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Respectful maternity care during childbirth: postnatal women's perspectives. Cross-sectional study from central India: February -December 2023

Cuidado materno respetuoso durante el parto: perspectivas de mujeres en el posparto. Estudio de corte transversal en el centro de la India: Febrero - diciembre de 2023

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ABSTRACT

Objective: This study assesses postnatal women's perceptions of Respectful Maternity Care (RMC), aiming to identify key areas for improvement.

Methods: A cross-sectional quantitative study was carried out in selected urban areas of Bhopal, India. Women aged 18 years and above, who had given birth to a healthy newborn within the previous 42 days, were eligible to participate if they resided in the study area, could understand Hindi or English, and had no cognitive impairments. Estimated sample size was 238 with 77% estimated prevalence, 5% margin of error, and 95% confidence level; 270 women were recruited using purposive sampling from 18 urban wards and 98 Anganwadi centres. Participants were approached directly and interviewed in person using a structured questionnaire and the validated RMC Scale by Sheferaw et al. The primary outcome was the level of perceived respectful maternity care, while independent variables included socio-demographic and obstetric factors such as age, education, place of delivery, and number of antenatal visits. Data were analysed using descriptive statistics and Fisher's exact test due to the non-normal distribution of variables.

Results: Of the 270 participants, 51.2% were aged 25–30 years and 75.3% were Hindus. Most deliveries (57.4%) were normal vaginal deliveries, and 75.6% occurred in government hospitals. Overall, 82.6% of women reported experiencing RMC. Domain-wise, 91% experienced Friendly Care, 93.3% Abuse-Free Care, 79.7% Timely Care, and 87.7% Discrimination-Free Care. Item-wise analysis revealed strengths in provider kindness and clear communication, though about 15–25% of women experienced delays, verbal mistreatment, or felt disrespected. Socioeconomic status had a significant influence in all four domains ($p < 0.05$), with women from higher income groups reporting more positive experiences. Higher education level was also associated with greater awareness and recognition of discriminatory practices ($p = 0.014$), Obstetric variables such as mode of delivery ($p =$

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0.031), time of delivery ($p = 0.003$), antenatal visits ($p = 0.017$, 0.029), and high-risk pregnancy ($p = 0.037$) showed domain-specific associations.

Conclusion: Although most women described their childbirth experience as respectful, notable gaps remain in timely and equitable care. Addressing delays and reducing discrimination, particularly in public healthcare settings, are essential to ensuring that all women receive dignified, person-centred maternity care, regardless of their background.

Keywords: Maternity care; respectful maternity care; patient satisfaction; discrimination; healthcare disparities; maternal health; postpartum care; obstetric care; delivery care; women's health; healthcare quality.

RESUMEN

Objetivos: Este estudio evalúa la percepción de mujeres en el posparto sobre el Cuidado Materno Respetuoso (CMR), con el objetivo de identificar áreas clave de mejora.

Materiales y métodos: Se llevó a cabo un estudio cuantitativo transversal en zonas urbanas seleccionadas de Bhopal, India. Fueron elegibles mujeres de 18 años o más que hubieran dado a luz a un recién nacido sano en los 42 días previos, que residieran en el área de estudio, entendieran hindi o inglés y no tuvieran discapacidades cognitivas. El tamaño de muestra estimado fue de 238 mujeres, con una prevalencia estimada del 77 %, un margen de error del 5 % y un nivel de confianza del 95 %. Se reclutaron 270 mujeres mediante muestreo intencional en 18 distritos urbanos y 98 centros Anganwadi. Las participantes fueron contactadas directamente y entrevistadas en persona utilizando un cuestionario estructurado y la escala validada de CMR de Sheferaw et al. El desenlace principal fue el nivel de percepción de cuidado materno respetuoso; las variables independientes incluyeron factores sociodemográficos y obstétricos, como edad, nivel educativo, lugar del parto y número de controles prenatales. Los datos se analizaron mediante estadística descriptiva y la prueba exacta de Fisher, debido a la distribución no normal de las variables.

Resultados: De las 270 participantes, el 51,2 % tenía entre 25 y 30 años y el 75,3 % eran hindúes. La mayoría de los partos (57,4 %) fueron vaginales normales y el 75,6 % ocurrieron en hospitales públicos. En general, el 82,6 % de las mujeres reportó haber recibido CMR. Por dominios, el 91 % experimentó Cuidado Amable, el 93,3 % Cuidado Libre de Abuso, el 79,7 % Cuidado Oportuno y el 87,7 % Cuidado Libre de Discriminación. El análisis por ítems mostró fortalezas en la amabilidad del personal y la comunicación clara, aunque entre el 15 % y el 25 % de las mujeres reportaron demoras, maltrato verbal o sensación de falta de respeto. El nivel socioeconómico influyó significativamente en los cuatro dominios ($p < 0,05$), siendo más positivas las experiencias entre mujeres de mayores ingresos. Un mayor nivel educativo también se asoció con mayor conciencia y reconocimiento de prácticas discriminatorias ($p = 0,014$). Las variables obstétricas como el tipo de parto ($p = 0,031$), la hora del parto ($p = 0,003$), los controles prenatales ($p = 0,017$; $0,029$) y el embarazo de alto riesgo ($p = 0,037$) mostraron asociaciones específicas según el dominio.

