ORIGINAL RESEARCH ARTICLE

A Study to Assess Respectful Maternity Care (RMC) And Child Birth Experience (CBE) Among Postnatal Mothers in a Selected Hospital of District Solan, Himachal Pradesh

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ABSTRACT

Introduction: In order to ensure a good Child Birth Experience (CBE), Respectful Maternity Care (RMC) entails giving birth care that is free from abuse and damage while maintaining a woman's autonomy, privacy, and dignity.

Material & methods: A quantitative - non experimental research approach and descriptive research design was adopted. Total 194 Postnatal Mothers were selected by using Convenient Sampling. Data collection employed by self-structured interviews including socio-demographic, obstetrical variables, Five - Point Likert Scale on RMC, and Three - Point Likert Scale on CBE.

Results: Results revealed that the majority of postnatal mothers 59.8% were highly satisfied with RMC, followed by 38.1% who were moderately satisfied, and only 2.1% who were less satisfied. Additionally, 83% of mothers reported a very good CBE, 14.9% reported a good experience, and 2.1% had an average experience. A significant positive correlation was observed between RMC and CBE scores $r = 0.488$, $p < 0.001$. The mean RMC score was 59.54 ± 8.79, while the mean CBE score was 50.77 ± 6.03.

Conclusion: The results underscore the vital role of in enhancing childbirth experiences. They highlight the need for targeted strategies to improve maternity services during childbirth.

Keywords: RMC, CBE, Postnatal Mothers, Likert Scale

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INTRODUCTION

RMC is fundamental to ensuring dignity, autonomy, and emotional support throughout childbirth.[1] Historically, clinical efficiency often overshadowed patient-centered care, resulting in mistreatment and neglect.[2]

Recognizing this, WHO underscores the profound impact of a positive birth experience on both maternal and neonatal health[3], while culturally sensitive care as essential in reducing childbirth-related anxiety and enhancing maternal satisfaction. Further the importance of continuous labour support, fostering confidence and minimizing unnecessary interventions.[4] Childbirth experiences are shaped by healthcare environments, provider interactions, and socio-cultural norms, with SOMMI research emphasizing the transformative role of personalized birth plans in mitigating fear and improving satisfaction.[5]

Evidence also links obstetric mistreatment to postpartum distress, affecting reproductive autonomy and maternal well-being, reinforcing WHO's call for respectful, evidence-based maternity practices. Studies affirm that RMC strategies such as informed consent, skin-to-skin contact, breastfeeding initiation, and the presence of a birth companion not only enhance maternal-infant bonding but also improve adherence to postnatal care.[6]

WHO's quality-of-care framework advocates for maternity services that are safe, effective, timely, equitable, and person-centered, underscoring the necessity of healthcare provider training and policy interventions to ensure childbirth is both dignified and empowering.[7]

RMC is essential for ensuring dignity, autonomy, and emotional support during childbirth[1]. Yet, A systemic review reveals that mistreatment in facility-based births remains widespread, with over 70% of women in India experiencing disrespect or abuse[8], and a study in Uttar Pradesh revealing that 99.1% faced at least one form of mistreatment during child birth[9]. Globally, 35% of women encounter mistreatment during childbirth, affecting maternal satisfaction.[10] RMC addresses obstetric violence, coercion, and lack of informed consent[11], as seen in Ethiopia, where only 42% of women reported receiving respectful care[12].

Healthcare environments, provider interactions, and cultural norms shape birth experiences[13], while research showed that emergency caesarean section rate was significantly lower in women with supportive care compared to women with routine hospital maternal care (3.3% vs 24%)[14]. Personalized birth plans and shared decision-making foster positive labour experiences and reduce fear.[15] Alarmingly, mistreated women are 2.5 times more likely to develop postpartum depression, reinforcing the urgent need for compassionate and equitable maternity care.[16]

RMC is essential not only for the physical safety of mothers and newborns, but also for their emotional wellbeing and future care-seeking behaviors. Research has shown that when women feel respected, informed, and supported, they are more likely to engage with healthcare services, leading to better maternal and neonatal outcomes. In India, studies estimate that around 70% of facility births involve some form of disrespect or abuse, with no consented care and verbal mistreatment being most common.[17] Therefore, assessing RMC offers a powerful pathway to improve service quality, rebuild trust, and support equitable maternal health coverage. So, we decided to conduct "A Descriptive Study to Assess Respectful Maternity Care (RMC) and Child Birth Experience (CBE) among Postnatal Mothers in a selected Hospital of District Solan, Himachal Pradesh".

