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Original Article

Women's Perception of Respectful Maternity Care During Childbirth: A Facility-Based Cross-Sectional Survey in Uttarakhand, India

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ABSTRACT

Background: In India, pregnant women and their families face considerable challenges when trying to access expert-level maternity care, primarily due to the inadequately rendered services within poorly managed healthcare facilities. Among these challenges, one of the most profound discouragements is the documented evidence of disrespect and mistreatment of women during childbirth within healthcare facilities. This type of mistreatment undermines the dignity and the psychological wellness of mothers and discourages them from pursuing prompt care within the facility. While it is of significant relevance, the disrespect and mistreatment of women during the childbirth process remain poorly documented, thus limiting the understanding of the phenomenon's size. This paper could be the first of its kind to document the ubiquity of discourtesy and mistreatment in maternity care in the context of facility childbirth in Uttarakhand, India, and to contribute to the understanding of disrespect and mistreatment in maternity care across the healthcare continuum.

Methods: A cross-sectional facility-based study was conducted from March 2021 to October 2021. In total, 120 women were selected using a total enumeration technique. A standardized tool (Women's Perception of Respectful Maternity Care) was used to retrieve the data. Data were entered into SPSS version 22.0 for analysis. Significant statistics were confirmed at a P-value of < 0.05.

Results: From 120 women's data, 83% of them received respectful maternity care. The mean whole respectful maternity care score was 86.4 with a range of 19 to 95. Subsequently, after adjusting for sociodemographic and obstetric features, the correlation between respectful maternity care and the mode of delivery (P=0.96), age (P=0.77), and gravida (P=0.79) was not significant.

Conclusions: Respectful maternity care is clearly practiced in Rishikesh's designated public wellness services. Positive experiences with perinatal care can increase use of parental care services. A more intensive study is needed to better recognise appropriate local factors, social norms, and patient-provider interactions.

Keywords: Respectful Maternity Care; Childbirth; Intrapartum Care; Postnatal Mothers; Institutional Delivery Services

Introduction

Respectful Maternity Care (RMC) includes safeguarding against verbal and physical mistreatment, disrespect, and unfairness while receiving care. It enables a woman to make educated decisions about her pregnancy and delivery. Gestation and labour are significant trials in the lives of women and families worldwide, and they characterize a period of heightened vulnerability. The perception of "safe motherhood" is typically limited to corporeal safety; however, for a woman and her family, childbirth is also a major ceremony, with profound personal and cultural significance. Because motherhood is a uniquely female experience, gender justice and violence are central to maternity care [1]. As a result, the concept of safe motherhood must be expanded beyond disease and death prevention to include respect for women's essential human rights, such as independence, self-esteem, sentiments, selections, and favourites, as well as company while motherhood care. A woman's connection with motherhood care caregivers and the maternity care system is critical in gestation and delivery. In addition, these experience meets the crucial and possibly life-saving health services, but women face caregivers at this period. It also influences to allow luxury or to impose long-term impairment and emotional trauma. Otherwise, women's memories of their motherhood experiences stay with them for a lifetime and are often shared with other women, contributing to either confidence or distrust around pregnancy.

All women have the right to expect humble maternity care. On the contrary, complications such as contempt, mistreatment, exploitation, and the urging for unofficial payments, as well as infrastructure problems such as a deficiency of water supply, hygiene, electricity, and congested rooms, are widespread throughout the world. Another issue raised is that women are either given "too much and too soon" or "too little and too late" [2] Disrespectful care is thus a theme of public health alarm, as it affects service utilisation. The White Ribbon Alliance issued the first approval on RMC mechanisms, which included "respect for women's autonomy, dignity, empathy, privacy, confidentiality, feelings, choices, and preferences, including companionship during maternity care and continuous care during labour and childbirth and prevention of harm and ill-treatment [3]. Almost two decades of rising concern about poor provider attitudes and women facing exploitation in health services, abuse of women in labour, and labor is a universal concern since it adversely impacts women's choices to pursue future childbirth care at health services and violates women's rights. Few maternal health service interventions have a primary goal that focuses on these issues [4].

