

DOI: <https://dx.doi.org/10.18203/2320-1770.ijrcog20260872>

Original Research Article

Experience of respectful maternity care and its determinants among women and midwives

Ansiya K. A., Namitha Subrahmanyam*

Department of Obstetrics and Gynaecological Nursing, Malankara Orthodox Syrian Church College of Nursing, Kolenchery, Ernakulam, Kerala, India

Received: 08 September 2025

Revised: 23 February 2026

Accepted: 24 February 2026

***Correspondence:**

Dr. Namitha Subrahmanyam,

E-mail: namithasubrahmanyam@moscmm.org

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Respectful Maternity Care (RMC) is an approach to care that highlights the fundamental rights of women, new-borns, and families, and that promotes impartial access to evidence-based care while recognizing the unique needs of both women and new-borns.

Methods: In a cross-sectional analytical study assessing experience of Respectful Maternity Care and its determinants among women and midwives, 33 midwives and 99 postnatal mothers from a tertiary care hospital, in central Kerala were enrolled in the study using convenience sampling. Structured and standardized questionnaire were used to collect data.

Results: The mean score of overall experience on RMC was higher among midwives (68.76) as compared to women (60.59). The domain wise comparison of RMC experiences revealed that midwives' scores on providing comfort (92.8) and participatory care (85.7) were significantly ($p < 0.001$) higher as compared to score obtained by women for providing comfort (75) and participatory care (71.4). The mean score for the factor 3 (Mistreatment) was same for both groups which was found to be the least (80). The study revealed significant disparity between the perception of caring experience on RMC among midwives and women.

Conclusions: More evidence-based interventions need to be implemented to ensure agreement on quality of RMC care provided by midwives and care received by women in the intrapartum care unit.

Keywords: Experience, Respectful maternity care, Midwives, Women

INTRODUCTION

Currently, Respectful Maternity Care is a top priority in the World Health Organization (WHO) recommendations on intrapartum care for a positive childbirth experience.¹ Institutional deliveries were promoted in India to reduce maternal mortality and morbidity by providing cash incentives to mothers. The rate of institutional deliveries in India ranges from 45.7% (Nagaland) to 99.8% (Kerala) according to latest National Family Health Survey.² The pooled prevalence in India (71.31%) shows that ill-treatment, disrespect, and abuse at various settings occurs not only in public and private sectors but also among high

and low-income groups in India.³ Kerala has different scenario compared to Indian condition considering RMC as the health care facilities in both the private and public sectors in the state is far better. Even though studies have been undertaken on RMC and related factors in middle east, African and Western countries, research in Indian context is very limited. Identification of factors related with intrapartum RMC will help the administrator to prepare guidelines to make the service providers competent in delivering the critical element of quality care, i.e., RMC. The quality of care is said to be of expected standard only when there is mutual understanding on the quality of care provided by health care provider and the

care received by the client.⁴ In order to analyse this fact, baseline information on the perceived experience of RMC among women and midwives need to be studied in systematic manner. Hence this study was undertaken to explore these aspects in a tertiary care hospital in central Kerala.

METHODS

This was a cross-sectional study conducted in the department of Obstetrics and Gynaecology of a tertiary care hospital in the state of Kerala, in the year 2022. The study was approved by the institutional ethics committee. All the postnatal mother who met the inclusion criteria and midwives who were working in the intrapartum unit in the same setting were participated for the study after explaining about the items of questionnaire in detail. After obtaining informed consent, 99 midwives and 33 women were enrolled in the study using convenience sampling. data were collected using Structured questionnaires on sociodemographic and clinical information from women, personal and professional information from midwives. Standardized scale on women's perception of RMC and

structured scale on midwives' perception on RMC were used to collect experience from women and midwives perceptively respectively.

