RESEARCH PAPER

To estimate the Prevalence of Ethical Practices in Respectful Maternity Care in Healthcare Facilities : A Cross-Sectional Analytical Study.

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ABSTRACT

Background: Respectful Maternity Care (RMC)care that safeguards dignity, privacy, autonomy, and freedom from abuse—is an essential component of quality maternal health services. However, region-specific evidence from Maharashtra remains limited.

Objectives: To estimate the prevalence Ethical Constrains of respectful maternity care experiences in healthcare facilities of Karad, Maharashtra, and to evaluate role of socio demographic profile on RMC experiences among mother.

Methods: A facility-based cross-sectional analytical study was conducted from February 2023 to June 2024 among 203 mothers who had delivered within the previous six months and were attending immunization clinics at selected teaching, government, and private healthcare facilities in Karad. Data were collected using a pretested, validated interviewer-administered questionnaire. Ethical permission was obtained from institute IEC. Descriptive statistics summarized RMC domains, and chi-square tests assessed associations between socio-demographic variables and RMC experiences.

Results: Privacy during examination was maintained for 94.6% of mothers and verbal consent was obtained in 80.3%; however, only 21.7% reported provider self-introduction, indicating gaps in respectful communication. RMC compliance was consistently higher in private hospitals than in teaching and government facilities. Mothers with higher education, better socioeconomic status, employment, and urban residence reported significantly better RMC experiences compared to disadvantaged groups.

Conclusion: Respectful maternity care practices remain uneven across facility types, with major gaps in interpersonal communication and equity of care. Strengthening provider sensitization, monitoring mechanisms, and accountability particularly in public healthcare settings is essential. Targeted interventions addressing socio-demographic disparities are required to ensure universal access to dignified and respectful maternity services.

Keywords: Respectful maternity care; patient experience; maternal health; socio-demographic determinants

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Introduction

Respectful Maternity Care (RMC) is a rights-based approach to childbirth services that emphasizes women's dignity, autonomy, privacy, confidentiality, and freedom from abuse or coercion (1). The World Health Organization defines RMC as care that maintains dignity, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth (1,9). The White Ribbon Alliance further recognizes respectful care as a fundamental right of all childbearing women and an essential component of quality maternal health services (8). These principles are embedded within global maternal health quality frameworks that emphasize respectful, person-centred care as a key determinant of positive childbirth experiences and improved maternal–newborn outcomes (2).

Despite global commitments, disrespect and abuse during facility-based childbirth remain widespread. Multi-country evidence suggests that more than one-third of women experience some form of mistreatment during childbirth (3), while systematic reviews estimate the prevalence of obstetric violence to be nearly 59% worldwide (4). In India, pooled estimates indicate that approximately 71% of women report at least one form of disrespectful maternity care (5), with regional studies documenting persistent gaps across public health facilities (6). Social inequities, heavy provider

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workload, and systemic constraints contribute to these disparities, disproportionately affecting women from vulnerable socioeconomic groups (1,5). Although national initiatives such as LaQshya and SUMAN aim to strengthen quality and respectful maternity services, region-specific empirical data from Maharashtra particularly Karad remain limited. Therefore, the present study was undertaken to estimate the prevalence of respectful maternity care in health facilities in Karad, Maharashtra, to generate local evidence for targeted quality-improvement interventions (2,7).

MATERIALS AND METHODS

- **STUDY DESIGN:** Cross Sectional Analytical study.
- **PLACE OF STUDY:** Immunisation clinics of Krishna Hospital, KIMS, KVV ,Karad , Sau Venutai Chavan Sub-District hospital ,Karad , Maharashtra and Private Nursing Homes.
- *STUDY PERIOD: - 2 year 5 months (From Feb 2023 to June 2024)*
- **STUDY SUBJECTS:**

1) Mothers delivered within last 6 month & attending immunisation clinic.

Inclusion Criteria

- Mothers Delivered Within Last 6 Month & Attending Immunisation Clinic.

Exclusion Criteria

- Mothers Delivered More Then 6 months..