India has seen a significant rise in institutional deliveries over the last two decades and this has been attributed to the national initiatives on maternal health like Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK) and strengthening of institutional capacity. The National Family Health Survey (NFHS) showed that the percentage of institutional births rose from about 39% in NFHS-3 (2005-06) to over 88% in NFHS-5 (2019-21). Although these endeavours have helped women access skilled birth attendance and facility-based care, there is now a growing focus on the quality and experience of maternity care that women receive during childbirth [29]. Despite the high level of institutionalization of deliveries, India remains one of the countries with a heavy burden of maternal mortality, contributing a large share of the maternal deaths in the world. While more than 80% of births take place in health facilities, maternal mortality is still a public health problem and the need to improve access to and quality of maternity care services is also key [5,7]. Even though over 80% of women deliver in health facilities, over 35,000 women die in India each year from maternal causes. Almost all these deaths could have been avoided, showing that the quality of treatment requires attention on many levels. In recent years, India has seen gains in maternal health, but the race to get women into facilities has escalated without adequate investment in the experience. As a result, India makes efforts to make RMC improve the quality of labor care in maternity facilities. The initial stage in such an attempt is to evaluate the present situation. Despite a wealth of published evidence on individual cases, there is limited evidence on the frequency estimate of RMC in facility-based childbirth, mostly in India [5].

Women's experience of childbirth can be measured with a number of validated questionnaires such as the Childbirth Experience Questionnaire (CEQ) which focuses on women's perceptions of their labour and delivery experiences and the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) which assesses fear and emotional experiences related to childbirth. These instruments have been broadly utilized to assess maternal and childbirth experiences and quality of maternity care among various populations [31]. Ayoubi et al. have developed and validated the Women's Perception of Respectful Maternity Care (WP-RMC) checklist, which involves three dimensions of providing comfort, participatory care, and mistreatment. It was designed based on principles of respectful maternity care and WHO

guidance on quality maternal and newborn care.[6] This checklist examines subjective aspects of delivery treatment quality. While labour and delivery, this can be used in maternity services to assess and enhance the care given to women. There is no particular survey or study done in the respected state (Uttarakhand). Hence, the main aim of this study was to assess the status of RMC at the selected hospital, All India Institute of Medical Sciences (AIIMS), Rishikesh, Uttarakhand, India, from March 2021 to October 2021.

Methodology

Study Setting and Design at the Department of Obstetrics and Gynaecology

The study used a quantitative, facility-based, cross-sectional survey design from March 2021 until October 2021 at AIIMS Rishikesh, Uttarakhand, India in the Department of Obstetrics and Gynaecology. AIIMS Rishikesh is a tertiary-care teaching and referral hospital that caters to patients from both urban and rural areas of Uttarakhand and neighbouring states. The hospital offers comprehensive maternity services, including antenatal care, intrapartum and emergency obstetric services, and postnatal care, making it a suitable setting for assessing women's perceptions of Respectful Maternity Care (RMC).

Participant Selection Criteria and Eligibility Requirements

Participants were women of reproductive age (18–45 years) who were admitted to All India Institute of Medical Sciences (AIIMS), Rishikesh, for normal vaginal delivery or Caesarean section (C-section). The study included women who could speak or understand Hindi or English. Women with maternal and/or neonatal complications during the postnatal period that may affect their overall health were excluded, as were women with neonatal death.

All eligible women who were postnatal during the study period were approached one by one and given information about the purpose and methods of this study, asking them to join the study. Volunteer women with informed written consent were added until the desired number of 120 participants was reached, with a total enumeration sampling methodology.

Sample Size Determination and Statistical Calculation Method

Sample size was estimated using the single population proportion formula with prevalence of respectful maternity care as reported by Mousa and Turingan (85%), confidence level = 95% and an allowable error of 6%. A minimum sample size of 120 participants was determined. [14]

Sample size in the trial was calculated using the following formula:

$$\text{Sample size (n)} = \frac{(Z_1\text{-}\alpha/_2)^{2*}(p)(q)}{(d)^2}$$

Data Collection tool, Translation, Sampling Technique, and Quality Assurance Procedures

The Women Perception- Respectful Maternity Care (WP-RMC) tool is standardized to evaluate women's experiences of Respectful Maternity Care. This tool comprises three factors, which include 19 items: Providing comfort (7 items), Participatory care (7 items), and Mistreatment (5 items). The WP-RMC questionnaire was translated into Hindi using a standard forward-backward procedure. First, the original English text was translated separately into Hindi by two bilingual language experts with an understanding of the terminology used in maternal health. The reconciled Hindi version was subsequently back translated into English by another independent translator unaware of the original questionnaire. Semantic, conceptual, and cultural equivalences were examined and addressed by the research team when discrepancies were found. The pre-final Hindi version was pilot-tested with postnatal women to evaluate clarity, comprehensibility and cultural appropriateness prior to use in the main study. Total enumeration approach was used to recruit the participants for the present study. During study period, all eligible postnatal women who fulfilled the inclusion criteria were invited to participate until the adequate number of women was obtained.