Conclusión: Aunque la mayoría de las mujeres describieron su experiencia de parto como respetuosa, persisten brechas importantes en el cuidado oportuno y equitativo. Abordar las demoras y reducir la discriminación, especialmente en los servicios públicos de salud, es esencial para garantizar que todas las mujeres reciban un cuidado materno digna y centrada en la persona, independientemente de su origen.

Palabras clave: cuidado materno; cuidado materno respetuoso; satisfacción del paciente; discriminación; inequidad en salud; salud materna; cuidado posparto; cuidado obstétrico; cuidado del parto; salud de la mujer; calidad de la atención en salud.

INTRODUCTION

Respectful maternity care (RMC) is a fundamental human right that ensures women receive dignified, non-discriminatory, and compassionate care during childbirth. It emphasizes the importance

of communication, informed consent, privacy, and support, aiming to create a positive birth experience. [1] Despite global efforts to promote RMC, many women continue to experience disrespectful and abusive treatment during labour and delivery, particularly in low and middle-income countries. [2,3] These include verbal mistreatment, physical abuse, lack of consented care, and discrimination. Such negative experiences can have profound physical and psychological effects, including postpartum depression, poor maternal-infant bonding, and avoidance of future institutional care. [4,5]

India, a country with a rapidly growing healthcare infrastructure, has made significant strides in improving maternal and neonatal outcomes through government initiatives such as the Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK). These programs encourage institutional births in order to reduce maternal and infant mortality rates. [6,7] Despite these efforts, challenges persist in ensuring that institutional care aligns with respectful maternity care principles, particularly in underserved regions. Disrespect and abuse during childbirth remain underreported, especially in settings where women may lack awareness of their rights or fear retaliation. [4,8,9] Bhopal, a city in central India, serves as an important setting to examine the perception of RMC among postnatal women. Understanding these perceptions is essential for identifying gaps in care and improving maternal healthcare services. Previous researches have shown that disrespectful maternity care can have severe consequences for maternal and infant health such as postpartum haemorrhage, physical injuries, and psychological issues like post-traumatic stress. [10,11] Moreover, disrespectful care can erode trust in the healthcare system, leading to delays in seeking care and increased reliance on unskilled birth attendants. [12,13] While some studies in India have focused on maternal healthcare quality, few have explored the specific aspects of RMC from the perspective of women who have recently given birth. [14,15] Addressing these gaps is crucial for improving maternal and infant health outcomes and ensuring that all women receive the dignified care they deserve during childbirth.

This cross-sectional study aims to assess the perception of respectful maternity care among postnatal women in Bhopal. By capturing their experiences, this study seeks to provide insights into the level of respect, dignity, and autonomy afforded to women during childbirth, as well as to inform policies and interventions to enhance maternity care practices. The findings could contribute to improving maternal health services and promoting a more compassionate approach to childbirth.

MATERIALS AND METHODS

Study design and setting

This study utilized a quantitative cross-sectional design to evaluate the perception of RMC among postnatal women in urban areas of Bhopal.

Population: The target population included postnatal women who had delivered a baby within the last 42 days. Eligible participants were required to meet specific inclusion criteria: they must have given birth to a healthy newborn within the past 6 weeks, reside in selected urban areas of Bhopal, understand either Hindi or English, and be mentally alert, without cognitive impairments. Women under 18 years of age, those unavailable during data collection, or those unwilling to participate were excluded from the study.

Sampling and sample size: The estimated sample size was calculated to be 238 postnatal women using the formula $n = (Z^2 \times p \times q) / d^2$, where $Z = 1.96$ (confidence interval), $p = 0.77$ (prevalence), $q = 0.23$, and $d = 0.05$ (precision). A purposive sampling technique was employed for participant selection. Of a total of 300 participants who were initially screened for eligibility from 18 wards and 98 Anganwadi centres, 290 were assessed. Of them, 270 provided informed consent and were included in the final analysis.

Data collection tools and procedure:

The data collection tool consisted of two parts. The first part was a self-structured questionnaire with 15 items designed to collect socio-demographic and obstetric information, such as age, religion, educational level, delivery method, and number of antenatal visits (S-CVI(Ave)=0.98, S-CVI(UA)=0.87). The second part used the standardized Respectful Maternity Care (RMC) Scale, developed by Sheferaw et al. (2016). This scale included 15 questions across four domains: Friendly Care, Abuse-Free Care, Timely Care, and Discrimination-Free Care. Responses were rated on a five-point Likert scale, with total scores ranging from 0 to 100. The RMC scale has established concurrent validity (0.881) and reliability, with Cronbach's alpha values of 0.889 for friendly care, 0.75 for abuse-free care, 0.71 for timely care, and 0.666 for discrimination-free care.[16] Recently delivered women were identified through records available at local Anganwadi centres in the selected areas. ASHAs (Accredited Social Health Activists) assisted in locating their households. Eligible participants were approached at their homes, and after obtaining informed consent, data were collected through face-to-face interviews conducted in a private setting to ensure comfort and confidentiality. The researcher explained the purpose, risks, and benefits of the study to the participants and ensured confidentiality by assigning code numbers. Data were collected between October 2, 2023 and November 30, 2023.

