International Journal of Community Medicine and Public Health
Devi G et al. Int J Community Med Public Health. 2025 Dec;12(12):5529-5535
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20254025

Original Research Article

Respectful maternity care: a comparative exploration of mothers' knowledge and experiences in Meghalaya

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Received: 22 July 2025
Accepted: 14 November 2025

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ABSTRACT

Background: Pregnancy and childbirth are vulnerable times for women, making respectful maternity care (RMC) essential to ensure safety, dignity, and autonomy. Despite global progress, mistreatment during childbirth remains common, affecting women's healthcare choices. This study assessed mothers' knowledge and experiences of RMC in selected healthcare facilities in Meghalaya, India, comparing urban and rural settings and exploring the link between their knowledge and experiences.
Methods: A descriptive cross-sectional comparative study was conducted between January 15 and February 10, 2024, among 120 mothers in selected healthcare facilities. A structured questionnaire assessed knowledge, while the Indian person-centered maternity care scale evaluated experiences. Data analysis included descriptive statistics, independent t-tests, and correlation coefficients.
Results: The study revealed that 65.8% of mothers had poor knowledge regarding respectful maternity care, with urban mothers showing significantly lower knowledge levels compared to rural mothers ($p \leq 0.012$). However, 86.7% of mothers reported positive experiences with respectful maternity care, with no notable difference between urban and rural mothers ($p=0.287$). A weak positive correlation ($r=0.17$) was identified between mothers' knowledge and their experiences of RMC.
Conclusions: The findings emphasize a knowledge gap regarding respectful maternity care among mothers, especially in urban areas, despite overall positive experiences. Increasing awareness and education on RMC is essential. Introducing ongoing quality improvement efforts and feedback systems in healthcare facilities can further strengthen respectful maternity care, ensuring the dignity and rights of all childbearing women are respected.

Keywords: Experience, Knowledge, Meghalaya, Respectful maternity care, Urban-rural comparison

INTRODUCTION

Pregnancy and childbirth are critical and vulnerable periods in women's lives, carrying deep cultural and personal significance for families worldwide.[1] While "safe motherhood" often focuses on physical safety, it must also include the protection of women's fundamental human rights, such as autonomy, dignity, emotional well-being, and the right to companionship during care. Issues like gender equality and violence must also be considered, making it essential to expand the concept of safe motherhood beyond preventing illness or death.[2,3]

"The respectful maternity care charter: the universal rights of childbearing women," issued by the "White Ribbon Alliance" in 2011, serves as a key advocacy tool in many countries.[4] In 2014, the "World Health Organization" reaffirmed childbirth as a fundamental human right, further advancing the concept of respectful care.[5] In December 2017, India's "Ministry of Health and Family Welfare" launched the "LaQshya" initiative to improve labor room standards and promote respectful maternity care. LaQshya aims to reduce maternal and newborn deaths, enhance care quality during delivery and

postpartum, and improve patient satisfaction in public health facilities.[6]

According to the "World Health Organization", respectful maternity care (RMC) ensures that women maintain dignity, privacy, and informed choice, while being free from harm, mistreatment, and abuse, with continuous support during labor and childbirth. Mistreatment during childbirth is a global issue, violating women's rights and discouraging them from seeking future obstetric care. RMC encourages positive behaviors from healthcare workers to enhance women's satisfaction and eliminate abuse or disrespect.[7]

In 2020, 287,000 women died from pregnancy and childbirth-related causes, with 95% of these deaths occurring in low- and lower-middle-income countries. Sub-Saharan Africa and Southern Asia accounted for 87% of global maternal mortality. In India, the "maternal mortality ratio (MMR)" dropped to 97 per 100,000 live births during 2018-20, thanks to improved hospital care, though disrespect and abuse (D and A) in maternity services remain a concern, impacting healthcare trust.[8]

The frequency of D and A in Indian states ranges from 15% to 98%, with the most common forms being non-consented care, lack of confidentiality, and physical abuse.[9] A 2018 study in New Delhi reported that 98% of labouring women experienced mistreatment, including 93% verbal abuse.[10] Another 2019 study in Aligarh found that 84.3% of women faced abuse during facility-based deliveries, particularly in public healthcare institutions.[11]

Understanding RMC is crucial for safeguarding women's rights and ensuring compassionate maternity care throughout pregnancy, delivery, and postpartum. Research in this area informs policies, healthcare provider training, and helps address treatment disparities. Despite numerous studies across India on RMC, there is limited research on mothers' experiences and knowledge of RMC in Meghalaya, making this study vital to clarifying these gaps in understanding and care practices in the region.