Data was obtained in the post natal period before discharge from hospital. The questionnaire was given by trained research staff not directly involved in the clinical management of the participants. Women were told that their responses would be kept confidential and anonymous before they participated and that the results would not affect the care given to them or their babies. These measures have been put in place to reduce the social desirability bias and elicit accurate responses regarding childbirth experiences [6].

Reliability and Validity Assessment of the WP-RMC Tool

The Women's Perception of Respectful Maternity Care (WP-RMC) checklist was originally developed and validated by Ayoubi et al. The instrument exhibited excellent psychometric properties in the original validation study, yielding an overall Content Validity Index (CVI) of 0.97, each item Content Validity Ratio (CVR) exceeding 0.79, a Cronbach's alpha coefficient of 0.91, and an intraclass correlation coefficient (ICC) of 0.90. The questionnaire was translated into Hindi using a standardized forward–backward translation procedure and was pilot-tested to ensure semantic, conceptual, and cultural equivalence before implementation in the present study.

Although the Hindi-translated questionnaire underwent standardized forward–backward translation and pilot testing to ensure semantic, conceptual, and cultural equivalence before implementation, the internal consistency reliability (Cronbach's alpha) of the translated version was not re-evaluated in the present study. Therefore, the psychometric properties reported by Ayoubi et al. are presented to support the validity and reliability of the original instrument. The absence of a local reliability assessment is acknowledged as a limitation of the present study. [6]

Data Preparation, Statistical and Scoring Interpretation of the WP-RMC Questionnaire

Before double-checking for accuracy, the data was prepared as an Excel sheet. The information was then cleaned and analysed with SPSS version 22.0. Responses were recorded on a five-point Likert scale presented as Never (1), Seldom (2), Sometimes (3), Often (4), and Always (5). For negatively worded items in the mistreatment domain, reverse scoring was applied during statistical analysis so that higher scores consistently reflected more respectful maternity care. The first factor, with seven questions, gets the lowest score of 7 and the highest of 35. The second factor also has a minimum score of 7 and a highest of 35. The third factor, with five questions, gets a minimal score of 5 and a highest of 25. The overall questionnaire minimum score is 19, and the maximum score is 95. The mean score of the questionnaire was 47. A higher score above the mean is considered desirable.

Additional inferential analyses were conducted to determine factors associated with women's perception of respectful maternity care. Independent t-tests were used for the dichotomus variables and one-way ANOVA was used for the variables which had more than two levels such as parity, educational status and socioeconomic status (Kuppuswamy classification). In addition, a multiple linear regression model was used to evaluate the individual effect of each sociodemographic and obstetric factor included in the overall WP-RMC score. Data were assessed for statistical significance at $p < 0.05$.

As each factor has a different number of items, these scores are calculated to make raw scale scores for each concept, transferred to a 0–100 scale. This standardisation method was used to better understand the scoring and comparability of the scores of the various factors of the questionnaire. The following formula was used to convert the questionnaire scores to 0 to 100:

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Standardized Score = [(Obtained Score − Minimum Possible Score) / (Maximum Possible Score − Minimum Possible Score)] × 100

For the overall WP−RMC questionnaire: Standardized Score = [(Obtained Score − 19) / (95 − 19)] × 100

For Factor 1 (Providing Comfort): Standardized Score = [(Obtained Score − 7) / (35 − 7)] × 100

For Factor 2 (Participatory Care): Standardized Score = [(Obtained Score − 7) / (35 − 7)] × 100

For Factor 3 (Mistreatment):Standardized Score = [(Obtained Score − 5) / (25 − 5)] × 100
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Also, the higher scores in the questionnaire show that women receive a better (desirable) RMC. Questionnaire scores can be reported as Good, Average, and Poor. Using the standardization method, the total score of the questionnaire is divided into three percentage points. A score of less than 33.3 shows poor; a score of 33.3 to 66.6 shows moderate, and a score above 66.6 indicates good RMC status [6].

