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Perceived Competencies and Self-Reported Practices on Respectful Maternity Care (RMC) During Childbirth Among Midwives in Health Facilities. A Descriptive Cross-Sectional Study from Kerala

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Abstract

Background The perceptions of midwives regarding Respectful Maternity Care (RMC) significantly influence the quality of care provided. This research aimed to investigate the level of perceived competencies and self-reported implementation of RMC among Kerala midwives during the childbirth process.

Methods A cross-sectional study was conducted between May and June 2025, focusing on perceived competencies and self-reported practice on RMC among 146 midwives selected by convenience sampling from the different units of two hospitals in Kerala. The participants were midwives with at least one year of experience in their roles. To evaluate their perceived competencies and self-reported practice, assessed by the Midwives' Knowledge and Practice Scale, was administered with Cronbach's Alpha reliability of 0.86 and 0.829, respectively, on Respectful Maternity Care. A chi-square was employed to examine the association between the midwives' age, educational background, and work experience with their perceived competencies and self-reported practice on RMC. Result: The findings indicated that midwives in Kerala exhibited strong perceived competencies and self-reported practices of RMC in their care approach. The average scores for overall perceived competencies and self-reported practices of RMC were 110. 4±6.2 and 109.8 ±6.37, respectively. Midwives recorded overall good perceived competencies and self -reported practices on Respectful Maternity Care (RMC) during Childbirth. The analysis revealed that a positive correlation between the perceived competencies and self-reported practices of RMC among midwives is significant at the 0.01 level ($p<0.05$; 2-tailed). There is a significant association between research variables and education at the ($p<0.05$)0.01 level.

Conclusions The study highlights strong perceived competencies and self-reported practices of RMC among midwives in Kerala, with education playing a significant role in these outcomes. Enhancing respectful maternity care necessitates the development of practical skills with adequate cognitive empowerment among midwives work in the maternal care unit.

Keywords: *Perceived competencies, self-reported practices, Respectful Maternity Care, Midwives, Health Facilities.*

