

**A study to assess the Knowledge, Attitude and Barriers in providing respectful Maternity Care during perinatal period among nursing officers of Safdarjung Hospital, New Delhi**

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**ABSTRACT**

**Introduction:** Childbirth is an important event in women's life and all women need and deserve to receive respectful care during labour and child birth. Respectful Maternity Care (RMC) represents a comprehensive and ethical approach to maternity services, emphasizing the fundamental human rights of women and newborns during childbirth and maternity care. **Objectives:** [1] To assess the knowledge, attitude, and barriers in providing Respectful Maternity Care among nursing officers. [2] To seek the relationship between knowledge and attitude of nursing officers in providing Respectful Maternity Care. [3] To find out the association between knowledge and attitude of nursing officers in providing Respectful Maternity Care with selected demographic variables. **Research Methodology:** The study used a descriptive survey research design including 200 nursing officers working in the maternity unit of the Safdarjung hospital, selected via purposive sampling technique. Data collected through structured questionnaire and technique used was questioning. **Results:** The findings of the study indicated that majority of nursing officers (79.0%) were from age group 26-35 years, 61.5% were qualified as B.Sc. Nursing. Most nursing officers were attended the training on Respectful Maternity care. The researcher concluded that majority of nurses (59.5%) had fair knowledge and favourable attitude in providing respectful maternity care. The staff shortage (89.0%) and heavy workload (86.0%) were the major barriers felt by most of the nurses. The researcher found a positive correlation between knowledge scores and attitude scores. The computed Chi-square value with selected variables previously attended training, conferences and workshops (0.002) were found to be statistically significant at 0.05 level of significant. The computed Chi-square value with selected variables such as age of nursing officers (0.024), marital status (0.007) and previously attended training, conferences, workshops (0.006) were found to be statistically significant.

**Keywords:** Knowledge, Attitude, Barriers, Respectful Maternity Care

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**Introduction**

A moment of unimaginable joy is what a mother feels when a newborn is placed on her arms a joy every mother should have the right to experience.<sup>1</sup> Childbirth is an important event in women's life and all women need and deserve to receive respectful care during labor and childbirth.<sup>2</sup> It is a significant event in a woman's life. This event is known to have deep mental, social, and emotional characteristics that stay in the mother's consciousness for the rest of her life; thus, unpleasant experiences during delivery can have a negative long-term mental influence. Respectful maternity care refers to care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth.<sup>3</sup> Respectful Maternity Care (RMC) represents a comprehensive and ethical approach to maternity services, emphasizing the fundamental human rights of women and newborns during childbirth and maternity care. The foundational principle of RMC is the consistent treatment of all women with dignity, respect, and compassion, which should be upheld irrespective of their economic status or cultural origins.

This approach to maternity care is deeply anchored in internationally recognized human rights norms. It seeks to foster a supportive and respectful environment that actively avoids any form of coercion during the childbirth process.<sup>4</sup> By promoting respectful and woman-centered care, RMC aims to empower women, build trust between healthcare providers and patients, and reduce maternal mortality and morbidity. It emphasizes the importance of fostering a healthcare environment where women feel safe, supported, and actively involved in decisions related to their well-being and that of their newborns. Nurse midwives have a crucial impact on a woman's maternal health experience during labor and childbirth, either by providing empowerment and comfort, or potentially causing lasting harm and emotional trauma.<sup>5</sup> According to the 2030 Agenda for Sustainable Development, all countries must be able to achieve universal health coverage (UHC) to meet the targets of the Sustainable Development Goals. However, achieving universal health coverage without a focus on quality of care has negative rather than positive consequences.<sup>6</sup>

**Background:** At the global level, previous successes in reducing in maternal mortality that occurred during the MDG era have stagnated in the first five years of the SDG era, from 2016 to 2020. In 2020, an estimated 287 000 women globally died from a maternal cause, equivalent to almost 800 maternal deaths every day, and approximately one every two minutes. This is more than a third lower than in 2000 when there were an estimated 446 000 maternal deaths. The global MMR in 2020 was estimated at 223 maternal deaths per 100 000 live births, down from 227 in 2015 and from 339 in 2000– a reduction of one third (34.3%) over the full 20-year period. The average annual rate of reduction (ARR) in the global MMR from 2000 to 2020 was 2.1%, meaning that on average, the global MMR declined by 2.1% every year between 2000 and 2020, although progress was uneven throughout this period.<sup>7</sup> Pregnancy and childbirth related complications are the leading causes of maternal mortality. In India, the National Health Policy (NHP) 2017 lay down the target to bring the MMR in India below 100/lakh live births by 2020. Owing to ceaseless efforts by the Government, India has successfully achieved the major milestone of bringing down its MMR to 97/lakh live births in 2018-20, well in time.<sup>8</sup>