Data Analysis

The data was entered into the Microsoft Excel sheet and analyzed by using SPSS version 22.0. Demographic characteristics and WP-RMC scores were summarized using descriptive statistics such as frequencies, percentages, means and standard deviations. To test for association between WP-RMC scores and selected sociodemographic and obstetric variables, independent t test and one-way ANOVA were used. If applicable, regression analyses were carried out to determine the independent predictors of WP-RMC scores. P-value < 0.05 was regarded as statistically significant. The Modified Kuppuswamy Socioeconomic Status (KPS) Scale was used to determine socioeconomic status for the families, which is based on the education, occupation, and family income of the families.

Results

Sociodemographic characteristics

Table 1 represents 120 women involved in the response rate of 100%. Figure 1 shows the frequency distribution of age, gravida and mode of delivery. Among the participants, 84.2% were Hindu by religion, 18% were Muslims, 92.5% were housewives, 34% were middle school educated, the duration of marriage for 52% was 1-2 years, 66% were from joint family settings, 69% came from the upper-lower socioeconomic class (KPS scale).

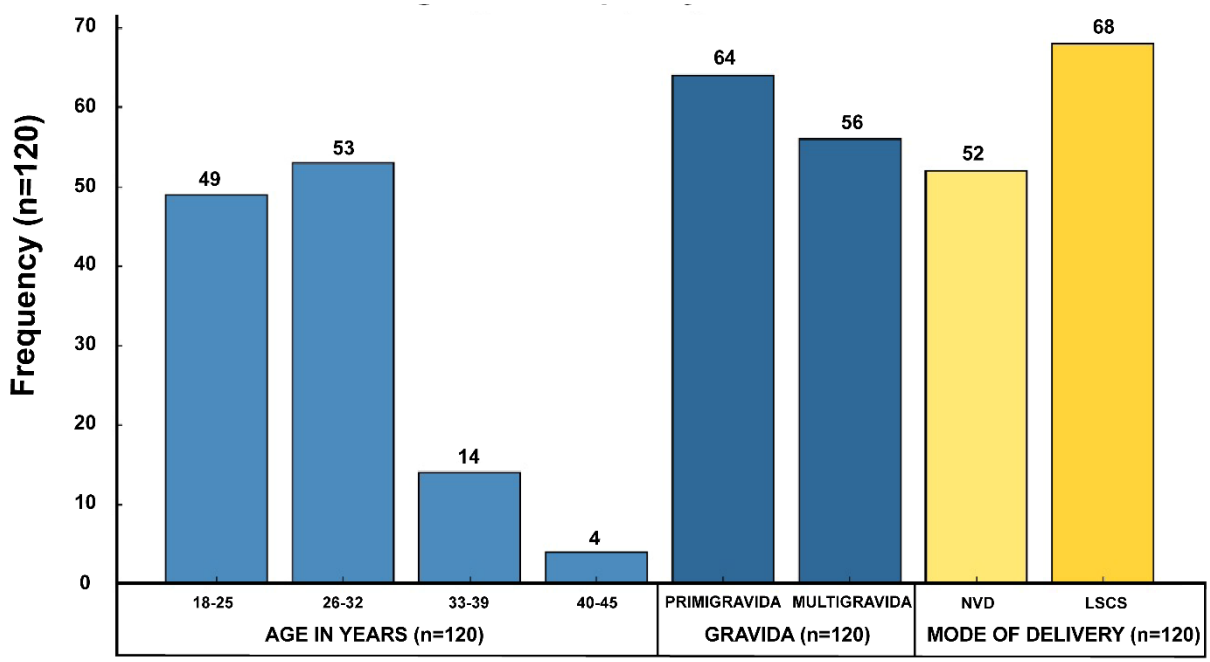

Figure 1: Frequency distribution of patients based on age, GRAVIDA and mode of delivery

Table 1: Socio-demographic profiles and Obstetric Characteristics of the participants