METHODS

Study design

A cross-sectional comparative study was conducted from January 2024 to February 2024 to assess the knowledge and experiences of postnatal mothers who delivered in selected urban and rural health centers in Meghalaya. The study took place at the Maternal and Child Hospital in Shillong (urban), as well as one Community Health Centre, and 2 Primary Health Centre (rural) at a distance of 60 km, 38 km, and 35 km respectively from "North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS)" to facilitate a comparison based on the research feasibility based on convenience sampling.

Study population

Participants included were postnatal mothers aged 18 years and above who had delivered within ten days in a selected healthcare facility and were available in the hospital/centres at the time of data collection. Participants who were excluded from the study were those who had delivered via elective or emergency cesarean section and had any complication following delivery, and Mothers who were not willing to participate. The required sample size was calculated to be 110 individuals using the prevalence estimation formula (10% attrition rate) and then divided it equally into two settings for comparison, with the following statistical assumptions: a Z-value of 1.96 corresponding to a 95% confidence interval (CI), the prevalence of maternal knowledge was determined to be 15%, based on findings from a study conducted by Alageswari et al.[12] The 120 participants were enrolled in the study, with 60 from each of the urban and rural areas, using a purposive sampling technique based on the inclusion and exclusion criteria.

Inclusion criteria

Mothers who had vaginal delivery at healthcare facilities of Meghalaya were included.

Exclusion criteria

Mothers who had a delivery of their child via elective or emergency caesarean section and has any complication following delivery were excluded.

Ethics statement

The research was approved by the College of Nursing's research committee which was then forwarded for review to the "thesis review and monitoring committee, North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS)" and the "institute ethical committee (IEC) North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS)" under thesis number T97/2023/97 for final approval. After approval from IEC, formal consent was obtained from the Directorate of Health Services (MI), Shillong, and the respective health center authorities. Participants were informed of the study's purpose and provided an information sheet outlining key details. Written consent was obtained after addressing participants' questions, with the option to withdraw at any time.

Variables

Independent variables were the demographic profile including age, educational status, occupational status, religion, area of residence, number of pregnancies, information about respectful maternity care, and the source of information.

The outcome variables were the knowledge and experience of mothers regarding respectful maternity care.

Data collection tools and techniques

Data collection was a critical component of this study and was executed using research instruments developed through a structured and systematic process. The development involved an extensive review of relevant literature, regular consultations with research supervisors, feedback from peers, and expert evaluations to ensure the content was clear, relevant, and aligned with the study objectives. Content validity and reliability of the tools were also established. Three tools were utilized: a semi-structured questionnaire to obtain socio-demographic data through face-to-face interviews; a structured questionnaire to assess participants' knowledge of respectful maternity care (RMC); and the Indian person-centered maternity care (PCMC) scale, a standardized 27-item Likert-type tool used to evaluate women's labor and delivery experiences within the Indian healthcare context.

The tool development process was carried out in several stages. Initially, questionnaires were designed based on a comprehensive literature review to align with the research aims. A preliminary draft of the instruments and a checklist for content validation were prepared under the guidance of the research supervisor. The data collection tool comprised three sections: section I included 11 items related to socio-demographic characteristics; section II originally contained 12 knowledge-based questions, later refined to 7 items; and section III incorporated the Indian PCMC scale. For section II, a blueprint was created to cover key aspects of RMC, including its definition, significance, and core components. Each knowledge question had four options, with one correct response scored as one point. A content validation checklist was also developed to evaluate the relevance, clarity, and adequacy of each item.

To ensure content validity, the tools were reviewed by nine subject matter experts from the fields of community health nursing, obstetrics and gynecology, and community medicine. Their feedback was incorporated into revised versions of the tools. Linguistic validation was also performed by translating the tools into Khasi and Hindi, followed by back-translation into English, with support from language experts, to ensure cultural and contextual accuracy. Final revisions were made based on both expert input and guidance from the research supervisor.