The objectives of the study were to assess Respectful Maternity Care (RMC) and Child Birth Experience (CBE) and to determine the relationship between RMC & CBE among postnatal mothers and also to find out association of RMC & CBE with Socio Demographic Variables and Obstetrical Variables.

METHODOLOGY

This descriptive study was conducted from November 2024 to March 2025 at Maharishi Markandeshwar Medical College and Hospital MMMC&H, Solan, Himachal Pradesh, evaluated RMC and CBE among primiparous postnatal mothers following normal vaginal delivery.

A total of 194 participants were selected via purposive sampling, based on informed consent, proficiency in Hindi or English, and the absence of neonatal mortality or major congenital anomalies. Mothers who underwent operative deliveries, had significant medical or psychological conditions, experienced major life stressors, or had communication impairments were excluded to ensure a homogenous study population. Postnatal mothers with normal vaginal delivery, no infant loss or malformation, primiparous, willing, and understanding Hindi/English were included. Excluded were those with LSCS/assisted delivery, severe complications, recent major stress, or communication disabilities. Participants gave informed consent and met inclusion criteria to ensure reliability and uniformity in the study sample.

Sample size calculation: The study was estimated using the Cochrane formula. Sample size calculation was based on the prevalence (88.7%) of healthcare providers did not commit any discrimination however this is only one component in RMC[18]. Taking 88.7% prevalence rate, a relative precision of ±5%, a 95% confidence interval, an alpha of 0.05, and a 10% attrition rate. So, the calculated sample size was 171. However, during data collection, a total of 194 postnatal mothers were included at the final stage of data collection.

Sample size was calculated using formula $n=z^2 \cdot p \cdot (1-p)/e^2$, where *e* is desired level of precision, the margin of error, *p is* the fraction of the population (as percentage) that displays the attribute; and *z* is standard normal deviate at 95% confidence level.

Measuring tools: Data were gathered using carefully constructed, self-administered questionnaires, organized into three comprehensive sections to capture postnatal mothers' experiences thoroughly: (1) socio-demographic and obstetric profiling, (2) evaluation of Respectful Maternity Care (RMC), and (3) assessment of Childbirth Experience (CBE).

Socio-Demographic & Obstetric Profile: This section recorded essential background and clinical information. Socio-demographic variables included maternal age, marital status, education level, occupation, place of residence (rural/urban), family type (nuclear/joint), monthly household income, religion, and perceived social support. To document obstetric context, respondents provided details on gestational age at delivery, total antenatal visits, the type and number of birth companions present, the number and roles of healthcare providers involved in labor and delivery, duration of labor, obstetric complications or pregnancy characteristics, pain relief methods used, and any previous abortion history.

Respectful Maternity Care (RMC) Scale: RMC was measured using a structured five-point Likert instrument spanning four domains. Domin 1: *Friendly Care* (7 items): e.g., "The staff treated me kindly."; Domain 2: *Abuse-Free Care* (3 items): e.g., "I was free from any physical maltreatment."; Domain 3: *Timely Care* (3 items): e.g., "I received attention when I needed it."; and Domain 4: *Non-Discriminatory Care* (2 items): e.g., "My care did not depend on my personal background."

Responses ranged from "Strongly Disagree" (1) to "Strongly Agree" (5), with an option for "No Comments" (3). This scale provided a nuanced view of respectful practices during facility-based childbirth.

Childbirth Experience (CBE) Inventory: Maternal birth experience was evaluated using a three-point Likert scale (Agree = 3, Neutral = 2, Disagree = 1), along with the Numeric Pain Rating Scale (NPRS), rated as Mild (3), Moderate (2), or Severe (1). Four domains were assessed: Domain 1: *Perceived Capacity* (9 items): e.g., "I felt strong during labor."; Domain 2: *Participation* (3 items): e.g., "I felt involved in decisions."; Domain 3: *Professional Support* (7 items): e.g., "My provider explained procedures to me."; and Domain 4: *Perceived Safety* (1 item): NPRS rating of labor pain severity.

This allowed an evaluation of mothers' emotional, physical, and professional support experiences during childbirth.

Content Validity & Reliability: To ensure content validity, the tools were reviewed by seven maternal health subject experts. They verified clarity, relevance, and completeness. Instruments were then translated into Hindi for linguistic accuracy and were pilot-tested for comprehension and feasibility at select hospitals in Solan in January 2025.

Reliability testing using Cronbach's alpha yielded a coefficient of 0.84 for the RMC scale demonstrating solid internal consistency among items.