SAMPLE SIZE

The sample size is calculated using the formula: $n = 4*P*Q / L^2$

P = Prevalence, L = Precision = 7, Q = 100 – P

Table.2. Prevalence of RMC factors to calculate Sample Size.[22]

Domains	**Abuse n (%) Present.**	**Abuse n (%) Present.**	***$n = 4*p*q/L^2$*** **P= Prevalence L= Precision**
Divinity and Respect	170(73.6)	61(26.4)	158
Support and care	16(72.3)	64(27.7)	163
Privacy and confidentiality	65(28.1)	166(71.9)	164
Trust	22(9.5)	20(90.5)	70
Facility and environment	179(77.5)	52(22.5)	142
Communication and autonomy	130(56.3)	101(43.7)	**200**
Predictability and transparency of payment	174(75.3)	57(24.7)	151

Domain wise Maximum of minimum sample sizes determined is 200. Thus minimum 203 mothers were included as per inclusion-exclusion criteria.

SAMPLING TECHNIQUE

1) Mothers: Data was collected via Random Sampling Technique (12/week max no. of mother's were interviewed in a Succession as they come, that is 6 from Krishna hospital and 6 from Sau-venutai Chavan sub-district hospital) on there respective immunisation days).

- These two selected hospitals are apex public healthcare institutions in Karad town and function as major referral centres catering to both urban and rural populations. The immunization clinics in these facilities receive a high footfall of postnatal mothers, irrespective of their place of delivery, due to limited private immunization services in the region.
- This allowed us to achieve wide and representative coverage of mothers, including those who delivered in private nursing homes, sub-centres, or the selected hospitals themselves. Hence, these facilities served as appropriate data collection sites to capture diverse maternal experiences across healthcare sectors.

ETHICAL CONSIDERATION

- Ethical clearance for the study was obtained from the Institutional Ethics Committee of Krishna Institute of Medical Sciences Deemed University (KIMSDU) prior to the commencement of data collection, dated 15th March 2023 (Ref. No. KIMSDU/IEC/02/2023).
- Administrative permission for conducting data collection at Krishna Hospital, Karad, was taken from the Medical Director on 4th April 2023 before collecting the data from the institute.

- Additionally, approval to collect data at the immunisation clinic of Sau-Venutai Chavan Sub-District Hospital was obtained from the Medical Superintendent of the Institution on 18th March 2023 (Ref. No. KIMS/PSM/343/2023).
- Written informed consent was obtained from all participants prior to their inclusion in the study. Strict confidentiality and privacy measures were observed throughout the process, and access to the data was restricted solely to the principal investigator.

METHODOLOGY :

- Data from postnatal mothers were collected at two healthcare institutions on their respective immunisation clinic days. At Krishna Hospital, Karad, mothers were interviewed every Thursday, while at Sau-Venutai Chavan Sub-District Hospital, Karad, data were collected every Monday. This schedule was followed consistently until the required sample size was achieved.
- Prior to participation, the purpose, methodology, and potential benefits of the study, to both society and the individual participants, were clearly explained to all eligible mothers Informed written consent was obtained from each participant before data collection commenced. Participation was entirely voluntary. All data were collected anonymously, with strict measures taken to ensure confidentiality and privacy. Access to the collected data was restricted solely to the principal investigator.

STUDY TOOL

- A pre-tested, modified, and validated questionnaire was used as the primary data collection tool, administered through face-to-face interviews.
- **Content validity** was ensured by obtaining expert review and feedback from faculty members and practitioners with expertise in maternal health and community medicine.
- **Construct validity** was assessed through a pilot study involving the first 20 mothers. Based on the responses and observed clarity of the items, necessary modifications were made. The revised tool was then re-tested and finalized for use in the main study and reliability was checked using cronbach alpha which was acceptable.

STATISTICAL ANALYSIS

- The data collected through the interview schedules were initially exported to local spreadsheets and organized using Microsoft Excel for preliminary cleaning and tabulation.
- **Descriptive statistics**, including frequencies and percentages, were used to summarize socio-demographic variables and response distributions.
- **For inferential statistics, Chi-square tests** were employed to determine associations between categorical variables related to experiences and perceptions of Respectful Maternity Care (RMC).