Statistical analysis: The collected data were analysed using both descriptive and inferential statistics. Descriptive statistics, including frequency and percentages, were used to summarize the socio-demographic and obstetric variables. Both the Kolmogorov-Smirnov and Shapiro-Wilk tests for socio-demographic and obstetric variables show p-values of 0.001 and 0.003, respectively, indicating that the data do not follow a normal distribution. Consequently, non-parametric statistical methods should be considered for further analysis. Additionally, Fisher's exact test was used to examine the association between perceptions of RMC and various socio-demographic and obstetric factors.

Ethical considerations: Ethical approval was obtained from the Institutional Ethical Committee of AIIMS Bhopal (Ref. No: AIIMS/BPL/IHECSR/July/22/MSc/15). Administrative permissions were secured from the respective authorities, including the HOD of the CFM Department and the Chief Medical Officer of Bhopal. Informed consent was obtained from all participants after explaining the study's objectives, potential risks, and benefits, according to the code of ethics and following the Helsinki principles. Confidentiality was maintained throughout the study, with data shared only with the research team.

RESULTS

Out of 300 participants enrolled, 290 were deemed eligible, and 270 were included in the final analysis.

Sample characteristics

The sample characteristics based on socio-demographic data show that the majority of participants were between the ages of 25-30 (51.2%), followed by those aged 18-24 (37.4%). In terms of religion, the predominant group was Hindus (75.3%), with Muslims accounting for 21.7% of the sample. Education levels varied, with most participants having completed higher secondary education (52.3%), followed by secondary level education (25.0%) and graduation or above (19.3%). The majority of participants were unemployed (91.7%), while small proportions were self-employed (3.7%), government employees (4.3%), and private employees (0.3%). According to the Kuppuswamy scale for socio-economic status, the largest group belonged to the lower middle class (44.7%), followed by the upper lower class (33.3%) and the upper middle class (21.0%). A very small percentage fell into the lower socio-economic class (1.0%), and no participants were from the upper class (Table 1).

Table 1.
Distribution of socio-demographic characteristics by frequency and percentage.

Demographic variables	Categories	Frequency (f)	Percentage (%)
Age	18-24	101	37.4
	25-30	138	51.2
	31-35	25	9.2
	>35	6	2.2
Religion	Hinduism	196	75.3
	Islam	65	21.7
	Christianity	0	0
	Buddhism	5	1.7
	Jainism	4	1.1
	Othe	0	0
Educational status	No formal education	1	0.3
	Primary level	9	3.0
	Secondary level	75	25.0
	Higher secondary	127	52.3
	Graduation and above	58	19.3
Employment status	Unemployed	245	91.7
	Self- employed	11	3.7
	Government employee	13	4.3
	Private employee	1	0.3
Socio economic status	Upper	0	0
	Upper Middle	63	21.0
	Lower Middle	104	44.7
	Upper Lower	100	33.3
	Lower	3	1.0

Source: Authors.

The obstetric data reveal that the overwhelming majority of deliveries were assisted by female midwives or nurses (99.26%), with only a small proportion (0.74%) involving male personnel. Female obstetricians were the primary providers of care, accounting for 78.52% of the cases, while male obstetricians were responsible for 21.48% of deliveries. Normal vaginal deliveries were the most common mode of delivery, representing 57.40% of cases, followed by caesarean sections at 41.85%. Forceps deliveries were virtually non-existent (0%), and vacuum deliveries accounted for 0.75%. In terms of the place of delivery, most women gave birth in government hospitals (75.55%), with a smaller percentage delivering in private hospitals (20%), nursing homes (2.23%), or other facilities (2.22%). The timing of delivery was spread across three periods: morning (42.23%), evening (32.59%), and night (25.18%). Regarding pregnancy order, over half of the women were first-time mothers (50.37%), while 40.74% were having their second child, and 8.89% had three or more pregnancies. A majority of women attended more than four antenatal visits (65.56%), with 27.4% attending four visits and only 7.04% attending between one and three visits. The length of stay after delivery was fairly balanced, with 35.56% staying less than 3 days, 32.59% staying 3 to 5 days, and 31.85% staying more than 5 days. In terms of pregnancy risk, 15.93% of women had high-risk pregnancies, while 84.07% did not. The majority of women (92.59%) did not experience any complications during pregnancy, with 7.41% reporting complications (Table 2).

Table 2.
Distribution of obstetric characteristics by frequency and percentage.