Pilot Testing & Ethical Approval: A preliminary pilot study confirmed that the questions were clear, culturally appropriate, and easy to complete. It also tested data collection procedures and time requirements, helping finalize logistics. Ethical approval was secured from the Institutional Ethics Committee of MMMC&H, Kumarhatti, ensuring compliance with ethical standards, including informed consent and confidentiality protections.

Ethical consideration: Prior to commencing the study, ethical clearance (MMMCH/IEC/25/986, Dated -27/1/2025) was obtained from the Institutional Ethical Committee of M.M. University, with additional approvals from the Principal of M.M. College of Nursing, the Medical Superintendent, and the Head of the Midwifery & Gynaecology Department at MMMC&H. Informed consent was diligently secured from all participants, ensuring their voluntary and informed participation.

Data collection: Data collection was conducted from January to February through a structured interview technique, with each session lasting approximately 15 to 20 minutes, ensuring comprehensive and reliable data acquisition.

Data Analysis: The study utilized both descriptive and inferential statistical techniques, combining manual calculations with software tools IBM SPSS 22 version. Analyses included frequencies and percentages for socio-demographic and obstetrical variables, along with measures of central tendency for RMC and CBE.

The Kolmogorov-Smirnov Test was used to check normality of data. Likert scales assessed perceptions, while correlation analyses explored relationships between RMC and CBE scores among postnatal mothers. Chi-square tests identified associations between these variables and various socio-demographic and obstetrical factors.

The methodological framework was comprehensive, detailing research design, study setting, target population, sampling methods, tool development, validation, reliability testing, ethical considerations, pilot testing, data collection, and analysis strategies, ensuring the study's rigor and the validity of its findings.

RESULTS

The analysis of socio-demographic variables revealed majority postnatal mothers in the study were young adults: 52.6% aged 19-26 and 46.4% aged 27-34, with only 1% aged ≤18 and none aged ≥35.

Table 1: Respectful Maternity Care (RMC) & Child Birth Experience (CBE) of Postnatal Mothers (N=194)

Variables	Range of Scores	Median	Mean±SD
RMC	35-75	60.00	59.54±8.79
CBE	29-59	52.00	50.77±6.03

RMC= Maximum Score: 75 Minimum Score: 15
CBE=Maximum Score: 60 Minimum Score: 20

All mothers were married. Educationally, 38.7% had completed secondary school, 32.5% were graduates, 16.0% had elementary education, and 10.3% were postgraduates, while 2.6% were illiterate. Over half (55.7%) lived in rural areas, and 44.3% resided in urban regions. A large majority (76.8%) were homemakers, with the rest engaged in private jobs (14.4%), government employment (2.6%), or health services (1.0%). In terms of religion, 94.8% were Hindu, and small minorities were Sikh (2.1%), Christian (2.1%), or Muslim (1.0%). Regarding family structure, 56.2% belonged to joint families, 39.2% to nuclear families, and 4.6% to extended families. Monthly household incomes varied: 45.9% fell in the Rs.10,001-Rs.40,000 range, 30.9% earned Rs.40,001-Rs.70,000, 14.9% exceeded Rs. ≥70,001, and 8.2% earned less than Rs.≤10,000. Finally, the main source of support was husbands (68%), followed by mothers-in-law (16.5%), relatives (14.9%), and friends (0.5%).