In India a significant initiative is the "LaQshya" program launched by the Indian Ministry of Health & Family Welfare in December 2017.<sup>9</sup> LaQshya was launched with the objective of reduction in the maternal and newborn mortality & morbidity due to occurrence of complication during and immediately after delivery, to improve Quality of Care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system to enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility. It is programmed to benefit every pregnant woman and newborn delivering in public health institutions.<sup>10</sup> Respectful maternity care not only contributes in ensuring positive outcomes for the mothers and newborns, but also supports cognitive development of the babies later in the life.<sup>9</sup>

**Aim:** The aim of this research study is to assess the knowledge and attitude and barriers in providing Respectful maternity care among nursing officers in Safdarjung Hospital. By evaluating their knowledge and attitude, the study seeks to identify potential barriers in providing respectful maternity care.

## Methodology

**Study Design and Setting:** This cross-sectional descriptive study was conducted at Safdarjung Hospital, a premier tertiary care government hospital in New Delhi, India. The focus was on the obstetrics and gynecology department, specifically labour rooms, antenatal wards, postnatal wards, maternity operating theaters, and related units.

**Population and Sample:** The study population included nursing officers with at least one year of work experience in maternity units. A purposive sampling technique was employed to select participants. The sample size was calculated using Cochrane's formula, yielding a target of 258. However, due to the availability of participants during the study period, 200 nursing officers were ultimately recruited.

## Inclusion and Exclusion Criteria

**Inclusion criteria** included nursing officers who had:

- ) A minimum of one year of maternity unit experience,
- ) Been available during the data collection period, and
- ) Provided informed consent to participate.

**Exclusion criteria** were:

- ) Nursing officers on long leave (e.g., maternity leave),
- ) Those posted in neonatal intensive care units.

**Data Collection Tools:** Three structured instruments were developed and validated:

1. **Structured Knowledge Questionnaire:** Comprised of 30 items assessing knowledge related to RMC. Scores were categorized as poor (<18), fair (18–24), or good (>24).
2. **Structured Attitude Scale:** A 21-item Likert-type scale measured attitudes toward RMC. Scores were categorized as unfavourable (21–49), neutral (50–77), or favourable (78–105).
3. **Structured Barriers Questionnaire:** Comprised of 21 dichotomous items (Yes/No) identifying perceived barriers to delivering RMC, grouped into administrative, clinical, client-related, training-related, and personal factors.

The tools underwent content validation by a panel of 13 experts in obstetrics and community health. Reliability testing yielded acceptable coefficients: KR-20 = 0.79 for the knowledge questionnaire, Cronbach's alpha = 0.80 for the attitude scale, and KR-20 = 0.82 for the barrier's questionnaire.

**Data Collection Procedure:** Data were collected over several weeks through direct administration of the structured tools. Participants were approached in their respective units and provided ample time to complete the tools (approx. 40 minutes total).

**Data Analysis:** Data were analyzed using both descriptive and inferential statistics. Descriptive statistics included frequencies, percentages, means, and standard deviations. Inferential analyses included Pearson's correlation coefficient (to assess the relationship between knowledge and attitude) and chi-square tests (to identify associations with demographic variables). A significance level of  $p < 0.05$  was considered statistically significant.

**Results**

A total of 200 nursing officers participated in the study. The majority (37.0%) were aged between 30–39 years, followed by 36.0% in the 20–29 age groups. Most participants (91.0%) were female. Regarding marital status, 75.5% were married. In terms of educational qualifications, 78.5% had completed General Nursing and Midwifery (GNM), while 21.5% held a B.Sc. Nursing degree. About 58.0% reported having 1–10 years of work experience in maternity units (Table-1).

**Table- 1:** Demographic Characteristics of Nursing Officers (N = 200)

Variable	Category	No.	%
Age (years)	20–29	72	36.0
	30–39	74	37.0
	40–49	45	22.5
	50 years & above	9	4.5
Gender	Female	182	91.0
	Male	18	9.0
Marital Status	Married	151	75.5
	Unmarried	49	24.5
Professional Qualification	GNM	157	78.5
	B.Sc. Nursing	43	21.5
Years of Experience	1–10 years	116	58.0
	11–20 years	60	30.0
	>20 years	24	12.0
Previous Training on RMC	Yes	21	10.5
	No	179	89.5

In Table- 2 the overall knowledge score was measured using a 30-item structured questionnaire. The findings revealed that 45.5% of participants had fair knowledge (scores between 18–24), 34.5% demonstrated good knowledge (scores >24), and 20% had poor knowledge (scores <18).

