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Original Research Article

An audit of respectful maternity care during pregnancy and childbirth in a tertiary healthcare facility

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ABSTRACT

Background: Respectful maternity care (RMC) ensures dignity, autonomy, and positive birth experiences for women. Despite international efforts, mistreatment persists, particularly in low-resource settings. This study evaluated the quality of maternity care at a tertiary healthcare facility and assesses adherence to RMC principles.
Methods: A prospective observational study was conducted in the department of obstetrics and gynecology at Government Medical College Manjeri over two months (June-July 2024). All consenting women who delivered at the facility were included, except those with severe mental illness or critical health conditions. Data were collected using a pre-tested questionnaire adapted from the Birthplace Lab, incorporating the mother's autonomy in decision-making (MADM) scale, the mothers on respect index (MOR), and the mistreatment index (MIST). The questionnaire was translated and back-translated for accuracy. Responses were gathered within 48 hours postpartum via self-administration or investigator-led interviews. Statistical analyses were performed using SPSS version 25.0.
Results: Among 149 participants, the mean age was 27.4 years; 59.7% were multiparous. The average gestational age at delivery was 38.5 weeks. Vaginal delivery occurred in 72.5%, and caesarean sections in 26.8%. High autonomy was reported by 70.5%, and high respect by 67.1%. Mistreatment, mainly privacy breaches, was reported by 6.7%.
Conclusions: While most women experienced high levels of RMC, privacy concerns remain. Strengthening awareness, staff training, and accountability mechanisms can enhance maternity care experiences and uphold women's rights.

Keywords: Autonomy, Childbirth experience, Dignity, Maternal health, Mistreatment, Respectful maternity care

INTRODUCTION

Every woman deserves high-quality care during pregnancy, childbirth, and postpartum to ensure her well-being. Respectful maternity care emphasises treating pregnant women with dignity and compassion while upholding their rights and choices. This approach promotes supportive communication, considerate actions, and a nurturing environment for a positive and empowering experience.

Across the world, many women face disrespectful and abusive treatment during childbirth in healthcare facilities. This not only violates their right to respectful care but also jeopardizes their rights to life, health, bodily integrity, and freedom from discrimination. In its 2014 statement, the World Health Organization affirmed that every woman has the right to the highest attainable standard of health, which includes dignified and respectful healthcare.[1] Recent research and guidance from human rights organizations have prompted the WHO to publish global recommendations on intrapartum care to promote a positive childbirth experience, including specific guidelines on respectful maternity care. This approach emphasizes providing care that upholds every woman's dignity, privacy, and confidentiality, ensures protection from harm and mistreatment, and supports informed

decision-making and continuous assistance throughout labor and childbirth, regardless of the circumstances.[2]

The right to health, as emphasized by the Centre for Reproductive Rights and UNFPA, requires reproductive services to be available, accessible, acceptable, and high-quality, ensuring equitable care for all.[3] Khosla et al highlight the importance of human rights standards in protecting women's rights during childbirth by addressing violations, enforcing accountability, training staff, and involving women in care reforms.[4] The 2030 agenda for sustainable development further reinforces the commitment to quality maternal healthcare, reproductive autonomy, and gender equality to promote health and empowerment for all.[5]

Despite significant progress by the WHO, the UN, and other human rights organizations in recognizing and addressing disrespectful and abusive maternal care, these issues persist in many countries. While efforts such as establishing international standards, raising awareness, and advocating for respectful maternity care have led to meaningful advancements, systemic challenges remain. Underfunded healthcare systems, lack of accountability, cultural norms, inadequate provider training, and deep-rooted gender inequalities continue to hinder progress.

Improving maternity care requires a thorough evaluation of respectful maternity care and identifying instances of mistreatment and disrespect. As the saying goes, solving a problem starts with recognizing it. In this study, we conducted an audit of the care provided in our hospital using standardized questionnaires to assess service quality and adherence to respectful maternity care practices.

Objectives

This study aimed to evaluate the quality of respectful maternity care provided during pregnancy and childbirth at a tertiary healthcare facility in a low-resource setting. The objectives of the study are as follows: 1) to assess the implementation of respectful maternity care throughout pregnancy and delivery, and 2) to identify and examine instances of mistreatment during pregnancy and childbirth.