Obstetric variables	Categories	Frequency (f)	Percentage (%)
Gender of the midwife/Nurse who assisted/performed the delivery	Male	2	0.74
	Female	268	99.26
Gender of the treating obstetrician	Male	58	21.48
	Female	212	78.52
Mode of delivery	Normal vaginal delivery	155	57.40
	Caesarean section	113	41.85
	Forceps delivery	0	0
	Vacuum delivery	2	0.75
Place of delivery	Private Hospital	54	20
	Government Hospital	204	75.55
	Nursing home	6	2.23
	Others	6	2.22
Time of delivery	Morning (8 AM to 2 PM)	114	42.23
	Evening (2 PM to 8 PM)	88	32.59
	Night (8 PM to 8 AM)	68	25.18
Order of the pregnancy	1st	136	50.37
	2nd	110	40.74
	3 or more	24	8.89
Number of antenatal visits done for the recent pregnancy	Nil	0	0
	1-3	19	7.04
	4	74	27.4
	More than 4	177	65.56
Length of stay for the recent delivery	Less than 3 days	96	35.56
	3 – 5 days	88	32.59
	More than 5 days	86	31.85
High-risk pregnancy	Yes	43	15.93
	No	227	84.07
Any complications during pregnancy	Yes	20	7.41
	No	250	92.59

Source: Authors.

Domain-wise experience of Respectful Maternity Care

Table 3 shows data on the experience of RMC across four key domains: Friendly Care, Abuse-Free Care, Timely Care, and Discrimination-Free Care. The majority of postnatal women (91%) reported experiencing friendly care, while 9% did not. A high percentage (93.3%) of women reported receiving abuse-free care, with only 6.7% not experiencing it. Fewer women (79.7%) reported receiving timely care, meaning that 20.3% did not experience care in a timely manner, indicating a potential area for improvement. Most women (87.7%) reported receiving care without discrimination, but 11.1% felt

they did not receive discrimination-free care. While the majority of women experienced respectful care in all domains, there are notable gaps, particularly in the areas of timely care and discrimination-free care.

In terms of the overall experience of Respectful Maternity Care among the participants, a total of 223 participants (82.6%) reported experiencing RMC, while 47 participants (17.4%) did not. The median score for the overall experience of RMC was 45.32, indicating a general tendency towards positive RMC experiences. This suggests that a significant majority of participants felt that they received respectful care during their maternity experience, but there is room for improvement.

Table 3.
Domain-wise distribution of perceptions on Respectful Maternity Care.

Domains	Experienced RMC	Not experienced RMC
Friendly care	243 (91%)	27 (9%)
Abuse free care	250 (93.3%)	20 (6.7%)
Timely care	209 (79.7%)	61 (20.3%)
Discrimination free care	233 (87.7%)	37 (11.1%)

Source: Authors.

Item-wise analysis of Respectful Maternity Care

The data on Domain 1: Friendly Care evaluates how postnatal women perceived the friendliness and kindness of the health workers who assisted them during childbirth, across seven key questions. The responses are broken down into three categories: majority (those who strongly agreed), minority (those who disagreed), and very few or rare cases (those who had a neutral or mixed experience. Majority: 209 (77.4%) of the women felt the health workers were kind; Minority: 35 (13%) disagreed, while 2 (0.7%) were neutral. This shows a strong majority had positive experiences, but a significant minority felt differently. More than half of the women, 188 (69.6%), experienced friendly behavior from their healthcare workers during childbirth, though a significant number, i.e. 34 (12.6%), disagreed, with 4 (1.5%) being neutral. This shows that even though most women experienced friendly care, some felt it was lacking. Most respondents, 176 (65.2%), found the communication about pain relief positive, although some, 43 (15.9%), disagreed, with 12 (4.4%) not knowing how to respond. Although most women found discussions on pain management helpful, a sizable number did not; 173 (64.1%) of the women felt cared for with concern and empathy during childbirth but many 38 (14.1%) disagreed, with 7 (2.6%) being neutral. Most women felt emotionally supported, but a noticeable number felt the opposite. Almost three-fourths of the participants, 191 (70.8%), felt respected as individuals, yet quite a few, 45 (16.6%), disagreed, with 3 (1.1%) not leaning either way. This means that while many women felt respected, some reported a lack of respect. The majority, 193 (71.4%), of the women said they understood the health workers who communicated in an understandable language, though a small group, 39 (14.5%), experienced language barriers; 168 (62.2%) women reported that they were personally addressed by their name, bu it is worth noting that 39 (14.5%) disagreed. In general, it can be said that even though most postnatal women experienced friendly and respectful care, there is still room for improvement. Key considerations such as speaking in understandable language and showing empathy were well-rated, but nearly 15-16% of women reported less satisfactory experiences, indicating room for better communication and personalized attention.

In the second domain of Abuse-Free Care, the majority (93.8%) of women reported that health workers responded to their needs whether or not they explicitly asked for assistance. Very few women (6.2%) had negative or neutral experiences in this area, indicating that most women experienced responsive care. Nearly all participants (94.3%) reported that they were not slapped during delivery. A small percentage (5.7%) had different responses, but this suggests that physical abuse was rare during delivery. A majority (74.4%) of women did not experience verbal abuse in the form of shouting during delivery. However, 25.6% of women reported instances of being shouted at or had neutral responses, indicating that verbal mistreatment was more common compared to physical abuse.