Introduction

Giving birth is a significant moment in a woman's life, and every woman deserves to receive respectful treatment during labor and delivery. Numerous midwives understand the idea of Respectful Maternity Care (RMC), yet there can be a disparity between their understanding and actual implementation in facility-based environments. Maternal care varies based on factors such as institutional backing, personal attitudes, and the particular childbirth setting. Key elements of RMC that midwives should recognize and actively try to incorporate include: encouraging informed choice, honoring women's autonomy, delivering continuous support, upholding privacy and confidentiality, employing respectful language, permitting the presence of companions, and tailoring care to individual preferences and cultural practices [1]. Training for health professionals and changes at the system level can assist in closing the gap between knowledge and the reliable application of RMC in hospital environments.[2] The World Health Organization endorses competency as essential for midwives to render safe and dignified care. One in 5About 20% of women reported mistreatment while receiving maternity care, and 45% almost half (45%) of women, held back from asking questions or sharing concerns during their maternity care [3]. The study explored that the factors influencing the clinical decision-making of midwives finding that midwives' knowledge is grounded in basic education and training, use of guidelines and protocols, in-service training, and continuous professional development, reading journals a consultation with colleagues [2]. Midwives have the ability to create and sustain a secure and welcoming birthing atmosphere for women through practices that recognize and support their needs.3 Care providers emphasized the importance of understanding respectful maternity care to ensure optimal outcomes for women, families, and communities. However, given the complexity of maternity care, it is crucial for policymakers, administrators, and midwives to comprehend and appreciate the various elements that define respectful care, as this understanding can significantly enhance its successful implementation [4]. Addressing the identified components and fostering a culture of respect and compassion within healthcare settings can greatly enhance care quality, ensuring that it is responsive to the needs of women and related people [4]. Women who experience respectful maternity care tend to have a greater likelihood of delivering vaginally, feeling satisfied, and having shorter labor durations [5]. This is due to the continuous support provided by midwives during childbirth, which forms a critical element of respectful maternity care.[6]. and knowledge and competencies, strengthening midwives and midwives' associations globally [7]. The World Health Organization (WHO) highlighted in 2018 the importance of the quality of communication between women and their healthcare providers, viewing positive interactions as essential for favorable childbirth outcomes [8]. The research investigates how midwives perceive and implement respectful maternity care throughout labor and childbirth [9]. Overall, midwives are aware of the seven rights of mothers and maintain a favorable perspective on delivering respectful maternity care (RMC). Nonetheless, certain abusive behaviors persist among midwives when offering RMC, accompanied by significant challenges such as overload and insufficient labor monitoring supplies. It is recommended to modify the midwife-to-client ratio and ensure the availability of necessary materials for labor monitoring [10]. and should ensure logistics for alternative birthing positions and maintain privacy. Additionally, all midwives and hospital staff should participate in the RMC training program to promote good practices [11]. Encouraging respectful maternity care necessitates vital interpersonal and communication skills, along with supportive attitudes from midwives. Such support encompasses emotional assistance such as continuous presence, physical touch, empathy, reassurance, positive reinforcement, and information regarding labor progress. It may also involve guidance on coping strategies and providing comfort [12]. Training focused on evidence-based practices, support and training for midwives on RMC, sufficient supplies and equipment, and redesigning the ward to include private delivery suites for birth companions and privacy are also necessary [13]. Policies and attitudes either have the potential to support or obstruct RMC [14]. These insights might contribute to a nationwide midwifery survey, educational curricula, and reforms in health systems to facilitate less restrictive policies and environments. Incidents of disrespectful care during childbirth have been noted by healthcare workers, [15,16] this leads to varying practices depending on individual midwives and the specific hospital context, with some midwives effectively employing patient-centered methods, while others may encounter difficulties in fully adopting RMC practices due to systemic limitations. The strong initiatives to enhance institutional policies, resources, training, and supervision of healthcare professionals regarding women's rights during childbirth to improve the quality of care and foster positive birth experiences [17]. Measuring the RMC during childbirth can be a powerful tool to help end the abuse. The study highlights all domains of RMC from the midwives' viewpoint and their practices. Improving the institutional poli-

cies, resources, and training of health care professionals about women's rights during childbirth would help strengthen the quality of care so that women receive evidence-based care and ensure positive birth experiences [16]. Disrespect and abuse perceived by mothers admitted in maternity areas, harsh and annoying maternity care behavior in terms of physical, verbal and emotional aspect which has been defined in various forms and there is gap in knowledge and practice of RMC among health workers [17]. Designing tailored interventions, policies and programs for various dynamic systems and regular monitoring and evaluation will help in achieving RMC at the national level [18]. This will not only address maternal mortality through the delivery of care but also focus on the quality of care with a more defined and standardized approach [19]. Sometimes, healthcare providers may normalize disrespectful treatment during childbirth, which intrudes on basic human rights. Immediate action is needed to improve and support RMC as a critical component of maternal care by adopting standardized measures, and training healthcare providers to practice the code of ethics as a core component of RMC [20,21]. The present study emphasizes the assessment of midwives' awareness and practice on RMC during institutional delivery. There is a need of better training programs for health professionals to implement RMC to fill the gap in knowledge and practice of RMC among Health workers so as to eventually improve the midwives' competencies and practice about RMC, and it may contribute to better maternal health outcomes.

MATERIALS AND METHODS

Research Approach and Design:

A quantitative approach was adopted for this descriptive research. This cross-sectional study was aimed to assess the perceived competencies and self-reported practice of midwives regarding Respectful Maternity Care (RMC) during childbirth, conducted from May to June 2025 at two private teaching hospitals in Idukki and Kannur districts of Kerala.