METHODS

Study settings

This study took place at the departments of obstetrics and gynecology, Government Medical College Manjeri.

Study design

This was a prospective observational qualitative study.

Study period

The duration of this study was 2 months (June and July 2024).

Study subjects

All women delivering at the department during the study period (June and July 2024) were included.

Inclusion criteria

All women who gave birth at the healthcare facility and consented to participate in the study were included.

Exclusion criteria

Women who were experiencing severe mental illness, critical health conditions, or were unable to communicate effectively were excluded

Materials and methods

Postpartum women in the postnatal wards who met the inclusion criteria were invited to participate in the study. Data were collected using a pre-designed and pre-tested questionnaire adapted from the Birthplace Lab website. The questionnaire contains the following components: the mother's autonomy in decision-making (MADM) scale, the mothers on respect index (MOR), and the mistreatment index (MIST).[6-8] The questionnaire was first translated into the local language, and its accuracy was verified through a back-translation process into English to ensure consistency and reliability. It was designed to assess multiple domains of respectful maternity care, including physical and verbal abuse, failure to meet professional standards, poor rapport between women and healthcare providers, and systemic constraints within the health system. Depending on the participant's preference or ability, the questionnaire was either self-administered or read aloud by the investigator. All participants were interviewed within 48 hours after delivery to ensure accurate recall of their experiences. The collected data were systematically entered into a spreadsheet, and descriptive statistical methods were used to analyze the findings, providing insights into the quality of maternity care received. The scores used to classify the levels of autonomy and the levels of respectful maternity care are depicted in Table 1.

Table 1: MADM and MOR decision-making scales.

MADM- total score	Indication of patient autonomy
7-15	Very low patient autonomy
16-24	Low patient autonomy
25-33	Moderate patient autonomy
34-42	High patient autonomy
MOR- total score	Indication of respect
14-31	Very low respect
32-49	Low respect
50-66	Moderate respect
67-84	High respect

Sample size

Based on the prevalence of respectful and abuse-free maternity care being 57%, as reported by Wassihun and Zelek, the minimum required sample size was calculated to be 147. This calculation assumes a desired confidence level of 95% and an absolute precision of 8%.[9]

Data analysis

The data were analyzed using Microsoft Excel and the Statistical Package for Social Sciences software version 25.0. Categorical variables were summarized as frequencies and percentages, while continuous variables were reported as means and standard deviations. Associations between categorical variables were evaluated using the Chi-square test or Fisher's exact test, and continuous variables were analyzed using the independent sample t-test or one-way analysis of variance.

RESULTS

A total of 149 postpartum patients were recruited for the study. The detailed demographic characteristics of the participants are presented in Table 2. The mean age of the participants was 27.44 years. The majority were multiparous (59.7%), while 60 women (40.3%) were primiparous. The average gestational age at delivery was 38.5 weeks.

Table 2: Demographic and clinical characteristics of study participants (n=149).

Variables	Value (n=149) (%)
Mean age (in years)	27.44±5.71
Parity	Primi: 60 (40.3)
	Multi: 89 (59.7)
Mean gestational age (in weeks)	38.5±1.01
Comorbidities	Nil: 106 (71.1)
	GDM: 21 (14.1)
	Hypertension: 10 (6.7)
	GDM/hypertension: 4 (2.7)
	Anaemia: 6 (4.0)
	Others: 2 (1.3)
Booked/referred	Booked: 128 (85.9)
	Referred: 21 (14.1)
Median number of days spent in hospital	5.00±1.96
Mean duration of stay in labor room (in hours)	11.44±10.60
Type of onset of labor	Spontaneous: 74 (49.6)
	Induced: 61 (40.9)
	Elective CS: 14 (9.4)
Mode of delivery	Vaginal delivery: 108 (72.5)
	Elective CS: 14 (9.3)
	Emergency CS: 26 (17.4)
	Instrumental delivery: 1 (0.7)
MADM Score (mean)	34.50±7.24, Min = 7, Max = 43
MOR Score (mean)	68.61±12.63, Min = 27, Max = 84

Table 3: MADM and MOR scores for primi versus multi groups.