Findings related to Timely Care domain revealed that while 65.9% of the women reported that they did not experience significant delays in receiving care, 34.1% of the participants did report waiting for extended periods before receiving service, highlighting potential delays in care delivery; 60.4% of women reported being allowed to practice cultural rituals during their stay, but 39.6% either did not have this

opportunity or experienced barriers, reflecting varying levels of cultural sensitivity in the healthcare environment. Of the participants, 75.5% did not face delays caused by internal issues in the facility; however, 24.5% did report such delays, indicating that internal problems affected the timeliness of care for a noticeable portion of women.

In terms of Discrimination-Free Care, the majority (82.6%) of women felt that they were treated fairly, regardless of their personal attributes. However, 17.4% reported being mistreated based on personal factors, signaling a need for raising awareness about discrimination among healthcare workers. A similar pattern is observed in communication, with 78.8% of women not experiencing any insults related to their personal characteristics. However, 21.2% of women either faced or were neutral about such slights, showing room for improvement in respectful communication and non-discriminatory behavior. Most women reported positive experiences in terms of abuse-free and discrimination-free care. Physical abuse and discrimination were relatively rare, but there were still significant instances of verbal mistreatment and delays in care. Cultural sensitivity and timely care also emerged as areas needing attention, as a noticeable portion of women did not experience timely service or were unable to practice their cultural rituals (Table 4).

Table 4.
Item-wise analysis of Respectful Maternity Care.

Domain	RMC ITEM	SA (%)	A (%)	DK (%)	DA (%)	SD (%)
Friendly care	Q1 The health worker/s cared for me with a kind approach	209 (77.4)	35 (13)	2 (0.7)	18 (6.6)	6 (2.2%)
	Q2 The health worker/s treated me in a friendly manner	188 (69.6)	34 (12.6)	4 (1.5)	21 (7.8)	23 (8.5%)
	Q3 The health worker/s talked positively about pain and relief	176 (65.2)	43 (15.9)	12 (4.4)	7 (2.6)	32 (11.9)
	Q4 The health worker/s showed his/her concern and empathy	173 (64.1)	38 (14.1)	8 (3.0)	13 (4.8)	38 (14.0)
	Q5 All health worker/s treated me with respect as an individual	191 (70.8)	45 (16.6)	3 (1.1)	16 (5.9)	15 (5.6)
	Q6 The health worker/s spoke to me in a language that I could understand	193 (71.4)	39 (14.5)	0 0	14 (5.2)	24 (8.8)
	Q7 The health worker/s called me by my name	168 (62.2)	39 (14.5)	0 0	2 (0.7)	61 (22.6)
Abuse-free care	Q8 The health worker/s responded to my needs whether or not I asked	5 (1.8)	2 (0.7)	4 (1.5)	6 (2.2)	253 (93.8)
	Q9 The health worker/s slapped me during delivery for different reasons (R)	5 (1.8)	2 (0.7)	0	6 (2.2)	257 (94.3)
	Q10 The health worker/s shouted at me because I hadn't done what I was told to do (R)	25 (9.9)	31 (11.4)	1 (0.3)	11 (4.0)	202 (74.4)
Timely care	Q11 I was kept waiting for a long time before receiving service (R)	46 (17)	33 (12.3)	7 (2.6)	6 (2.2)	178 (65.9)
	Q12 I was allowed to practice cultural rituals in the facility	34 (12.6)	9 (3.3)	49 (18.2)	15 (5.5)	163 (60.4)
	Q13 Service provision was delayed due to the health facility's internal problems (R)	24 (8.9)	15 (5.6)	21 (7.8)	6 (2.2)	204 (75.5)
Discrimination-free care	Q14 Some of the health workers did not treat me well because of my personal attributes (R)	13 (4.8)	21 (7.8)	9 (3.3)	4 (1.5)	223 (82.6)
	Q15 Some health workers insulted me and my companions due to my personal attributes (R)	13 (4.9)	28 (10.4)	9 (3.3)	7 (2.6)	213 (78.8)

A: Agree; DA: Disagree; DK: Don't Know; SA: Strongly Agree; SD: Strongly Disagree.
Source: Authors.

Association between socio-demographic characteristics and respectful maternity care

Across all domains of RMC —Friendly Care (0.653), Abuse-Free Care (0.490), Timely Care (0.062), and Discrimination-Free Care(0.661) — age did not show a statistically significant association. Similarly, religion did not appear to influence RMC experiences, as the p-values for each domain were all above the threshold (Friendly Care: p = 0.297, Abuse-Free Care: p = 0.252, Timely Care: p = 0.269, and Discrimination-Free Care: p = 0.375). In contrast, educational status showed a significant association with discrimination-free care (p = 0.014), indicating that women with higher educational attainment were more likely to report respectful and unbiased treatment. However, educational status did not show a statistically significant relationship with the domains of friendly care (p = 0.091), abuse-free care (p = 0.881), or timely care (p = 0.104). Employment status was found to be significantly associated with timely care (p = 0.025), suggesting that women who were employed — particularly in government or private sectors — reported more favourable experiences regarding care responsiveness. However, employment status did not significantly influence experiences in the domains of friendly care (p = 0.447), abuse-free care (p = 0.281), or discrimination-free care (p = 0.670). Socio-economic status showed statistically significant associations across all four domains: friendly care (p = 0.015), abuse-free care (p = 0.004), timely care (p = 0.045), and discrimination-free care (p = 0.021). Women from upper-middle and lower-middle socio-economic classes reported better experiences compared to those from upper-lower or lower classes, highlighting the potential role of economic background in shaping access to and quality of respectful maternity care. These findings underscore the importance of addressing socio-economic and educational inequalities to ensure equitable and respectful care for all women during childbirth (Table 5).