RESULT

Table 1. Socio-Demographic Profile of Mothers(N=203)

Education	**Frequency**	**Percent**
Illiterate	2	1.0
Middle And Primary School	23	11.3
High School	42	20.7
Intermediate/Diploma	7	3.4
Graduate	106	52.2
Professional Degree	23	11.3
Total	203	100.0
Type Of Family	Frequency	Percent
Nuclear Family	62	30.5
Three Generation Family	70	34.5
Joint Family	71	35.0
Total	203	100.0
Occupation	Frequency	Percent
Unemployed	156	76.8
Skilled Worker	2	1.0
Clerical/Shop/Farm	4	2.0
Professional/Semi-Professional	41	20.2
Total	203	100.0
Age	Frequency	Percent
15-20years	4	2.0
21-25years	84	41.4
26-30 Years	98	48.3

31-35 Years	16	7.9
36-40years	1	0.5
Total	203	100.0
Address	Frequency	Percent
Urban Slum	115	56.7
Rural Slum	4	2.0
Urban	53	26.1
Rural	31	15.3
Total	203	100.0
Religion	Frequency	Percent
Hindu	187	92.1
Muslim	15	7.4
Christian	1	0.5
Total	203	100.0
Socio Economic Status	Frequency	Percent
Class I	87	42.9
Class II	61	30.0
Class III	38	18.7
Class IV	17	8.4
Total	203	100.0

- The majority of participants were in the 26–30 years age group (98; 48.3%), followed by those aged 21–25 years (84; 41.4%). Educationally, over half were graduates (106; 52.2%), with others holding high school qualifications (42; 20.7%) or professional degrees (23; 11.3%). Only a few had studied up to primary/middle school (23; 11.3%), intermediate/diploma (7; 3.4%), or were illiterate (2; 1.0%).
- In terms of occupation, most participants were unemployed (156; 76.8%). A notable proportion were professional or semi-professional workers (38; 18.7%), with very few employed as clerical/shop/farm workers (4; 2.0%), skilled workers (2; 1.0%), or unskilled (3; 1.5%).
- Family structure was nearly evenly distributed, with joint families (71; 35.0%) and three-generation families (70; 34.5%) being slightly more common than nuclear families (62; 30.5%).
- The majority resided in urban areas, with maximum from urban slums115 (56.7%), followed by 53 (26.1%) from non-slum urban areas, and 31 (15.3%) from rural regions.
- Religion-wise, the participants were predominantly Hindu (187; 92.1%), with a minority being Muslim (15; 7.4%) and Christian (1; 0.5%).
- Socio-economic classification showed that maximum belonged to Class I (87; 42.9%) and Class II (61; 30.0%), followed by Class III (38; 18.7%) and Class IV (17; 8.4%)

Table 2.Association of Ethically Factors of Respectful Maternity Care Practices.

2.1.Did the care provider introduced themselves to you.					
Response	**Place of Delivery**				
	Teaching Hospital	**Governm**	**Private Hospital/ Nursing Homes**		
Yes N (%)	**10**	**2**	**32**	**44**	**χ = 89.5**
	8.3%	5%	74.4%	21.70%	**p = 0.001**
No N (%)	110	38	11	159	
	91.7%	95%	25.6%	78.30%	
2.2. Did the care provider take verbal consent before any action or practice like major procedure, sampling and inserting an iv line etc.					
Yes N (%)	95	26	42	163	**χ = 14.2**
	79.2%	65%	97.7%	80.30%	**p = 0.001**
No N (%)	25	14	1	40	
	20.8%	35%	2.3%	19.70%	

2.3. Was your privacy maintained while examination using the curtain.					
Yes N (%)	113	36	43	192	$X^2 = 4.14$
	94.2%	90%	100%	94.60%	p = 0.126
No N (%)	7	4	0	11	
	5.8%	10%	0.00%	5.40%	
2.4. Improper hand washing by health professionals during care delivery or touching the unsterile field after wearing gloves.					
Yes N (%)	11	3	2	16	$X^2 = 0.89$
	9.2%	7.5%	4.7%	7.90%	p = 0.638
No N (%)	109	37	41	187	
	90.8%	92.5%	95.3%	92.10%	
Total	120(100%)	40(100%)	43(100%)	203(100%)	

Table 2 Assessed ethically respectful maternity and revealed considerable variation across different healthcare settings, particularly between public (teaching and government) and private institutions.