**Table-2:** Knowledge Scores on Respectful Maternity Care

Knowledge Category	Score Range	No.	%
Poor Knowledge	<18	40	20.0
Fair Knowledge	18–24	91	45.5
Good Knowledge	>24	69	34.5

Notably, 82% of respondents were aware that women have the right to information and informed consent, while 79.5% recognized a woman's right to freedom from abuse and neglect. However, only 25% were aware of the legal consequences of disrespectful maternity care, indicating significant knowledge gaps in medico-legal implications.

Attitudes were assessed using a 21-item Likert scale. Results showed that 49.5% of participants exhibited a favourable attitude (scores 78–105), 47.0% had a neutral attitude (scores 50–77), and 3.5% had an unfavourable attitude (scores <50) [Table-3].

**Table- 3:** Attitude Scores toward Respectful Maternity Care

Attitude Category	Score Range	No.	%
Unfavourable	21– 49	7	3.5
Neutral	50– 77	94	47.0
Favourable	78–105	99	49.5

Despite the generally positive attitudes, some problematic beliefs persisted. Approximately 38.5% of participants agreed that it is sometimes necessary to raise one’s voice to make a woman cooperate during labour, while 31% believed that procedures such as fundal pressure can be justified to hasten delivery. These findings suggest ambivalent attitudes toward certain coercive practices.

Barriers to RMC were assessed through a 21-item dichotomous questionnaire. Administrative barriers were most commonly reported, with 96.5% citing lack of privacy infrastructure and 94.0% indicating staff shortages as major impediments. Clinical barriers were also prominent: 93% reported that unmanageable patient loads hinder the delivery of respectful care (Table-4).

**Table - 4:** Perceived Barriers to Providing Respectful Maternity Care

Barrier Type	Examples	Reporting 'Yes' in (%)
Administrative Factors	Lack of privacy, inadequate beds	96.5
Staffing Factors	Staff shortages, excessive workload	94.0
Clinical/Practice Barriers	High patient load, emergencies, multitasking	93.0
Training-Related Barriers	No RMC-specific training or workshops	94.5
Personal Factors	Stress, lack of motivation, low inter-staff support	90.0

Training-related constraints were identified by 94.5% of participants, who stated they had not received specific in-service education or workshops on RMC. Furthermore, 90.0% of participants identified personal factors—such as stress, burnout, and lack of support from senior staff—as barriers to practicing respectful maternity care.

Pearson's correlation analysis showed a statistically significant positive relationship between knowledge and attitude scores ( $r=0.422$ ,  $p<0.001$ ). This suggests that higher knowledge levels are associated with more favourable attitudes toward respectful maternity care (Table-5).

**Table -5:** Correlation between Knowledge and Attitude Scores

Variable	Correlation Coefficient (r)	p-value	Interpretation
Knowledge vs. Attitude	0.422	<0.001	Significant Positive Correlation

Chi-square analysis revealed statistically significant associations between knowledge and selected variables such as age ( $p=0.016$ ), years of experience in maternity units ( $p=0.020$ ), and professional qualification ( $p=0.018$ ). Attitude was significantly associated with age ( $p=0.012$ ), experience ( $p=0.028$ ), and prior RMC training ( $p=0.030$ ). These associations highlight the potential value of targeted training interventions and policy support (Table-6).

**Table- 6:** Association of Knowledge and Attitude with Demographic variables

Demographic Variable	P- value		Significance
	Knowledge	Attitude	
Age	0.016	0.012	Significant
Experience	0.020	0.028	Significant
Qualification	0.018	NS	Knowledge Only
Prior RMC Training	NS	0.030	Attitude Only
NS = Not Significant ( $p>0.05$ )			

## Discussion

This study aimed to assess the knowledge, attitude, and barriers among nursing officers regarding Respectful Maternity Care (RMC) during the perinatal period in a tertiary care public hospital in India. The findings reveal moderate knowledge, ambivalent attitudes, and multiple systemic and organizational barriers that hinder the consistent delivery of RMC.

**Knowledge of Respectful Maternity Care:** The results showed that only 34.5% of participants demonstrated good knowledge of RMC, while a significant proportion (45.5%) had fair knowledge, and 20% had poor knowledge. Although most participants were aware of women's rights to informed consent and freedom from abuse, gaps were noted in areas such as medico-legal accountability and standards of professional conduct.