Research Population:

The study population comprised all midwives employed in the two hospitals, totaling 146 participants. All midwives from the selected hospitals were invited to take part in the survey. Those who consented and signed the informed consent form participated in the study. Participants had to meet the inclusion criteria of being midwives employed in the labor unit, having obtained a midwifery academic degree or diploma, and possessing at least one year of work experience or having previously worked in the same unit.

Sample and sampling technique

The total accessible population was utilized for the study. Data from the both hospitals shows that there are currently one hundred and ninety-seven (197) midwives in the selected hospitals. Midwives with less than one year of experience or no experience and uninterested were excluded, totaling 51 midwives. The selection of midwives was done using a consecutive sampling method, resulting in 146 midwives included from a total of 197 working at the hospitals, while 51 were excluded from the study. Interviews took place in convenient locations like the nurses' station or the classroom within the hospitals. For data collection tools included a questionnaire for demographic information and an open-access standardized version of 5-point Likert scale on the Midwives' Knowledge and Practice Scale on Respectful Maternity Care (MKP-RMC),[27,28,34] which was used to evaluate midwives' perceived competencies and self-reported practice on RMC. Reliability of the tools is 0.86 and0.829 respectively.

Details of the data collection Tool

The questionnaire on demographic data consists of 6 items, Respectful Maternity Care (RMC) perception and practice, each section with 23 items, these encompassed various aspects of RMC to execute care during labor and delivery. For each item, the response was scored as strongly agree (5), agree (4), don't know (3), disagree (2), and strongly disagree (1) on the awareness section and always (5) , often (4), sometimes (3) rarely (2) never (1) on practice of RMC. Total score was 115in each section. A score of more than 90% was perceived as good competencies and self -reported practice on RMC, 70% to 90% average RMC, and less than 70% poor RMC. The content validity index of the RMC knowledge and practice questionnaire was 0.85. The reliability was established by Cronbach's alpha, which was 0.86 and .829 respectively. The perceived competencies and self -reported practice of RMC were assessed using a structured questionnaire with 46 items of two aspects. The pilot study was conducted with 15 members to find out the feasibility of the study.

Data Collection Procedure:

The data collection of this study was conducted after getting ethical clearance from the ethical committee and written permission from the authority concerned the data was collected from selected midwives of assigned hospitals. Sample selection was done by using a non-probability consecutive sampling technique, data collected from1st May 1st to June 30th 2025. All the selected participants were asked to gather in their respective nurses' station or classroom. Then explained

the purpose of the study and requested to informed consent and maximum cooperation with honesty in filling in questions. After clarifying their doubts and getting all the needed information, data was collected from each sample.

Data Analysis and interpretation

The collected data were entered in to a Microsoft excel data sheet after being reviewed for consistency and completeness. The IBM SPSS Statistics for Windows, version 30.0, was used to analyze the data, that was descriptive statistics of frequencies, percentages, graphs and tables. Data on midwives' perceived competencies and self -reported practice of RMC was assessed using a 5-point Likert scale which was considered as an interval scale. A composite score was computed for all respondents using their responses to the 46 items, assuming equal weighting of the items. A score of one was given for the least correct answer and a score of 5 was given for the most correct answer giving a minimum score of 23 and a maximum score of 115 for section. In instances where the negative response was the most correct answer, the reverse was the case. For the proposed study the data analysis methods are; Descriptive statistics: Mean, percentage, and standard deviation, Kaul Pearson's correlation test and chi-square test used for inferential statistics assess the awareness and practice for providing RMC by midwives in health facilities. Participants all provided written informed consent in an English language of their preference prior to administering survey questionnaire. All study documents were reviewed and approved by the ethics review board of institution.