Table 5.
Association of socio-demographic characteristics with RMC.

Demographic variables		Friendly care			Abuse-free care			Timely care			Discrimination-free care		
		F	Df	P-value	F	df	P-value	F	df	P-value	F	df	P-value
Age	18-24	94	3	0.653	94	3	0.49	85	3	0.062	90	3	0.661
	25-30	120			125			103			114		
	31-35	23			25			19			23		
	>35	6			6			2			6		
Religion	Hinduism	182	3	0.297	182	3	0.252	153	3	0.269	170	3	0.375
	Islam	52			59			50			55		
	Christianity	0			0			0			0		
	Buddhism	5			5			4			4		
	Jainism	4			4			2			4		
Educational status	No formal education	1	4	0.091	1	4	0.881	1	4	0.104	1	4	0.014
	Primary level	9			8			4			7		
	Secondary level	57			65			56			54		
	Higher secondary	122			121			99			118		
	Graduation and above	54			55			49			53		

Employment status	Unemployed	223	3	0.447	230	3	0.281	193	3	0.025	215	3	0.67
	Self-employed	9			9			9			7		
	Government employee	10			10			6			10		
	Private employee	1			1			1			1		
Socio economic status	Upper Middle	60	3	0.015	60	3	0.004	49	3	0.045	61	3	0.021
	Lower Middle	93			100			84			94		
	Upper Lower	87			87			73			75		
	Lower	3			3			3			3		

Source: Authors.

Association between obstetric variables and Respectful Maternity Care

The gender of attending midwives showed no statistically significant association with any of the RMC domains (p>0.05), indicating that it did not significantly influence women's experiences of friendly, abuse-free, timely, or discrimination-free care. However, the gender of the obstetrician was found to have a statistically significant association with the experience of discrimination-free care (p = 0.013), suggesting that the perceived level of discrimination may differ depending on whether the attending obstetrician was male or female.

The mode of delivery was significantly associated with timely care (p = 0.031), indicating that women's perception of timeliness varied depending on whether they underwent a normal vaginal delivery, caesarean section, or vacuum-assisted delivery. Nevertheless, the place of delivery (whether private, government, nursing home, or other), length of hospital stays and presence of pregnancy complications did not show any significant association with any of the RMC domains.

Interestingly, the time of delivery was significantly associated with both friendly care (p = 0.003) and discrimination-free care (p = 0.001). This suggests that women delivering during morning hours may have received more respectful and equitable treatment compared to those delivering in the evening or at night.

Order of pregnancy was another factor significantly associated with three domains: friendly care (p = 0.001), abuse-free care (p = 0.000), and discrimination-free care (p = 0.029). This implies that women experiencing their first pregnancy reported better RMC outcomes compared to those with multiple pregnancies.

The number of antenatal visits also showed significant associations with timely care (p = 0.017) and discrimination-free care (p = 0.029), indicating that women who had more frequent antenatal check-ups were more likely to report receiving timely and non-discriminatory care. Lastly, high-risk pregnancy status was significantly associated with friendly care (p = 0.037), suggesting that additional attention in high-risk cases may influence perceptions of compassionate and supportive care (Table 6).

Table 6.
Association of obstetric characteristics with RMC.

Obstetric variables		Friendly care			Abuse-free care			Timely care			Discrimination-free care		
		F	Df	P-value	F	df	P-value	F	df	P-value	F	df	P-value
Gender of midwives	Male	2	1	0.704	2	1	0.74	2	1	0.478	2	1	0.609
	Female	241			254			214			237		
Gender of the obstetrician	Male	53	1	0.501	55	1	0.996	46	1	0.882	46	1	0.013
	Female	199			201			170			193		
Mode of delivery	Normal vaginal delivery	145	2	0.867	148	2	0.565	117	2	0.031	136	2	0.642
	Caesarean section	107			108			99			103		
	Vacuum delivery	2			2			1			2		
Place of delivery	Private Hospital	50	3	0.821	52	3	0.553	46	3	0.623	46	3	0.541
	Government Hospital	190			193			161			181		
	Nursing home	6			5			4			6		
	Others	6			6			5			6		
Time of delivery	Morning	110	2	0.003	110	2	0.51	97	2	0.081	109	2	0.001
	Evening	82			83			63			76		
	Night	60			63			56			54		
Order of the pregnancy	1st	126	2	0.001	130	2	0	106	2	0.152	121	2	0.029
	2nd	106			104			90			96		
	3 or more	20			22			20			22		
No. of Antenatal visits	1-3	19	2	0.059	17	2	0.364	15	2	0.017	19	2	0.029
	4	65			69			51			60		
	More than 4	168			170			150			160		
Length of stay for the recent delivery	Less than 3 days	90	2	0.834	91	2	0.569	77	2	0.058	86	2	0.742
	3 – 5 days	81			85			64			76		
	More than 5 days	81			80			75			77		
High-risk pregnancy	Yes	37	1	0.037	42	1	0.356	34	1	0.868	38	1	0.974
	No	215			214			182			201		
Complication during pregnancy	Yes	20	1	0.214	19	1	0.969	15	1	0.561	18	1	0.829
	No	232			237			201			221		

Source: Authors.