These findings are consistent with studies conducted by Devassy et al. and Bobade et al., which showed that most staff nurses possess only moderately adequate or inadequate knowledge of RMC.<sup>11,12</sup> Similarly, a study by Lusambili et al., highlighted that healthcare workers often lack comprehensive understanding of all RMC domains, particularly in areas such as abandonment, detention, and emotional abuse<sup>13</sup>.

The knowledge gap is concerning given that respectful care is not only an ethical and professional obligation but also a recognized determinant of positive maternal outcomes<sup>6</sup>. This study reinforces the need for integrating RMC into continuing nursing education and pre-service curricula to address critical knowledge deficits.

**Attitudes toward Respectful Maternity Care:** Nearly half (49.5%) of the respondents exhibited favorable attitudes toward RMC, but 47% remained neutral and 3.5% held unfavorable views. While many participants recognized the importance of respecting patient autonomy and ensuring informed consent, some normalized coercive practices such as fundal pressure or shouting to gain compliance during labour. These findings reflect a larger trend reported in other settings. For example, Mirzania et al. reported that a substantial number of maternity care providers in Tehran endorsed coercive practices, believing them necessary to manage labour efficiently<sup>14</sup>. Similarly, Mannava et al. found that providers often justified disrespectful behaviours due to workload, cultural norms, or lack of supervision<sup>15</sup>.

This highlights a crucial insight: even when knowledge is present, attitudes may not align due to prevailing institutional cultures or provider stress. Addressing these attitudes requires more than training; it demands a shift in institutional norms, accountability systems, and leadership expectations.

**Barriers to Providing Respectful Maternity Care:** The most frequently reported barriers in this study were systemic in nature: inadequate infrastructure for privacy (96.5%), staff shortages (94%), lack of RMC-specific training (94.5%), and poor support from senior staff. Personal factors, including burnout and lack of motivation, were also commonly cited (90%). These results are consistent with prior research. Yadav et al. reported similar administrative and staffing barriers in Odisha, noting that high patient loads and lack of privacy infrastructure directly impede the delivery of respectful care<sup>16</sup>. Mgawadere et al. and Orpin et al. further emphasized the role of weak policy implementation, low staffing ratios, and insufficient provider training in perpetuating disrespectful care environments<sup>17,18</sup>.

The WHO's framework for quality of maternal and newborn care stresses the need for enabling environments where respectful, evidence-based, and compassionate care can thrive<sup>3</sup>. Without addressing institutional factors such as policy, resource allocation, and staff empowerment, even the best training efforts may fail to translate into practice.

**Relationship between Knowledge and Attitude:** A significant positive correlation ( $r=0.422$ ,  $p<0.001$ ) was found between knowledge and attitude. This indicates that nursing officers with greater understanding of RMC principles are more likely to adopt favourable attitudes, which aligns with previous findings by Devi et al. and Hajizadeh et al.<sup>19,20</sup>

However, knowledge alone may not be sufficient. Behavioural change requires reinforcement through mentorship, supportive supervision, and performance feedback mechanisms. Organizations must create learning environments that reinforce respectful care as a standard of quality and safety not an optional ideal.

**Association with Demographic Variables:** Significant associations were found between knowledge and variables such as age, experience, and professional qualification. Similarly, attitude scores were significantly associated with age, experience, and prior training on RMC. These findings suggest that more experienced or formally trained nursing officers are better positioned to provide respectful care, likely due to their greater exposure to varied clinical situations and possibly stronger professional grounding.

This observation supports calls for institutional investment in structured, competency-based training programs. Initiatives like India's *LaQshya* and *SUMAN* schemes emphasize RMC, but their impact can only be realized if frontline providers are adequately trained, supported, and monitored<sup>9,10</sup>.

**Implications for Practice and Policy:** This study highlights the urgent need for:

- ) Mandatory RMC training as part of induction and in-service education,
- ) Staffing reforms to reduce workload and ensure one-to-one care in labor wards,
- ) Infrastructure improvements to uphold privacy and dignity,
- ) Leadership-driven cultural change in maternity settings.

By aligning policy, training, and resources, healthcare systems can significantly enhance the quality of maternal care and reduce instances of disrespect and abuse. Nursing officers, being the frontline providers, play a pivotal role in this transformation.

## Conclusion

This study found that nursing officers had moderate knowledge and largely favorable or neutral attitudes toward Respectful Maternity Care (RMC), though gaps remain in understanding legal and ethical aspects. Systemic barriers—such as staff shortages, lack of privacy and insufficient training—impede the delivery of respectful care. A significant correlation between knowledge and attitude suggests that education can positively influence provider behaviour. Strengthening training programs, improving infrastructure, and promoting institutional accountability are essential to ensuring every woman receives respectful, dignified maternity care.

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