Characteristics		**Frequency n= 120 (%)**
Age group (years)		
	18-25	49 (40.8)
	26-32	53 (44.2)
	33-39	14 (11.7)
	40-45	04 (3.3)
Education (score)		
	No formal schooling	04(3.3)
	Primary school certificate	12(10.0)
	Middle school certificate	34(28.3)
	High school certificate	27(22.5)
	Intermediate or diploma	19(15.8)
	Graduate	20(16.7)
	Profession or Honours	04 (3.3)
Religion		
	Hindu	101 (84.2)
	Muslim	18 (15.0)
	Christian	01 (0.8)
Occupation		
	Home maker	111 (92.5)
	Craft & Related Trade Workers	04 (3.3)
	Skilled Workers and Shop & Market Sales Workers	02 (1.7)
	Clerks	03 (2.5)

Duration of Marriage		
	0-2 year	52 (43.3)
	3-4 year	17(14.2)
	5-6 year	26 (21.7))
	> 6 year	25 (20.8)
Type of Family		
	Nuclear	54 (45.0)
	Joint	66 (55.0)
Mode of delivery		
	Normal vaginal delivery	52(43.3)
	Caesarean section	68(56.6)
Parity (P)		
	P 1	66(55)
	P 2	40 (33.3)
	P 3-5	14 (11.7)
Gravida (G)		
	G 1	64 (53.3)
	G 2	32 (26.7)
	G 3- 5	24 (20)
Abortion (A)		
	A 0	101 (84.2)
	A 1-3	19 (15.8)
Live baby (L)		
	L 1	66 (55.0)
	L 2	43 (35.8)
	L 3-5	11 (9.2)
Socioeconomic KPS class		
	Upper Middle	10 (8.3)
	Lower Middle	36 (30.0)
	Upper Lower	69 (57.5)
	Lower	05 (4.2)

Table 2: Distribution of Participant Responses on Respectful Maternity Care (WPRMC) Factors: Providing Comfort, Participatory Care, and Mistreatment (n = 120) 94 (78.3)

Items	**Never (1)**	**Seldom (2)**	**Sometimes (3)**	**Often (4)**	**Always (5)**
Factor 1: (Providing comfort)					
1.1. My caregivers supported me emotionally.	0	0	0	17 (14.2)	103 (85.8)
1.2. I was in a calm and quiet environment.	1 (0.8)	1 (0.8)	2 (1.7)	29 (24.2)	85 (70.8)
1.3. My caregivers treated me in a friendly manner.	0	3 (2.5)	1 (0.8)	14 (11.7)	102 (85.0)
1.4. My caregivers provided me with timely care based on my needs.	0	1 (0.8)	0	13 (10.8)	106 (88.3)
1.5. My caregivers gave understandable answers to my questions.	0	2 (1.7)	4 (3.3)	12 (10.0)	102 (85.0)
1.6. My caregivers preserved my privacy.	0	0	4 (3.3)	12 (10.0)	104 (86.7)

1.7. My caregivers introduced themselves and showed me the labour unit.	5 (4.2)	2 (1.7)	3 (2.5)	16 (13.3)	94 (78.3)
Factor 2: (Participatory care)					
2.1. My caregivers gave required information about care and procedures.	21 (17.5)	0	0	0	99 (82.5)
2.2. I was informed about the progress of my labour.	23 (19.2)	2 (1.7)	0	0	95 (79.2)
2.3. My caregivers performed examinations and care with my permission.	20 (16.7)	2 (1.7)	0	0	98(81.7)
2.4. I was free to choose my favorable position.	21 (17.5)	1 (0.8)	0	0	98(81.7)
2.5. My relatives were informed of the progress of my labour.	18 (15.0)	1 (0.8)	0	0	101 (84.2)
2.6. I was allowed to have companion of my choice during labour.	19 (15.8)	1 (0.8)	0	6 (5.0)	94 (78.3)
2.7. I could freely ask questions.	21 (17.5)	2 (1.7)	0	0	97 (80.8)
Factor 3: (Mistreatment)					
3.1. I was threatened/ insulted.#	0	0	0	120 (0.0)	0
3.2. My caregivers beat me.#	0	0	0	120 (0.0)	0
3.3. My caregivers shouted at me if I would not follow their instructions.#	0	1 (0.8)	0	119 (99.2)	0
3.4. My caregivers treated all women equally.	27 (22.5)	12 (10.0)	12 (10.0)	2 (1.7)	67 (55.8)
3.5. My caregivers spoke privately with his/her colleague in my presence.#	0	6 (5.0)	23 (19.2)	90 (75.0)	1 (0.8)

***Reverse-scored items**: For these statements, responses were reverse coded during analysis so that higher scores consistently indicated lower levels of mistreatment and higher levels of respectful maternity care.*

Table 2 shows the response categories presented in the standard order of the Likert scale (Never to Always) for ease of interpretation. Response frequencies were not affected by reverse scoring and were only applied during statistical analysis of negatively worded items in the mistreatment domain.