RESULTS

Data were entered in MS Excel software and checked for consistency; R software was used to analyse the data. Table 1 shows that majority of midwives could always provide privacy (93.9%) and treat women in a friendly manner (90.9%) during intrapartum care. Surprisingly it was noted that only 48.5% could always support women emotionally and introduce and orient women to labour unit (57.6%). Few (6.17%) have never oriented their clients to labour unit. All midwives (100%) had given women permission to ask question freely and 93.9% of midwives had always conveyed the information regarding the progress of labour. Even though 12% of midwives had conveyed the progress of labour to relatives, the choice of labour companion to women was allowed by merely 6%. All midwives neither insulted nor beaten the women. 78.8% reported that they never shouted at women when the instructions were not followed.

Table 1: Percentage of midwives caring experience on various components of RMC (n=33).

RMC component	Always %	Not always %	Never %
Factor 1: (providing comfort)			
Supported emotionally	48.5	51.5	
provided a calm and quite environment	72.7	27.3	
Treated in a friendly manner	90.9	10.1	
provided timely care based on needs	69.7	30.3	
Given understandable answers to questions	60.6	36.4	
Maintained privacy	93.9	6.1	
Introduced and oriented to the labour unit	57.6	36.4	6.1
Factor 2: (participatory care)			
Given required information about care and procedures	45.5	54.5	
Informed about the progress	93.9	6.1	
Performed examinations and care with the permission	57.6	42.4	
Provided the permission to choose favorable position	81.8	18.2	
Informed the relatives about the progress of labour	12.1	87.9	
Allowed to choose labour companion as per choice	6.1	94	
Given the permission to ask questions freely	100		
Factor 3: (mistreatment) insulted			
Beaten			100
Shouted when instructions were not followed		21.3	78.8
Treated all women equally			100
Spoken privately with colleague		15.1	84.8

Table 2 implies that 75.8% women received emotional support during intrapartum care but 59.6% were never introduced and oriented to labour unit. 83.8% women were permitted to ask questions freely 74.7% had received required information about care and procedure. 93.9% of women were never allowed the choice of companionship during labour. None of the women reported insult or beating during intrapartum care. All of them experienced

equal treatment. A minimal portion of women (6%) reported midwives speaking privately with colleague as a mistreatment. Table 4 depicts that the median (IQR) scores for the domain "providing comfort" was found high among midwives {92.8(89.2,96.4)} as compared to that of women {75(64.2,85.7)}. Similarly, the score on "participatory care" was found high with midwives {85.7(78.5,85.7)} than that of women {71.4(67.8,78.5)}. But on the third

factor “mistreatment” similar score were observed among women {80(75,80)} and midwives {80(80,80)}. As the items of 3rd domain “mistreatment” were reverse scored, it

is interpreted that both groups reported least mistreatment during intrapartum care.

Table 2: Percentage of various component of women’s experience of RMC during childbirth (n=99).

RMC component	Always %	Not always %	Never %
Factor A: (providing comfort)			
Supported emotionally	75.8	24.2	
Provided a calm and quiet environment	32.3	67.7	
Treated in a friendly manner	46.5	53.5	
Provided timely care based on needs	50.5	49.5	
Provided understandable answers to questions	53.5	46.5	
Preserved privacy	44.4	55.5	
Introduced and oriented to the labour unit	13.1	27.3	59.6
Factor B: (participatory care)			
Gave required information about care and procedures	74.7	25.3	
Informed about the progress	71.7	28.2	
Performed examinations and care with permission	47.5	52.6	
Free to choose favourable position	24.2	53.5	22.2
Relatives were informed of the progress	63.6	36.4	
Allowed to have labour companion of choice		6.1	93.9
Freely ask questions	83.8	16.1	
Factor C: (mistreatment)			
Threatened/ insulted			100
Beated			100
Shouted when instruction not followed		7.1	92.9
Treated all women equally	100		
Spoke privately with colleague	7.1	92.9	

Table 3: Overall mean and SD scores of caring experiences of midwives and women experience of RMC (n=132).

Group	Mean	SD
Midwives(n1=33)	68.76	2.37
Women(n2=99)	60.59	4.96

Table 4: Domain wise RMC score among midwives caring experience and women experience of RMC (n=132).