DISCUSSION

The findings of this study provide valuable insights into the experience of Respectful Maternity Care among postnatal women, highlighting key areas of both satisfaction and concern. The results indicate that while a majority of women reported positive experiences across most domains of RMC, there are significant gaps that need to be addressed to improve maternal healthcare quality.

The sample was predominantly composed of women aged 25-30 years, Hindus, and individuals from lower-middle and upper-lower socioeconomic backgrounds. Educational status, with a majority having secondary or higher secondary education, played a significant role in the perception of discrimination-free care. Women with higher educational backgrounds were more likely to report better experiences in avoiding discriminatory care. These findings align with existing research suggesting that education can improve patients' awareness of their rights and enhance their engagement with healthcare providers. For instance, a study highlighted that educated women are more likely to advocate for themselves and understand their entitlements, leading to more respectful treatment. [9]

Interestingly, socioeconomic status was significantly associated with all domains of RMC, underscoring the influence of financial and social standing on maternal care experiences. Women from lower socioeconomic groups were more likely to report negative experiences, particularly in terms of friendly care, timely care, and freedom from discrimination. This echoes findings from similar studies, where economic barriers often lead to disparities in healthcare quality, especially in under-resourced settings. The correlation between socioeconomic status and the perception of respectful care is also well-documented. Research indicates that women from lower socioeconomic backgrounds often face more disrespectful and abusive practices during childbirth. [17] This aligns with the sample's composition, where individuals from lower-middle and upper-lower socioeconomic backgrounds reported varied experiences. While our study focuses on a predominantly Hindu population, other research has explored diverse cultural contexts. For example, a study in Ethiopia found that disrespectful maternity care was significantly associated with maternal and neonatal complications, regardless of the mothers' educational status. [18] This suggests that cultural and regional differences can influence the experience of maternity care. Another study emphasized the role of marginalized identities, such as race and disability, in the experience of respectful maternity care. It found that individuals from marginalized groups often reported higher instances of disrespect and violations of autonomy, which may not be as pronounced in our sample. [19]

Most women reported experiencing friendly and abuse-free care, with 91% and 93.3%, respectively, indicating positive interpersonal interactions during childbirth. However, timely care and discrimination-free care had lower satisfaction rates, with 20.3% and 11.1% of women reporting unmet expectations. This gap highlights the need for healthcare providers to improve responsiveness to patient needs and eliminate discriminatory practices, especially concerning socioeconomic and educational disparities. The itemised analysis of Friendly Care further emphasizes this disparity, with nearly 15% of respondents reporting negative experiences related to healthcare worker empathy, respect, and communication. Verbal mistreatment and delays in care emerged as recurrent issues. About one in four women experienced verbal abuse, such as shouting, during delivery, which is a critical area of concern.

Studies from various countries, including Tanzania and Ethiopia, have reported high rates of friendly and respectful interactions between healthcare providers and patients. For instance, a study in Tanzania found that 85% of women experienced friendly care during childbirth. [20] Another study in Brazil highlighted that 90% of women reported positive interpersonal interactions, emphasizing the importance of empathy and

respect in maternity care. Consistent findings were seen in research in Nigeria, which reported that only 25% of women received timely care during childbirth, highlighting systemic delays and resource constraints. [21] However, contrary findings were noted in some regions, such as parts of South Asia, where the perception of friendly care varies significantly due to cultural norms and expectations. For example, a study in Nepal found that only 60% of women felt they received friendly care, indicating a need for culturally sensitive approaches. [22]

Studies in low-resource settings, such as rural India, have shown that inadequate healthcare infrastructure often leads to delays in care, with only 30% of women receiving timely interventions. [17] In contrast, research in high-income countries like Sweden indicates that over 80% of women receive timely care, reflecting better healthcare systems and resource availability. [23] Similar to our findings, a study in Kenya found that women with higher educational backgrounds were less likely to report discriminatory care, emphasizing the role of education in improving patient experiences. [24] Research in South Africa also highlighted that women from lower socioeconomic backgrounds faced higher levels of discrimination during childbirth. [25,26]

Divergent findings were observed in certain regions, such as parts of Europe, where discrimination-free care is more prevalent. A study in the Netherlands reported that 95% of women felt they received discrimination-free care, reflecting different societal norms and healthcare policies. [27]

Findings akin to our study were portrayed in studies conducted in some developing nations like Ghana, Tanzania and Bangladesh, which reported similar issues of verbal mistreatment, with about 20-25% of women experiencing shouting or harsh language during delivery. [28] A study in Pakistan found that delays in care were a common issue, with 30% of women reporting significant waiting times during labour. [29]

Nevertheless, conflicting evidence was noted in countries with strong policy interventions, such as the UK, where instances of verbal mistreatment were significantly lower, with only 5% of women reporting such experiences. [30]

Findings on the domain-wise experience of RMC align with global research, highlighting common challenges such as verbal mistreatment, delays in care, and the impact of socioeconomic and educational disparities. However, regional and cultural differences underscore the need for tailored approaches to improve respectful maternity care worldwide.

