Ajzen I. From intentions to actions: A theory of planned behavior. Action control: From cognition to behavior. Berlin, Heidelberg: Springer Berlin Heidelberg; 1985. pp. 11–39. DOI: 10.1007/978-3-642-69746-3_2.
12. Heydari MR, Taghva F, Amini M et al. Using Kirkpatrick's model to measure the effect of a new teaching and learning methods workshop for health care staff. BMC Res Notes 2019;12:388. DOI: 10.1186/s13104-019-4421-y.