2.1. Care Provider Introduction:

Only **44 out of 203 mothers (21.7%)** reported that the care provider introduced themselves, with the highest in **private hospitals (32; 74.4%)**, followed by **teaching hospitals (10; 8.3%)**, and the least in **government hospitals (2; 5.0%)**. A large majority **(159; 78.3%)** did not receive any introduction, with **teaching hospitals alone accounting for 110 cases (91.7%)**.

The difference was statistically significant ($\chi^2 = 89.5$, **p = 0.001**), reflecting a major gap in respectful communication in public facilities.

2.2. Verbal Consent Before Procedures:

A total of **163 mothers (80.3%)** confirmed that verbal consent was obtained before procedures, with the highest compliance in **private hospitals (42; 97.7%)**, followed by **teaching hospitals (95; 79.2%)**, and lower in **government hospitals (26; 65.0%)**. However, **40 women (19.7%)** reported that no consent was taken—**25 in the teaching hospital (20.8%)**, and **14 in government hospitals (35.0%)**. The association was statistically significant ($\chi^2 = 14.2$, **p = 0.001**), indicating better adherence in private facilities and highlighting the need for consent protocol enforcement in public sectors and apex institutes.

2.3. Privacy During Examination:

Privacy was reportedly maintained for **192 participants (94.6%)**, with full compliance in **private hospitals (43; 100%)**, high in **teaching hospitals (113; 94.2%)**, and **government hospitals (36; 90.0%)**.

A small proportion **(11; 5.4%)** experienced compromised privacy, all from public institutions—**7 from teaching (5.8%)** and **4 from government hospitals (10.0%)**. Though the overall difference was **not statistically significant ($\chi^2 = 4.14$, p = 0.126)**, private hospitals showed relatively more consistent privacy assurance than public facilities.

2.4. Observed Improper Hand Hygiene:

The study found that **16 women (7.9%)** reported witnessing improper handwashing or touching of unsterile surfaces, highest in **teaching hospitals (11; 9.2%)**, followed by **government hospitals (3; 7.5%)**, and least in **private hospitals (2; 4.7%)**. The remaining **187 participants (92.1%)** did not observe such lapses.

The association between facility type and hygiene practices was **not statistically significant ($\chi^2 = 0.89$, p = 0.638)**, though a higher concern was noted in the teaching hospital.

These results highlight significant gaps in respectful maternity care across healthcare settings. Courteous communication, informed consent, privacy, and hygiene practices were inconsistently upheld, **government hospitals performed markedly worse**, followed by **teaching hospitals**, with **private hospitals** demonstrating better performance. The shortfalls observed in public institutions, such as lack of provider introductions, low consent rates, inadequate privacy, and hygiene lapses , suggest systemic issues in institutional behaviours and resource limitations that undermine women's dignity and rights during childbirth.

Private hospitals, likely benefitting from **lower patient loads** and **greater accountability**, showed improved adherence. These findings support the study's objectives and reinforce the **urgent need for targeted interventions in provider training, protocol enforcement, and institutional accountability**, ensuring that all women receive **respectful, autonomous, and safe maternity care** regardless of delivery setting

Figure 1. Impact of socio-demography profile on Respectful maternity care delivery.