Table 3: Relationship between WP-RMC scores and ages, mode of delivery, gravidity, parity, educational status and socioeconomic class.

Demographic variable		**Mean ± SD**	***p* value**
Mode of delivery*	Caesarean section	90.63 ± 4.84	0.963
	Normal vaginal delivery	90.68 ± 4.89	
Age (years)†	18–25	90.49 ± 5.86	0.774
	26–32	90.75 ± 4.12	
	33–39	90.21 ± 3.83	
	40–45	93.00 ± 4.00	

Gravida*	Primigravida	90.76 ± 5.22	0.794
	Multigravida	90.53 ± 5.42	
Parity (P)†	P1	90.73 ± 4.81	0.167
	P2	92.12 ± 3.76	
	P3–5	89.81 ± 5.15	
Educational status	Illiterate	92.00 ± 4.69	0.144
	Primary school	89.75 ± 4.96	
	Middle school	89.88 ± 4.67	
	High school	89.44 ± 3.69	
	Intermediate/Diploma	92.74 ± 5.58	
	Graduate	91.15 ± 5.64	
	Professional/Honours	94.50 ± 0.58	
Socioeconomic status (Modified Kuppuswamy)†	Upper Middle	92.10 ± 5.15	0.446
	Lower Middle	90.83 ± 5.37	
	Upper Lower	90.57 ± 4.36	
	Lower	87.80 ± 7.01	

Independent t-test in two-group comparison; †One way ANOVA test in more than two-group comparison, significant at p<0.05;

Quality of Intrapartum Care: Comfort, Participation, and Mistreatment Dimensions; WPRMC scores of the participants

Providing comfort (Factor 1):

Figure 2 shows that overall, 83% of mothers received comfortable care. The majority of the women stated that their caretakers provided them with appropriate care based on their requirements. 38% of participants did not always get a quiet and calm environment, 18% of women experienced that the staff were not friendly and cooperative, and 13% of participants did not get privacy. In comparison, 5% of the participants have never been introduced by their caregivers [Table 2]

Participatory care (Factor 2):

Participatory care represents 82% of women who were given information regarding their care and condition by staff, while 17% of women did not always receive information. Twenty per cent of participants were not informed about the progress of labour, 22% of participants' staff did not take permission for examination, and only 5% of participants were permitted to have a person of their choice during delivery [Table 2].

Mistreatment (Factor 3):

In this category, most women received adequate care only in one sub-item (My caregivers treated all women equally) 44% of the women did not receive adequate care. The overall scoring of mistreatment 86% of women received good care (Figure 2).