	Primi (n=60)	Multi (n=89)	P value
MADM score	34.95±5.85	34.20±8.05	0.538
MOR score	72.57±9.83	65.94±13.63	0.001

Table 4: MADM and MOR scores for booked versus referred groups.

	Booked (n=128)	Referred (21)	P value
MADM score	34.66±7.49	33.57±5.51	0.526
MOR score	68.64±12.66	68.43±12.80	0.943

Table 5: MADM and MOR scores for delivery types.

	Normal delivery (n=108)	Elective cesarean (n=12)	Emergency cesarean (n=28)	Instrumental delivery (n=1)	P value
MADM score	34.07±7.69	34.58±9.15	36.32±3.62	29.00	0.439
MOR score	70.13±12.19	60.92±16.42	66.36±11.53	60.00	0.059

Table 6: MIST index.

Item	The number of patients reported positively (n=149)
Your private or personal information was shared without your consent	1
Your physical privacy was violated, for example, being uncovered or having people in the delivery room without your consent	5
A healthcare provider shouted at or scolded you	1
Healthcare providers withheld treatment or forced you to accept treatment that you did not want	1
Healthcare providers threatened you in any other way	1
Healthcare providers ignored you, refused your request for help, or failed to respond to requests for help in a reasonable amount of time	1
You experienced physical abuse, such as aggressive physical contact, inappropriate sexual conduct, a refusal to provide anesthesia for an episiotomy, etc.	0
None of the above	139

Regarding comorbidities, 106 women (71.1%) had none. The most common conditions were gestational diabetes (21 women, 14.1%), hypertension (10 women, 6.7%), and a combination of both (4 women, 2.7%). Most participants (128, 85.9%) were booked cases, while 21 (14.1%) were referred. The mean hospital stay was 5.00 days, with an average labor room stay of 11.44 hours. Labor onset was spontaneous in 74 women (49.6%), induced in 61 (40.9%), and elective cesarean section in 14 (9.4%). Delivery modes included vaginal delivery in 108 women (72.5%), elective cesarean section in 14 (9.4%), emergency cesarean section in 26 (17.4%), and instrumental delivery in 1 woman (0.7%).

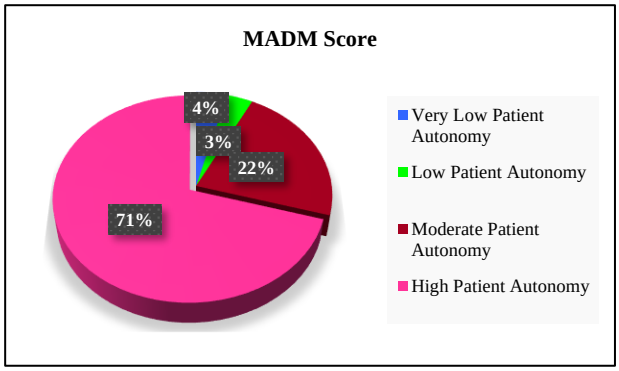

Figure 1: MADM score distribution.

The Figure 1 shows the breakdown of the mother's autonomy in decision-making scores. The majority of participants (70.5%) had a high level of patient autonomy, with a MADM score between 34-42. Around 22.1% had moderate patient autonomy, with a score between 25-33. A smaller proportion, 3.4% and 4% had low and very low patient autonomy, respectively, with scores between 16-24 and 7-15, respectively.

Figure 2 illustrates the breakdown of the mothers on respect index scores. The majority of participants, 67.1%, had a high level of respect, with a MOR score between 67-84. Around 20.8% had moderate respect, scoring between 50-66. A smaller proportion, 11.4% and 0.7% had low and very low respect, respectively, with scores between 32-49 and 14-31. Overall, the study findings suggest that most women in this setting experienced high levels of respect and autonomy during their childbirth experience.