Results

Demographic characteristics of Participants

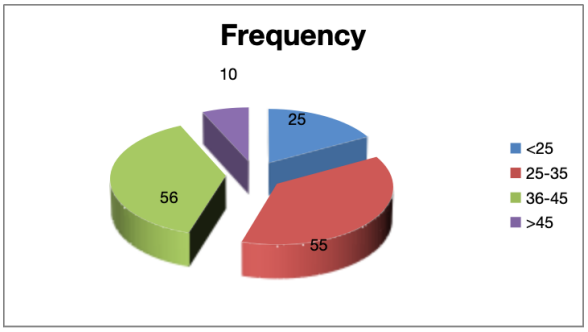

Figure 1. Distribution of sample according to age n=146

According to the graphic, 10 (14.6%) samples were older than 45, whereas 56 (38.4%) samples were between the ages of 36 and 45.

The table above indicates that the majority of participants were permanent employees, comprising 63%, while the remaining was on temporary contracts. A notable percentage of participants had less than five years (61%) of experience in intra-partum care units. The majority of midwives had achieved a B.Sc. in nursing (45.9%), with only 12.3% possessing a M.Sc. degree. A significant portion of them (68.5%) were married, and 26% had two children.

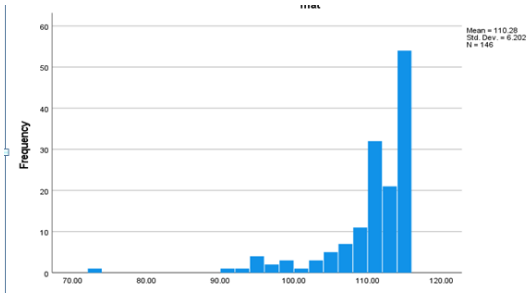

Figure 2. Perceived competencies of midwives on respectful maternity care n=146
Perceived competencies

The histogram presented above indicates that 137 midwives, accounting for 93.82%, were rated as having a good level of perceived competencies.

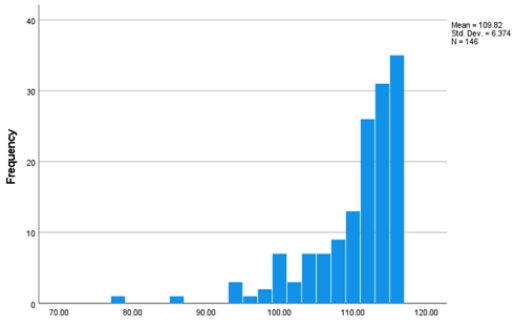

Figure 3. Self- reported practice of midwives on respectful maternity care n=146
Self -reported practice

The histogram presented above indicates that 136 midwives, accounting for 93.12%, were rated as having a good level of self-reported practices.

DISCUSSION

The cross-sectional study conducted between May and June 2025 among 146 midwives in two hospitals in Kerala provides valuable insights into their perceived competencies and self-reported practices regarding Respectful Maternity Care (RMC) during childbirth. The findings are discussed below, with comparisons to previous similar studies to contextualize the results and highlight their significance. The sample was predominantly married (68.5%), with most midwives having less than 5 years of experience (61%) and permanent employment status (63%). These characteristics may influence RMC practices, as stability in employment

Table 1. Frequency and Percentage distribution of subjects based on demographic characteristics n=146

SLNO	Variables	Frequency	Percentage
1	Marital status a) Single b) Married	 46 100	 31.5 68.5
2	Educational level a) ANM b) GNM c)Bachelor in nursing d)MSc in nursing e) PhD in nursing	 6 55 67 18 Nil	 4.1 35.7 45.9 12.3 Nil
3	Work experience in the birth unit (years) a) <5 b) 5–10 c) 11–15 d) 16–20 e) 21–25 f) >25	 89 29 17 9 1 1	 61.0 19.9 11.6 6.2 .7 .7
4	Numbers of children a 0 b 1 c 2 d>2	 54 28 38 26	 37 19.2 26 17.8
5	Employment status a) Permanent b) Temporary	 92 54	 63 37

Table 2. Total means score of perceived competencies and self-reported practices on respectful maternity care among midwives n=146