Section I collected socio-demographic information such as age, education, occupation, religion, type of family, place of residence, parity, place and type of delivery, duration of hospital stays, and awareness of RMC. Section II assessed knowledge on RMC through seven multiple-choice questions, with one point awarded for each correct answer. The total possible score was 7, where a score of 4 or more indicated good knowledge and a score of 3 or less indicated poor knowledge. Section III employed the Indian Person Centered Maternity Care Scale (available under common attribution 4.0) (PCMC) scale to evaluate mothers' experiences during childbirth, with scores of 51 and above indicating a good experience, and scores of 50 or below indicating a poor experience.[13]

The content validity of the instruments was confirmed through expert review. Reliability testing was conducted using the Spearman-Brown formula for the knowledge questionnaire, resulting in a coefficient of 0.892, and Cronbach's alpha for the Indian PCMC scale [20], yielding a value of 0.92, both indicating high internal consistency. A pilot study was conducted from October 16 to 21, 2023, involving 20 postnatal mothers from two hospitals in an urban area and one CHC in a rural area in Meghalaya. Interviews were conducted using the validated tools and lasted approximately 20-25 minutes. The results of the pilot study confirmed that the instruments were reliable, valid, and feasible for use in the main study.

Statistical analysis

The raw data was entered and organized using Microsoft Excel 2019 MSO (version 2006) and analyzed with the "Statistical Package for Social Sciences (SPSS) version 22. Data analysis was conducted per the study's objectives, employing descriptive statistics such as mean, standard deviation, frequency, and percentage based on variable distribution. An independent t-test was used to compare knowledge and experience, while the correlation coefficient was applied to assess the relationship between knowledge and experience.

RESULTS

Socio-demographic characteristics

Table 1 shows that 30 (50%) of the postnatal mothers in both urban and rural areas are aged 18-25. Regarding education, 17 (28.3%) of urban mothers completed upper primary, while 20(33.3%) of rural mothers reached secondary level. The vast majority of mothers are housewives, with 93.3% in urban areas and 95% in rural areas. Most urban 49 (81.7%) and rural 42 (70%) mothers identify as Christian. Additionally, 37 (61.7%) of urban mothers and 44 (73.3%) of rural mothers come from nuclear families. In terms of childbirth, 25 (41.7%) of urban and 26 (43.3%) of rural mothers are 2nd or 3rd gravida. Interestingly, 35 (58.3%) of urban mothers are unfamiliar with respectful maternity care, whereas 46 (76.7%) of rural mothers are aware of RMC.

Knowledge regarding respectful maternity care

Figure 1 highlights the awareness levels of 120 mothers, 60 each from both urban and rural healthcare settings, regarding various components of respectful maternity

care (RMC). In urban areas, 11 mothers (18.3%) and in rural areas, 18 mothers (30%) understood the meaning of disrespect and mistreatment. Knowledge of confidential care was reported by 15 urban mothers (25%) and 24 rural mothers (40%). Understanding of freedom from bias was observed in 9 urban (15%) and 17 rural mothers (28.3%). Awareness of equitable treatment was found in 11 urban (18.3%) and 21 rural mothers (35%). The concept of RMC was recognized by 18 urban (30%) and 31 rural mothers (51.6%). Additionally, 20 urban mothers (33.3%) and 36 rural mothers (60%) were aware that RMC should be provided, while 9 urban (15%) and 26 rural mothers (43.3%) understood the importance of ensuring a woman's privacy during maternity care.

Table 1: Socio-demographic variables of the participants (n=120).