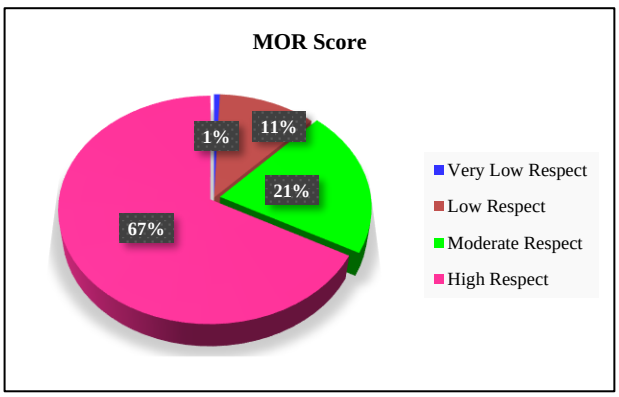

Figure 2: MOR score distribution.

Further analysis revealed no significant differences in autonomy in decision-making between primiparous and multiparous women, between booked and referred cases, or across delivery types. However, primiparous women

reported higher respect scores than multiparous women, with no differences between booked and referred cases or across delivery types (Tables 3-5).

The study also examined the prevalence of mistreatment, with the findings reported in Table 6. While the rates of mistreatment were relatively low within the study population, we identified a total of 10 out of 149 responses describing instances of mistreatment, half of which pertained to violations of privacy. In all, 6.7% of the participants reported experiencing some form of mistreatment during their childbirth experience. Tables 7 and 8 illustrate the response patterns for individual items in the MADM and MOR questionnaires, along with the median response and interquartile range.

Table 7: MADM questionnaire

Items	Median score (IQR)
My doctor or midwife asked me how involved in the decision-making I wanted to be	5 (1)
My doctor or midwife told me that there are different options for my maternity care	5 (1)
My doctor or midwife explained the advantages/disadvantages of the maternity care options	5 (1)
My doctor or midwife helped me understand all the information	5 (1)
I was given enough time to thoroughly consider the different care options	5 (1)
I was able to choose what I considered to be the best care options	5 (1)
My doctor or midwife respected my choices	5 (1)

(Score: strongly disagree- 1, disagree- 2, somewhat disagree- 3, somewhat agree- 4, agree- 5, strongly agree- 6).

Table 8: MOR scale: decision-making, perceived poor treatment, and barriers to communication.

Category	Serial number	Item	Median score (IQR)
MOR scale A: decision-making about pregnancy/birth care	1	I felt comfortable asking questions	5 (1)
	2	I felt comfortable declining the care that was offered	5 (1)
	3	I felt comfortable accepting the options for care that my doctor or midwife recommended	5 (1)
	4	I felt pushed into accepting the options my doctor or midwife suggested	5 (1)
	5	I chose the care options that I received	5 (1)
	6	My personal preferences were respected	5 (1)
	7	My cultural preferences were respected	5 (1)
MOR scale B: reasons for feeling poorly treated	8	My race, ethnicity, cultural background, or language	6 (1)
	9	My sexual orientation and/or gender identity	6 (1)
	10	My type of health insurance or lack of insurance	6 (1)
	11	A difference of opinion with my caregivers about the right care for myself or my baby	6 (1)
MOR scale C: reasons for holding back questions or concerns	12	My doctor or midwife seemed rushed	6 (1)
	13	I wanted maternity care that differed from what my doctor or midwife recommended	6 (1)
	14	I thought my doctor or midwife might think I was being difficult	6 (1)

(Score: strongly disagree-1, disagree-2, somewhat disagree -3, somewhat agree- 4, agree- 5, strongly agree- 6. Question number 4, 8, 9, 10, 11, 12, 13, and 14 were reverse scored).

DISCUSSION

This audit, conducted over two months in a tertiary care centre on postpartum women, highlighted key aspects of respectful maternity care in the local context. The majority of women had high levels of autonomy in decision-making during their childbirth experience, as reflected by the MADM scores. Additionally, most participants reported high levels of respect from their healthcare providers, as measured by the MOR index. Interestingly, the study found that primiparous women reported higher respect scores compared to multiparous women. Even though the instances of mistreatment were low in our study, 5 patients reported a breach in privacy, which is of concern.