Sl.No	Variables	n	Mean	Standard deviation	Std. Error	Skewness
1	Perceived competencies	146	110.2808	6.20205	.201	-2.558
2	Self-reported practices	146	109.8219	6.37418	.201	-2.019

and personal life could contribute to better focus and commitment to quality care. Notably, midwives with no children (37%) or two children (26%) were well-represented, which may reflect varying levels of empathy or understanding of maternal needs based on personal experiences. However, the study did not explicitly analyze this variable's impact on RMC. The study found that midwives in Kerala demonstrated strong perceived competencies (mean score: 110.4 ± 6.21) and self-reported practices (mean score: 109.8 ± 6.37) in RMC. These high scores indicate that midwives feel confident in their ability to provide respectful and dignified care during childbirth and report consistent application of these practices. The use of the Midwives' Knowledge and Practice Scale, with Cronbach's alpha values of 0.86 for perceived competencies and 0.829 for self-reported practices, confirms the reliability of the tool in assessing these constructs. These values align with standards for acceptable internal consistency (0.7), suggesting robust measurement quality. Similar studies, such as those by Afulani et al. (2019) in Kenya and Tanzania, reported moderate to high levels of perceived RMC competencies among midwives, but self-reported practices were often lower due to systemic barriers like understaffing or resource constraints. In contrast, the Kerala study's high scores for both competencies and practices suggest a supportive environment, possibly due to better training programs or institutional policies in the selected hospitals [24,35]. A 2020 study in Ethiopia by Shiferaw et al. found that midwives' RMC practices were influenced by their knowledge and training. The Kerala study's significant correlation between competencies and practices supports this, indicating that targeted training could bridge gaps between knowledge and application [36]. A statistically significant positive correlation ($p < 0.05$, 2-tailed) was observed between perceived competencies and self-reported practices of RMC. This suggests that midwives who feel competent in RMC are more likely to report implementing respectful care practices in their work. This finding is consistent with the Theory of Planned Behavior, which posits that perceived self-efficacy influences behavioral outcomes.[42,43,44]. The chi-square analysis revealed a significant association between educational level and both perceived competencies and self-reported practices ($p < 0.05$). Midwives with

Table 3. Relationship between perceived competencies and self -reported practice of midwives on respectful maternity care n=146

SLNO	VARIABLES	r value	p value
1	Perceived competencies	**.364****	**.000**
2	Self-reported practices		

Correlation is significant at the 0.01 level (2-tailed).

Table 4. Association between perceived competencies of midwives and demographic variables n=146

SLNO	Variables	Level of perceived competencies Poor <80	average 81-100	Good >100	df	Chi-square value	P value
1	Age <25 25-35 36-45 >45	1	0 3 6 1	25 52 50 8	3	5.422	.143
3	Marital status Single Married		3 8	85 50	1	.002	.964
3	Educational level ANM GNM Bachelor in nursing MSc in nursing PhD in nursing	1	0 1 3 6 0	6 53 64 12	3	19.784a	.000
4	Work experience in the birth unit (years) <5 5–10 11–15 16–20 21–25 >25	1	9 1 0 0	85 48 1 1	3	1.621	.655
5	Numbers of children a 0 b 1 c 2 d>2		2 2 2 4	52 26 35 21	3	3.451a	.327
	Employment status Permanent Temporary	1	6 4	85 50	1	.002	.965

The above table shows that there is significant association between perceived competencies of midwives and education at 0.01(p<0.000) level.

higher educational qualifications, such as Bachelor's (45.9%) or Master's degrees in nursing (12.3%), likely reported higher competencies and better adherence to RMC practices compared to those with Auxiliary Nurse Midwife (ANM) (4.1%) or General Nursing and Midwifery (GNM) (35.7%) qualifications. This aligns with the idea that advanced education enhances knowledge, skills, and confidence in applying patient-centered care principles. The significant association between education and RMC outcomes aligns with findings from a 2023 study in Nigeria by Okonofua et al., which showed that midwives with higher educational qualifications were more likely to implement RMC principles. This may be attributed to advanced curricula that emphasize patient-centered care, communication skills, and ethical considerations, which are critical for RMC [37]. While the Kerala study did not explicitly report a significant association between work experience and RMC outcomes, the distribution of experience (61% with <5 years) suggests a relatively young workforce. A 2018 study in Ghana by Dzomeku et al. found that more experienced midwives were more confident in RMC