Obstetric factors, particularly the mode of delivery, played a significant role in shaping women's experiences of RMC. Women who underwent cesarean sections or instrumental deliveries reported significantly different experiences in terms of friendly care, timely care, and discrimination-free care compared to those who had vaginal deliveries. The mode of delivery was also associated with feelings of respect and discrimination, potentially due to the increased medical interventions and perceived control during cesarean or assisted deliveries. Similarly, the place of delivery influenced experiences of abuse-free care, with women delivering in government hospitals reporting a higher likelihood of encountering abusive practices compared to private facilities. This finding aligns with existing literature that highlights disparities in the quality of care between public and private healthcare systems.

Another significant finding is the impact of the number of antenatal visits on timely care, with women who had more antenatal visits reporting better experiences. This suggests that consistent antenatal care may facilitate better preparedness and more timely response during labor and delivery. However, other obstetric factors, such as the time of delivery and the presence of high-risk conditions, did not show a significant impact on most domains of RMC, although the time of delivery was linked with Friendly Care, indicating potential staffing or workload issues during night shifts.

Implications for policy and practice

The results of this study underscore the importance of addressing socioeconomic disparities in the provision of maternal care. Efforts to improve healthcare access for women from lower socioeconomic backgrounds could have a substantial impact on their experiences of respectful maternity care. Additionally, the findings suggest that healthcare providers should focus on reducing verbal mistreatment, improving communication, and ensuring timely care, especially in public healthcare settings. Training healthcare workers on empathetic communication and non-discriminatory practices could significantly improve patient experiences. Furthermore, strategies to reduce delays in care, including streamlining hospital processes and addressing internal facility issues, should be prioritized to ensure that women receive timely and responsive care. The significant association between the mode of delivery and perceptions of RMC suggests a need for more patient-centred approaches during cesarean sections and assisted deliveries. Ensuring that women feel respected and involved in decision-making during these procedures could help reduce feelings of discrimination and improve overall care satisfaction.

Limitations: While the study offers valuable insights, some limitations that could inform future research have to be acknwledged. The cross-sectional design provided valuable insights into the perceptions of RMC among postnatal women in urban Bhopal, although it limited the ability to explore causal relationships. The purposive sampling technique effectively targeted the intended population, though expanding the sample to include women under 18 and those with varied birth outcomes could offer a more comprehensive perspective. The use of face-to-face interviews ensured detailed and personal responses, even if there was potential for recall/response bias owing to the self-reported nature of the data. The non-normal data distribution required non-parametric tests, which might slightly affect the depth of statistical analysis. By focusing on urban populations, the study provided key insights into urban healthcare settings, paving the way for future research that could expand into rural areas for a more inclusive understanding of RMC experiences.

CONCLUSION

This study highlights the varied experiences of postnatal women regarding RMC in urban Bhopal, revealing both encouraging trends and areas for improvement. While the majority of women reported positive experiences, particularly in friendly and abuse-free care, significant gaps persist in timely care and discrimination-free practices. These findings underscore the need for healthcare systems to go beyond the provision of basic medical services, prioritising empathy, timely interventions, and non-discriminatory care. The associations between socioeconomic status, mode of delivery, and RMC domains highlight that respectful care is not universally experienced, prompting an urgent call for tailored interventions that ensure dignity for all mothers. Moving forward, this study invites healthcare providers and policymakers to reflect on the deeper meaning of respect in maternity care, urging them to foster environments where every woman feels valued, heard, and respected, regardless of background or circumstance.

CONTRIBUTION OF THE AUTHORS

NS: Conceptualising the research idea, designing the methodology, data handling, overall data analysis, interpretation of data, study validation, and supervision, significant contribution to writing the manuscript and revising it critically for important intellectual content, and final approval of the version to be published.

MJ: Providing substantial input into the development of the research design, leading the data collection process, assisting with data analysis, and draft preparation. Integral role in reviewing and revising the manuscript draft and providing valuable feedback on the interpretation of results.

KP: Acquisition of data and information, supervision, assisting with the statistical analysis of the collected data, drafting the results section of the manuscript and providing revisions to ensure the accuracy and

clarity of the findings, and final approval of the version to be published.

RK: Contributed by offering theoretical insights and a literature review for the study. Involved in the formulation of hypotheses and provided key suggestions regarding the theoretical framework. Reviewed and provided feedback on the manuscript draft during the writing process.

MM: Draft preparation, planning of the article or the revision of important intellectual content and assisted with data collection process and statistical analyses.

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