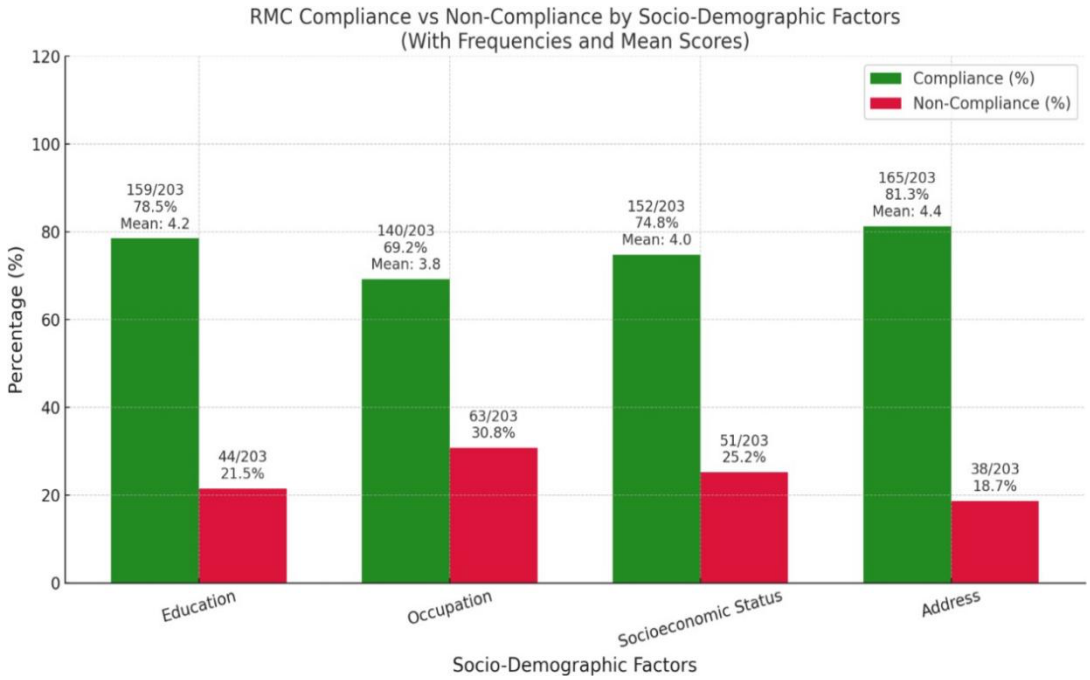

Figure 1. Describe the disparities seen on the basis of socio-demography profile on Respecfult maternity care delivery.

Figure describe Frequencies, percentages, and mean scores of the compliance on green bars and non-compliance on red bars .

1. **Education**

- **Compliance: 159/203 (78.5%) | Mean Score: 4.2**
- **Non-Compliance: 44/203 (21.5%)**

Educated mothers were more likely to experience respectful care, with high compliance and satisfaction. However, nearly one-fifth still reported ethical or communication lapses.

2. **Occupation**

- **Compliance: 140/203 (69.2%) | Mean Score: 3.8**
- **Non-Compliance: 63/203 (30.8%)**

Working mothers or those with decision-making autonomy reported better.
care. Nonetheless, nearly one-third of mothers lacked RMC, often tied to informal labor or homemaker status.

1. **Socioeconomic Status**

- **Compliance: 152/203 (74.8%) | Mean Score: 4.0**
- **Non-Compliance: 51/203 (25.2%)**

Mothers from higher socioeconomic classes enjoyed more respectful services, possibly due to better facility access. Gaps remain for economically weaker sections.

2. **Locality (Urban vs Rural)**

- **Compliance: 165/203 (81.3%) | Mean Score: 4.4**
- **Non-Compliance: 38/203 (18.7%)**

Urban mothers had the highest RMC compliance and mean satisfaction scores, indicating benefits of better infrastructure and monitoring. Rural mothers remain relatively underserved.

- This comparative analysis clearly demonstrates that socio-demographic factors significantly influence the experience of respectful maternity care. Mothers with higher education levels, formal employment, urban residency, and better socioeconomic status were more likely to receive respectful and dignified treatment during childbirth.
- These groups not only showed higher compliance percentages but also reported higher mean scores, reflecting a more consistent and satisfactory care experience.
- Conversely, the relatively high non-compliance rates were seen in less educated, economically disadvantaged, and rural mothers highlight structural and behavioural disparities in care delivery. These findings highlight the need for economical empowerment and education and awareness counselling regarding the RMC services of mothers to stand for their right to- respectful maternity care services and targeted health system interventions.

DISCUSSION

The present study conducted in Karad identified substantial gaps in the delivery of respectful maternity care (RMC), particularly in interpersonal communication practices. Only 21.7% of mothers reported that healthcare providers introduced themselves, with markedly higher compliance in private hospitals compared to teaching and government institutions. Although procedural aspects such as obtaining verbal consent (80.3%) and maintaining privacy during examination (94.6%) showed relatively better compliance, variations across facility types

indicate that institutional workload and systemic factors may significantly influence respectful care delivery. Similar findings have been reported globally, where communication-related respectful practices are often less consistently implemented than clinical components of care (11).