Domains of RMC	Midwives (n1=33)		Women (n2=99)	
	Median	IQR	Median	IQR
Factor1(providing comfort)	92.86	89.2,96.4	75	64.2,85.7
Factor2(participatory care)	85.7	78.5,85.7	71.4	67.8,78.5
Factor3(mistreatment)	80	75.80	80	80.80

Table 5 shows that mean and SD score of midwives caring experience on RMC (68.76,2.37) was higher than the mean and SD score of RMC experience of women (60.59,4.96) and the difference observed between two groups with regard to the score was found statistically significant (p <0.0001). Table 6 shows that median (IQR) scores for the domain “providing comfort” was found high among

midwives [92.8 (89.2,96.4)] as compared to that of women [75 (64.2,85.7)]. Similarly, the score on “participatory care” was found high with midwives [85.7 (78.5,85.7)] than that of women [71.4 (67.8,78.5)]. In the third factor “mistreatment”, similar scores were observed among women [80 (75,80)] and midwives [80 (80, 80)].

Table 5: Comparison of overall mean and SD scores of caring experiences of midwives and women's experience of RMC (n=132).

Group	Mean	SD	T -value	P- value
Midwives (n ¹ =33)	68.76	2.37		
Women (n ² =99)	60.59	4.96	-9.09	<0.0001*

Level of significance p<0.05*

Table 6: Comparison of domain wise score of caring experience of midwives and women experience of respectful maternity care (n=132).

Domains of RMC	Midwives (n ¹ =33)		Women (n ² =99)		U value	P value
	Median	IQR	Median	IQR		
Factor 1 (providing comfort)	92.86	89.2,96.4	75	64.2,85.7	606	<0.001*
Factor 2 (participatory care)	85.7	78.5,85.7	71.4	67.8,78.5	365	<0.001*
Factor 3 (mistreatment)	80	75.80	80	80.80	1386	0.053

Level of significance p<0.05*

DISCUSSION

The present study findings shows that majority of midwives treat women in a friendly manner (90.9%). Few (6.17%) have never oriented their clients to labour unit. Only 12% of midwives had conveyed the progress of labour to relatives. All midwives neither insulted nor beaten the women. 75.8% women received emotional support during intrapartum care. None of the women reported insult or beating during intrapartum care. All of them experienced equal treatment. A minimal portion of women (6%) reported midwives speaking privately with colleagues as a mistreatment. Dr. Manju Bala Dash reported that most of the women (85%) received abuse free care and discrimination free care but 9.3% of women have experienced verbal abuse.⁵ On the contrary Thapaliya et al, conducted a descriptive cross sectional study among 231 postnatal mother reported that 34.6% of them suffered physical abuse, 22.5% received non dignified care.⁶ Studies from different settings report varying findings indicating difference in institutional culture and midwives performance with regard to RMC. From the study it was revealed that no mistreatment was prevailed in the study groups may be because of higher social status, educational status and awareness of patient care rights and media influence in Kerala. Qualitative study conducted by Valentine Uwamahoro among 28 midwives reported that most of the participants revealed that they have knowledge on RMC and perceived that they provided maternal health care based on women's rights.⁷ However, a considerable number of participants reported the existence of abusive practices among midwives. Cross-sectional retrospective study conducted at child health hospital in Egypt among 501 postnatal mothers to assess quality of care in the delivery room focused on RMC revealed that postpartum mothers received moderate degree of RMC.⁸ The present study reported that no significant association was found between experience of RMC and personal/professional characteristics of midwives. A cross-sectional study carried out to evaluate midwives' awareness and performance of RMC during childbirth at four public hospitals in Urmia province, Iran reported contradictory

findings to the present study in which work experience and a Master's degree in midwifery had positive significant effects on midwives awareness along with performance on RMC.⁹ The differences observed between studies may be related to variation in cultural and sociodemographic situation among study groups in the professional attitude and competency levels of midwives in the hospital and small sample size. To determine factors related to experience of RMC among women study reported that there is no significant association was found between experience of RMC and socio demographic/clinical characteristics of women. The disparity found between studies may be due to the variation in sample size and methodology adopted in both studies.