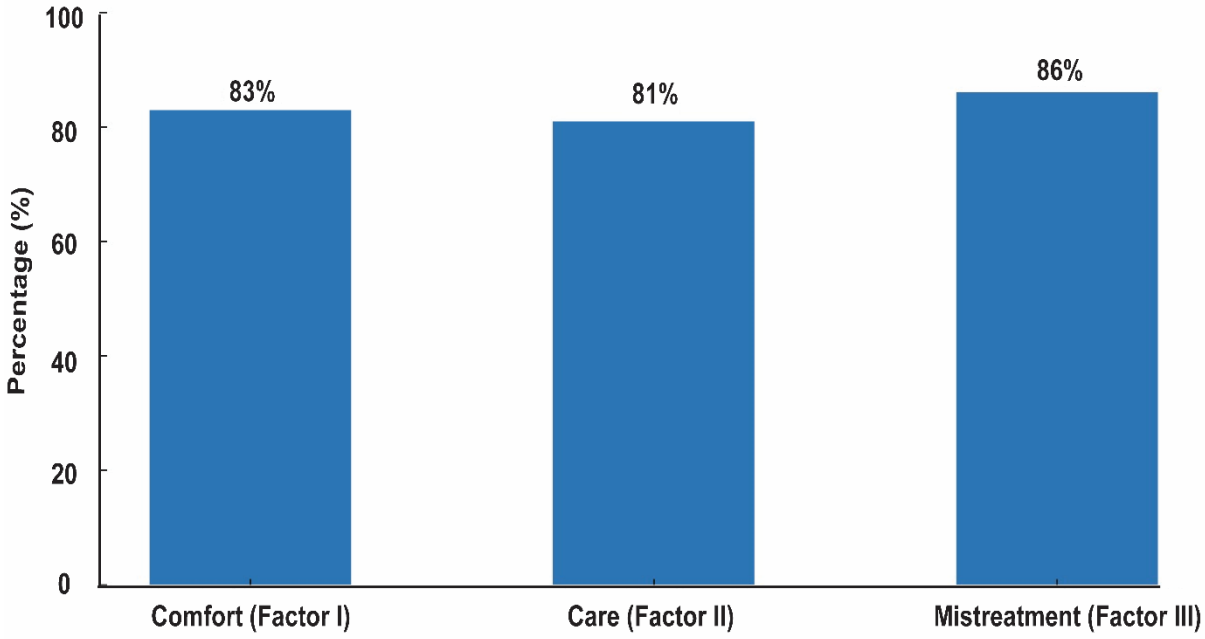

Figure 2: Overall scoring of women who received respectful maternity care

Factors associated with respectful maternity care

Independent t-test and one-way analysis of variance (ANOVA) were used to explore the relationship of WP-RMC scores and selected sociodemographic and obstetric characteristics, as appropriate. Statistically, no significant differences were noted in the overall WP-RMC scores between the different modes of delivery, age group, gravida, parity, educational status and socioeconomic status (Modified Kuppuswamy classification) (Table 3). Additionally, multiple linear regression analysis revealed that none of these variables was independently associated with women's experience of respectful maternity care (p value > 0.05 for all variables).

Discussion

There is significant evidence that institutional delivery and skilled birth attendants play an important role in reducing maternal and neonatal mortality. The focus of global maternal health programmes is therefore shifting to not only access to care, but also the quality of care, and the experience of care, at the time of childbirth [29,30]. With the increasing institutional delivery rates, policy attention is now shifting to improving care quality. The disrespect and mistreatment experienced by women in health care services during labor and delivery is one source of concern regarding poor quality of care [7, 8]. With this goal in mind, our study focused primarily on three factors: participatory care, providing comfort, and mistreatment, all of which were assessed using the WP-RMC standardised tool. According to this study, 83, 81, and 86 percent of women received comfort, care, and treatment in designated territory hospitals. Overall, 83% of women received respectful maternity care.

The percentage of women who face stressful childbirth varies by nation (the Netherlands 0.16%, Sweden 0.7% [9], Norway 21% [10], and Iran 37% [11]. Various intrapartum factors can influence the stressful birthing event. Panic of labor, lethargic to take analgesics, a lack of care [12], and the transfer of the newborn to the Neonatal Intensive Care Unit (NICU)[13], are just a few of the risk factors for stressful childbirth. Our findings are similar to the Mousa study, which found that 85 percent of their participants reported receiving respectful maternity care [14]. RMC was given to 83 percent of the women in this research. This result is higher than those found in Addis Ababa (21%), Ethiopian hospitals (66%), Bahir Dar, Ethiopia (57%), Uttar Pradesh, India (43%), and Kenya (80%), but lower than those found in Tanzania (85%) [15-19].

According to Sharma G et al. [20] findings, at least one sign of mistreatment was seen by all participants. Significant incidence was present in not allowing for choice of birthing position (92 %) and routine physical exploration of the uterus (80%) in private and government centres. Also, primigravida women had the highest mistreatment scores, contradicting our findings, as we discovered no significant difference between primigravida and multigravida mothers. Another study by Dey et al. also supports the Sharma et al. study, which claims that most participants (77.3%) self-reported mistreatment in at least 1 of the 17-item measures. Another study

reported that 22.4% of women were mistreated. However, in our study, the mistreatment score (14%) is less than in these studies.

For the current study, parity, educational status and socioeconomic status were also explored as factors associated with perceptions of respectful maternity care. However, none of these variables was significantly related to overall WP-RMC scores. This finding indicates a similar perception of care for women with varying levels of education and socioeconomic status in the context of this study. However, larger multicentric studies are warranted to further investigate the impacts of these factors and contextual variation between healthcare facilities.