Respectful maternity care (RMC) is a fundamental right for every woman. The relationship between women and their maternity care providers, as well as the maternity care system, is crucial during pregnancy and childbirth. Studies have shown that disrespectful and abusive care during

childbirth can lead to adverse maternal and infant health outcomes, negatively impact women's trust in the healthcare system, and reduce their willingness to seek care.[10] A 2020 study on the status of RMC among women during childbirth in health institutions in central Ethiopia found that out of 567 women, only 35.8% received RMC. Despite this, 76.5% were protected from physical harm and abuse, and 89.2% received services free from discrimination. The study concluded that increasing awareness among care providers about RMC standards, improving communication between care providers and clients, and enhancing accountability mechanisms are essential for improving RMC.[11] In 2020, a systematic review and meta-analysis of RMC during childbirth in India reported an overall pooled prevalence of disrespectful maternity care of 71.31% (95% CI: 39.84-102.78). Prevalence was higher in community-based studies at 77.32% (95% CI: 56.71-97.93) compared to studies conducted in health facilities, which reported 65.38% (95% CI: 15.76-115.01). The most common form of ill-treatment was non-consent (49.84%), followed by verbal abuse (25.75%), threats (23.25%), physical abuse (16.96%), and discrimination (14.79%). Other contributing factors included lack of dignity, lack of privacy, poor hygiene and sanitation, informal payments, and deliveries conducted by unqualified personnel. The determinants of disrespectful maternity care were sociocultural factors such as age, socioeconomic status, caste, parity, women's autonomy, empowerment, and comorbidities. Environmental factors included overcrowding, poor infrastructure, ill-equipped facilities, supply constraints, and limited healthcare access.[12] A cross-sectional study by Yadav et al at a tertiary care hospital in Odisha found that 61.38% of 246 women received good RMC, while 1% experienced poor RMC. The study recommended significant efforts to improve institutional policies, resources, training, and supervision of healthcare professionals to enhance positive birth experiences.[13]

While it is encouraging to observe high levels of autonomy, respect, and a low incidence of mistreatment, it is crucial not to become complacent. A mixed-methods study in Tanzania, comparing the prevalence of mistreatment during childbirth through observation and self-reporting, found a significant gap between the two measures. At baseline, 69.83% of observations reported mistreatment, while only 9.91% of women self-reported it. At the endline, 32.91% of observations showed mistreatment, compared to 7.59% in self-reports. This suggests that both patients and healthcare providers may internalize and normalize mistreatment. This does not diminish the significance of the mistreatment experienced but rather highlights the need for a more nuanced interpretation of the data. It implies that women, with low expectations of care, may accept poor-quality care, including mistreatment, as satisfactory.[14] Patients with low literacy and socioeconomic disadvantage are often unaware of their rights. Following delivery, when both the mother and infant are healthy, patients tend to express gratitude and may not prioritize concerns regarding disrespect or mistreatment. This underscores the need for continuous efforts to educate all patients, irrespective of their background, about their rights and ensure they are consistently treated with dignity and respect throughout their care.

This study was a single-centre investigation, which may limit its generalizability to the broader region or population. Additionally, the reliance on a questionnaire could introduce response bias, as participants may provide socially desirable answers, and recall bias, as they may have difficulty accurately remembering or interpreting events, particularly those that occurred during childbirth. These factors may affect the reliability and validity of the findings, highlighting the need for caution when interpreting the results.

Future prospects

While notable progress has been made in advancing respectful maternity care, with many women reporting high levels of autonomy and respect, and low instances of mistreatment during childbirth, there remains considerable potential for further improvement. It is imperative to ensure that all women, irrespective of their socioeconomic status or literacy levels, are informed about their rights, thereby fostering a healthcare environment characterized by dignity, respect, and the consistent delivery of high-quality care. Ongoing initiatives aimed at enhancing awareness, improving provider training, and strengthening healthcare infrastructure are essential to achieving equitable and respectful maternity care for all women

CONCLUSION

This audit revealed encouraging results regarding respectful maternity care, with the majority of women reporting high levels of autonomy and respect during their childbirth experience. The study highlighted that primiparous women experienced higher respect scores compared to multiparous women, although the rates of mistreatment remained low overall. Nonetheless, the breach of privacy reported by some participants is a concern that requires attention. While this study aligns with broader findings on the positive impact of respectful maternity care, it also emphasizes the need for continuous improvement in communication, staff training, and awareness among healthcare providers to minimize mistreatment and uphold women's rights during childbirth. Ensuring high-quality, respectful care remains crucial for both maternal and infant health outcomes, as well as for building trust in the healthcare system.

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