Socio-demographic characteristics were also significantly associated with RMC experiences in the present study. Mothers with higher education, better socioeconomic status, urban residence, and employment reported comparatively higher compliance with respectful maternity care practices, whereas women from disadvantaged and rural backgrounds experienced lower levels of respectful care. Comparable socio-demographic disparities have been reported in international studies demonstrating that women from lower socioeconomic groups and marginalized communities are more likely to experience disrespect and abuse during childbirth (12).

National-level Indian evidence similarly indicates persistent public–private differences in RMC implementation, with private healthcare facilities demonstrating better compliance with communication, consent, and dignity-related practices than public-sector institutions (13). Regional studies from Maharashtra further support these findings, reporting inconsistent adherence to respectful communication and patient involvement practices in high-volume public hospitals despite acceptable compliance in clinical care domains (14,15).

Overall, the findings of the present study suggest that while certain structural components of maternity care are reasonably maintained, interpersonal and communication-related aspects of respectful care require focused strengthening. Targeted provider sensitization, supportive supervision, and institutional accountability mechanisms under national initiatives such as LaQshya and SUMAN are essential to ensure equitable and consistent implementation of respectful maternity care across healthcare settings

Strengths

- Inclusion of mothers from multiple delivery settings (teaching hospitals, government hospitals, and private nursing homes) enabled comparison across facility types.
- Data collection from postnatal mothers attending immunization clinics allowed inclusion of women irrespective of the place of delivery, improving representativeness.
- Use of a pretested, validated questionnaire ensured consistency and reliability of collected data.
- Assessment of both facility-level practices and socio-demographic determinants provided a comprehensive understanding of respectful maternity care (RMC) experiences.

Limitations

- The study relied on self-reported maternal experiences, which may be subject to recall bias and social desirability bias..
- The study was conducted in selected facilities of Karad, which may limit the generalizability of findings to other regions.

Public Health Implications

- The observed gaps in communication-related respectful care highlight the need for structured provider sensitization and communication-skills training.
- Strengthening monitoring mechanisms and accountability systems in public healthcare facilities is essential to ensure consistent implementation of respectful maternity care practices.
- Targeted interventions are required to address socio-demographic disparities, particularly among rural, less educated, and economically disadvantaged mothers.
- Integration of respectful maternity care indicators into existing maternal health quality-improvement initiatives can support equitable and dignified maternity services across healthcare settings.

REFRENCE

1. White Ribbon Alliance. Respectful Maternity Care Charter. 2022.
2. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: WHO; 2018.
3. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. 2014.
4. Bohren MA, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS Med. 2015.
5. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility- based childbirth. USAID/TRAction Project; 2010.
6. Wassihun B, Zeleke S. Compassionate and respectful maternity care during facility-based childbirth and women's intent to use maternity service in Bahir Dar, Ethiopia. BMC Pregnancy Childbirth. 2018.
7. Amini L, et al. Iranian women's perception of respectful maternity care: A cross-sectional study. BMC Pregnancy Childbirth. 2021.
8. National Institute of Health and Family Welfare. Disrespect and abuse in maternity care in India. NIHFW; 2021.
9. Ansari H, Yeravdekar R. Respectful Maternity Care in India: A Systematic Review and Meta-analysis. 2020.
10. Sharma G, et al. Respectful Maternity Care in Manipur: A cross-sectional study. Indian J Public Health. 2019.
11. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al.The mistreatment of women during childbirth in health facilities globally: A

mixed-methods systematic review. *PLoS Med.* 2015;12(6):e1001847.

12. Wassihun B, Zeleke S.Compassionate and respectful maternity care during facility-based childbirth and women's intent to use maternity service in Bahir Dar, Ethiopia. *BMC Pregnancy Childbirth.* 2018;18:294.
13. Ansari H, Yeravdekar R.Respectful maternity care in India: A systematic review and meta-analysis. *J Postgrad Med.* 2020;66(3):133-140.
14. Sharma G, Penn-Kekana L, Halder K, Filippi V.An investigation into mistreatment of women during labour and childbirth in India: A mixed-methods study. *Indian J Public Health.* 2019;63(2):108-115.
15. Gogoi A, Zodpey S, Farah S, Ramani S.Respectful maternity care practices in public health facilities in Maharashtra, India: A cross-sectional assessment. *WHO South East Asia J Public Health.* 2022;11(2):120-126.