Demographic variable	Urban (n=60)	Rural (n=60)
	N (%)	N (%)
Age (in years)		
18-25	30 (50.0)	30 (50.0)
26-34	24 (40.0)	27 (45.0)
35-43	06 (10.0)	03 (05.0)
Education		
Illiterate	0 (0)	02 (03.3)
Primary school	13 (21.7)	11 (18.3)
Middle school	17 (28.3)	17 (28.3)
High school	15 (25.0)	20 (33.3)
Intermediate/diploma	06 (10.0)	07 (11.7)
Graduate	09 (15.0)	03 (05.0)
Occupation		
Housewife	56 (93.3)	57 (95.0)
Business	02 (03.3)	01 (01.7)
Farmer	01 (01.7)	01 (01.7)
Teacher	01 (01.7)	01 (01.7)
Religion		
Christian	49 (81.7)	42 (70.0)
Hindu	07 (11.7)	01 (01.7)
Khasi	04 (06.7)	17 (28.3)
Type of family		
Nuclear	37 (61.7)	44 (73.3)
Joint	23 (38.3)	16 (26.7)
Gravida		
Primi	18 (30.0)	23 (38.3)
2nd and 3rd gravida	25 (41.7)	26 (43.3)
4th gravida and above	17 (28.3)	11 (18.4)
Place of delivery		
Urban	60 (100)	0
Rural	0	60 (100)
Information about respectful maternity care		
Yes	25 (41.7)	46 (76.7)
No	35 (58.3)	14 (23.3)

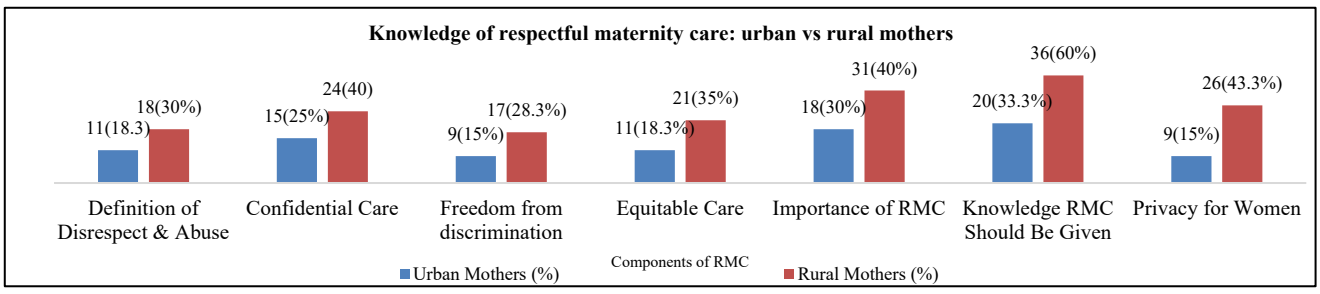

Figure 1: Percentage distribution of knowledge score on respectful maternity care on different components among the mothers delivering in the selected urban and rural settings.

Table 2 provides an overview of the knowledge and experience of respectful maternity care in urban and rural healthcare facilities. In terms of knowledge, 14 (23.3%) of urban participants demonstrated good knowledge, while 46 (76.7%) had poor knowledge, with a mean score of 1.23 (SD 0.426). In contrast, 24 (45.0%) of rural participants showed good knowledge, while 33 (55.0%) had poor knowledge, with a higher mean score of 1.45 (SD 0.501). When it comes to experience, 50 (83.3%) of urban participants reported good experiences, compared to 54 (90.0%) in rural areas. The mean experience scores were slightly higher in rural areas (1.90, SD 0.302) compared to urban areas (1.83, SD 0.376). Overall, rural participants exhibited better knowledge and experience in respectful maternity care than their urban counterparts.

Table 2: Level of knowledge and experience on respectful maternity care among mothers delivered in selected healthcare facilities (n=120).

Respectful maternity care	Health care facility	Level	N (%)	Mean (SD)
Knowledge	Urban (n=60)	Good (≥4)	14 (23.3)	1.23 (0.426)
		Poor (≤3)	46 (76.7)	
	Rural (n=60)	Good (≥4)	27 (45.0)	1.45 (0.501)
		Poor (≤3)	33 (55.0)	
Experience	Urban (n=60)	Good (≥51)	50 (83.3)	1.83 (0.376)
		Poor (≤50)	10 (16.7)	
	Rural (n=60)	Good (≥51)	54 (90.0)	1.90 (0.302)
		Poor (≤50)	6 (10.0)	

Table 3: Differences in mothers' knowledge and experience of respectful maternity care between urban and rural healthcare facilities (n=120).