To our knowledge, this study is the only study that has taken the participant response by using the WP-RMC standardised tool. Whereas all other studies observed respectful maternity care through interviews as their data collection method [17, 18, 21-23]. This study had several advantages. A one-of-a-kind quantitative community-based study in India investigated disrespect and mistreatment of women by caregivers in an institutional setup. This is one of the first studies undertaken in Uttarakhand that adopts a standard tool to measure women's experiences of respectful maternity care on various dimensions. An instrument used in the study was previously validated, WP-RMC, which is used to assess the domains of providing comfort, participative care, and mistreatment. However, because the unintended aspects of mistreatment for women are influenced by their perception of what defines mistreatment, self-declared data were considered a suitable measure. Because different types of mistreatment can take place concurrently, several sorts of abuse overlapped. This study has a number of limitations that need to be taken into account when interpreting the results. First, the questionnaire was filled out individually, but data collection took place in the healthcare facility just after childbirth. Social desirability bias and courtesy bias are not ruled out, however, because some women may have been unwilling to report negative experiences, for fear that their current or future childbirth care could be affected, or that of their newborn could be impacted. This bias might have led to an overestimation of the perceptions of respectful maternity care.

Secondly, the study was done in AIIMS Rishikesh, which is a tertiary-care teaching and referral hospital with relatively better infrastructural facilities, staffing patterns, availability of specialists and quality assurance systems as compared to many peripheral health units. Thus, the observed prevalence of respectful maternity care may not be a reflection of the experience of women in primary health centres (PHCs), community health centres (CHCs), district hospitals (DHs), and other resource-constrained settings in Uttarakhand, or in India. Hence, care needs to be taken when extrapolating these results to other comparable tertiary care centres.

Also, the sample size was small, and data collection took place during the COVID-19 pandemic, which posed a challenge to recruiting a larger sample size and to conducting more subgroup analyses. More representative evaluations of respectful maternity care practices at different levels of the health care system are needed through future multicentre studies in a wider range of health care settings and with larger populations. In addition, the categorization of scores for respectful maternity care was not conducted using externally validated psychometric scales but rather using the procedures of score standardization and thresholds set by the sample. Thus, caution should be used when comparing other populations and healthcare settings. In addition, although the WP-RMC questionnaire underwent standardized translation and pilot testing before implementation, the internal consistency reliability (Cronbach's alpha) of the Hindi-translated version was not re-evaluated in the present study. Future studies should evaluate the psychometric properties of the translated instrument in larger and more diverse Indian populations.

Conclusion

Findings from this research indicate that 83% of surveyed women experienced participatory care, comfort, and respectful treatment during childbirth. This indicates that most women viewed intrapartum care positively and respectfully. Nonetheless, there is still mistreatment in other low- and middle-income countries during maternity care. Disrespect, neglect, and abuse during childbirth not only indicate healthcare system failures but also violate basic human rights, especially women's rights to dignity, autonomy, and freedom from discrimination [24, 25]. Such experiences discourage women from seeking institutional delivery and undermine the maternal health programs that aim to reduce preventable maternal morbidity and mortality

Respectful maternity care (RMC) requires multi-level interventions, as it is the first of the three health system requirements. Addressing health system barriers that separate service providers from women is necessary, as empowered women and their providers are key to RMC delivery. Gunther's regular community–facility dialogues, participatory feedback

mechanisms, and accountability structures are examples that facilitate trust, transparency, and service utilisation. At the facility level, there is also a need for RMC training, supportive supervision, and recognition of continuous professional development at primary, secondary, and tertiary levels for all the physicians, midwives, and nursing staff.

Research indicates that training providers in communication and empathy boosts women's satisfaction with care, minimizes mistreatment, and increases compliance with RMC standards [19, 26]. The fairly high RMC within Rishikesh public health facilities indicates that even in resource-limited environments, adoption of rights-based, patient-centred frameworks is feasible. Positive childbirth experiences offer powerful incentives that encourage women and their families to use institutional delivery services, with expectations socialized in their networks, ultimately fostering trust in health systems for the entire community [27]. Understanding local determinants of women's experiences, including social contextual factors, health system constraints, and patient-provider interaction dynamics, is necessary to advance understanding of this issue. These factors can be used to develop focused strategies with proactive refinements that improve the technical quality and the interpersonal dynamics of maternity care [28].

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