Table 5. Association between self-reported practices of midwives and demographic variables n=146

SLNO	Variables	Level of self-reported practices Poor <80	average 81-100	Good >100	df	Chi-squre value	P value
1	Age <25 25-35 36-45 >45	1	0 3 6 1	25 52 50 8	6	9.583a	.143
3	Marital status Single Married	1	6 8	38 93	4	3.346a	.502
3	Educational level ANM GNM Bachelor in nursing MSc in nursing PhD in nursing	0 1 0	1 1 6 6	5 54 58 14	6	16.921a	.010
4	Work experience in the birth unit (years) <5 5–10 11–15 16–20 21–25 >25	0 1	9 5 1 1	84 43 1 1	6	2.193a	.901
5	Numbers of children 0 1 2 >2	1 0 0 0	6 2 1 5	46 26 37 20	6	7.322a	.292
6	Employment status Permanent Temporary	0 1	11 5	80 49	2	3.217a	.200

The above table shows that there is significant association between perceived competencies of midwives and education at 0.01(p<0.010) level

practices due to cumulative exposure to diverse childbirth scenarios. The Kerala findings may differ due to the predominance of less experienced midwives, yet their high scores suggest effective training or mentorship programs in these hospitals [39,45]. The high RMC scores in Kerala may reflect the state's strong healthcare infrastructure and emphasis on maternal health, as noted in studies comparing Kerala's health outcomes to other Indian states (e.g., Thankappan et al., 2019). Unlike studies in low-resource settings (e.g., Bowser Hill, 2010), where disrespect and abuse in maternity care were prevalent, the Kerala midwives' performance suggests a cultural or systemic inclination toward respectful care, possibly reinforced by state-level policies or community expectations [38,40]

Implications

- Training and Education: The significant association with education underscores the need for continuous professional development, particularly for midwives with lower qualifications (e.g., ANM or GNM). Incorporating RMC-specific modules in nursing curricula and in-service training could further enhance competencies and practices.
- Policy and Practice: The positive correlation between perceived competencies and practices suggests that fostering midwives' confidence through supportive supervision and feedback mechanisms could improve RMC implementation. Hospitals should ensure resources and staffing levels support RMC practices, as systemic barriers could undermine even competent midwives.
- Research Gaps: The study's reliance on self-reported practices may introduce social desirability bias, as midwives might over report adherence to RMC. Future studies could incorpo-

rate observational data or patient perspectives to validate these findings. Additionally, exploring the impact of personal factors (e.g., number of children) or workplace culture on RMC could provide deeper insights.

Limitations

- The use of convenient sampling limits generalizability beyond the two hospitals in Kerala. A broader, randomized sample could strengthen the findings.
- The study did not explore patient outcomes or perspectives, which are critical for assessing the actual impact of RMC practices.
- The lack of detailed analysis on how specific demographic variables (e.g., marital status, number of children) influence RMC limits the depth of interpretation.

Conclusion

The study highlights strong perceived competencies and self-reported practices of RMC among midwives in Kerala, with education playing a significant role in these outcomes. Compared to previous studies, the findings suggest that Kerala's healthcare context may provide a conducive environment for RMC, possibly due to robust training and systemic support. However, further research is needed to validate these self-reported practices and explore patient experiences to ensure that RMC translates into meaningful improvements in maternal care quality.

Ethical and Administrative Permission

Ethical permission was taken from the Institutional Ethics Committee of Institution .CN/A/35/2025 dated on 09.09.2025, and required administrative permissions were received from every single authority wherever necessary. Informed consent from the respondents was collected before the interview took place.

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Competing Interest: Nil

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