Variables	Health care facility	Mean (SD)	"t" value	P value
Knowledge	Urban (n=60)	1.23 (0.42652)	-2.549	0.012*
	Rural (n=60)	1.45 (0.50169)		
Experience	Urban (n=60)	1.83 (0.37582)	-1.070	0.287
	Rural (n=60)	1.90 (0.30253)		

*P≤0.05.

Comparison of mother's knowledge and experience regarding RMC

Table 3 presents the results of an independent t-test using SPSS version 22, indicating a significant difference in knowledge of respectful maternity care between urban and rural mothers (t=0.012, p<0.05), with rural mothers having better knowledge. However, a second t-test on experiences showed no significant difference (t=0.287, p>0.05) between urban and rural mothers in the selected healthcare facilities in Meghalaya.

Correlation between knowledge and experience

Table 4 shows a weak positive correlation (r=0.170) between mothers' knowledge and experience of respectful maternity care.

Table 4: The relationship between mothers' knowledge and experience of respectful maternity care in selected healthcare facilities.

Variables	Pearson correlation coefficient (r)	P value
Knowledge	0.170	0.063
Experience		

However, the p value (0.063) indicates the relationship is not statistically significant, suggesting that while experience may improve with increased knowledge, the correlation is not strong enough to be conclusive.

DISCUSSION

In this study, 50% of both urban and rural mothers were aged 18-25 years. In the urban setting, 28.3% had completed upper primary education, 93.3% were housewives, 81.7% identified as Christian, and 61.7% came from nuclear families. Additionally, 41.7% were in their 2nd or 3rd pregnancy, with 41.7% aware of respectful maternity care (RMC), and 56% of information came from nurses. In rural areas, 33.3% had completed secondary education, 95% were housewives, 70% were Christian, and 73.3% were from nuclear families. Among rural mothers, 43.3% were in their 2nd or 3rd pregnancy, 76.7% were aware of RMC, with 67.4% received information from nurses. Out of 120 participants, 65.8% had poor knowledge of RMC, with 23.3% of urban mothers and 45% of rural mothers showing good knowledge. This is consistent with Alageswari et al, which reported that 85% of mothers had poor knowledge.[13] In terms of experience, 86.7% reported a positive experience with RMC, including 83.3% in urban areas and 90% in rural areas.[12] This aligns with findings

from Neupane et al, where 62.7% had a positive experience.[13] There was a significant difference in knowledge between urban and rural mothers ($p<0.05$), with rural mothers demonstrating greater knowledge. A weakly positive correlation ($r=0.170$) was found between knowledge and experience, though it was not statistically significant ($p=0.063$). While no direct comparison exists, other studies, such as that by Poudel et al, indicate that sociodemographic factors influence RMC experiences.[14] Limitations of this study include a sample that may not represent all postnatal mothers in Meghalaya, as it is restricted to those who delivered in selected healthcare facilities. Reliance on self-reported data may introduce recall and social desirability biases. Additionally, the study's focus on knowledge and experiences related to RMC does not encompass other crucial aspects of maternity care quality or maternal outcomes. The cross-sectional design captures data at a single point, and the limited 4-week data collection period may restrict the depth of information gathered. Recommendations include providing educational sessions during prenatal visits to inform mothers about their rights regarding RMC, implementing continuous quality improvement initiatives to evaluate and enhance maternal care services, and establishing a feedback mechanism for mothers to share their experiences and suggest improvements. Longitudinal studies using qualitative methods could yield deeper insights, and integrating the SUMAN scheme into training and community engagement initiatives could further promote RMC. In conclusion, pursuing respectful maternity care is vital for ensuring women's well-being and empowerment during childbirth.

CONCLUSION

This study highlighted the need for respectful practices in healthcare settings to uphold women's rights, dignity, and autonomy throughout the maternity care continuum. By prioritizing ongoing training for healthcare providers, fostering community engagement, implementing quality improvement initiatives, advocating for policy changes, and conducting further research, we can create a healthcare environment that values respect, compassion, and cultural sensitivity. Embracing RMC not only enhances childbirth experiences for women but also contributes to positive maternal and neonatal outcomes, fostering healthier communities overall.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Devi G, Myrthong CE, Kom KR. Respectful maternity care: a comparative exploration of mothers' knowledge and experiences in Meghalaya. Int J Community Med Public Health 2025;12:5529-35.