Limitations of the study

Limitations of the study was carried out in a single setting. In this study the women delivered through LSCS was not considered. This study is focusing only caring experience of midwives.

CONCLUSION

In order to bring up the value for women, improvement measures should be adopted in the sphere of maternity care, policies and respectful behaviour of midwives in the hospital environment. The quality improvement strategies must focus on reducing the disparity between midwives and women's perception on caring experience.

ACKNOWLEDGEMENTS

Authors would like to thank all midwives and women who were participated in the study.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. World Health Organization. Trends in maternal mortality: 1990-2015: estimates from WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. World Health Organization. 2015. Available at: <https://www.who.int/newsroom/factsheets/detail/maternal-mortality>. Accessed on 08 August 2025.
2. Bhattacharya S, Sundari Ravindran TK. Silent voices: institutional disrespect and abuse during delivery among women of Varanasi district, northern India. *BMC pregnancy childbirth*. 2018;18(1):338.
3. Sudhinaraset M, Treleaven E, Melo J, Singh K, Diamond-Smith N. Women's status and experiences of mistreatment during childbirth in Uttar Pradesh: A mixed methods study using cultural health capital theory. *BMC Pregnancy Childbirth*. 2016;16:332.
4. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Boston: USAID-TRACTION Project, Harvard School of Public Health. 2010.
5. Alageswari A, Dash MB, Chitra AF. Knowledge and Perception of Postnatal Mothers on Respectful Maternity Care – A Explorative Study. Available at: <https://zenodo.org/record/2604720>. Accessed on 08 August 2025.
6. Singh A, Chhugani M, James MM. Direct Observation on Respectful Maternity Care in India : A Cross Sectional Study on Health Professionals of three different Health Facilities in New Delhi. 2018.
7. Pazandeh F, Huss R, Hirst J, House A, Baghban AA. An evaluation of the quality of care for women with low risk pregnancy: The use of evidence-based practice during labour and childbirth in four public hospitals in Tehran. *Midwifery*. 2015;31(11):1045-53.
8. Bayu H, Adefris M, Amano A, Abuhay M. Pregnant women's preference and factors associated with institutional delivery service utilization in Debra Markos Town, North West Ethiopia: a community based follow up study. *Int J Women's Health*. 2015 ;7:123-30.
9. Kayongo M, Esquiche E, Luna MR, Frias G, Vega-Centeno L, Bailey P. Strengthening emergency obstetric care in Ayacucho, Peru. *Int J Gynaecol Obstet*. 2006;92(3):299-307.
10. Behruzi R, Hatem M, Fraser W, Goulet L, Misago C. Facilitators and barriers in the humanization of childbirth practice in Japan. *BMC pregnancy childbirth*. 2010;10(1):1-8.
11. Bayu H, Adefris M, Amano A, Abuhay M. Pregnant women's preference and factors associated with institutional delivery service utilization in Debra Markos Town, North West Ethiopia: a community based follow up study. *BMC pregnancy childbirth*. 2015;15(1):1-9.
12. Campbell OM, Graham WJ. Lancet Maternal Survival Series steering group. Strategies for reducing maternal mortality: getting on with what works. *lancet*. 2006;368(9543):1284-99.
13. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, et al. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. *BMC pregnancy childbirth*. 2015;15(1):1-11.
14. Moyer CA, Adongo PB, Aborigo RA, Hodgson A, Engmann CM. 'They treat you like you are not a human being': maltreatment during labour and delivery in rural northern Ghana. *Midwifery*. 2014;30(2):262-8.

Cite this article as: Ansiya KA, Subrahmanyam N. Experience of respectful maternity care and its determinants among women and midwives. *Int J Reprod Contracept Obstet Gynecol* 2026;15:1195-9.