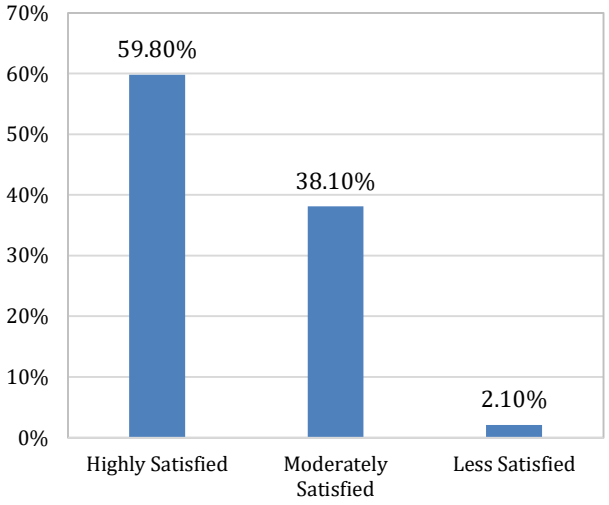

Figure 1: Frequency and Percentage of Range of RMC Score

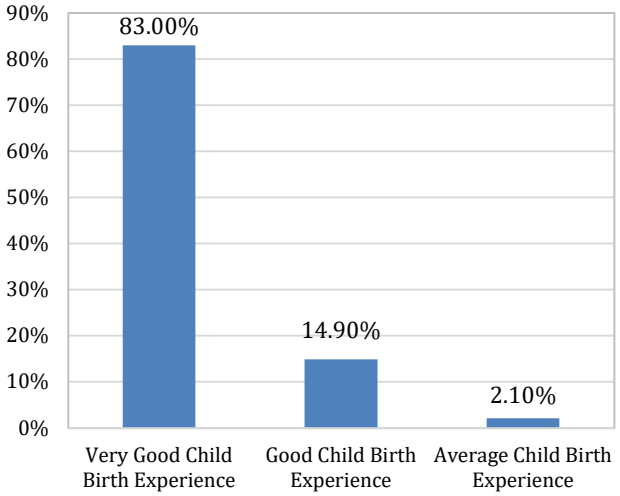

Figure 2: Frequency and Percentage of Range of CBE Score

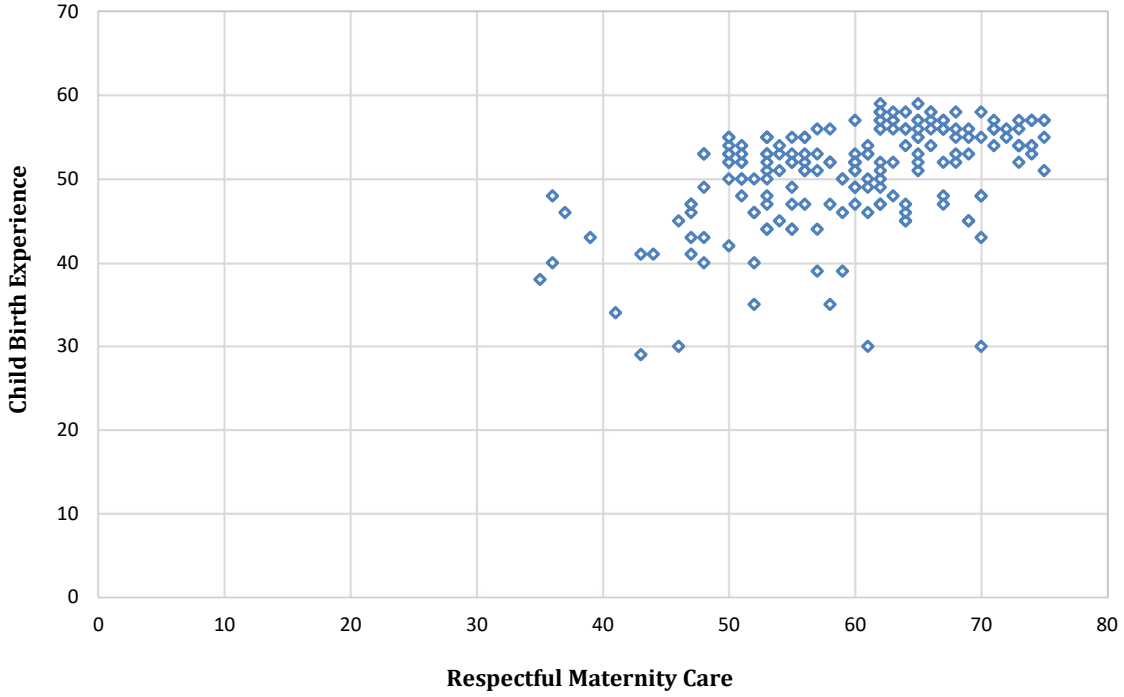

Figure 3: Correlation between RMC & CBE Score

Table 2: **Association of Respectful Maternity Care (RMC) with Socio Demographic Variables (N=194)**

Socio Demographic Variables	Number of Subject	RMC Score Mean±SD	F/t test	df	p value
Age in Years					
18 years	02	70.00± 0.00	1.67	2/191	0.191^{NS}
19-26 years	102	50.09±8.29			
27-34 years	90	59.88±9.31			
≥35 years	00	00±00			
Educational Status of Postnatal Mother					
Illiterate	05	50.00±3.67	3.58	4/189	0.00*
Elementary	31	63.29±6.92			
Secondary Education	75	58.40±9.21			
Graduate	63	59.26±8.83			
Above Graduation	20	61.25±8.11			
Area of Residence					
Urban	86	60.89±7.13	3.71	192	0.05*
Rural	108	58.46±9.81			
Occupation of Postnatal Mother					
Private Job	28	57.39±7.28	1.66	4/189	0.15^{NS}
Government Job	05	60.60±6.50			
Self Employed	10	60.50±10.91			
Health Worker	02	73.00±1.41			
Home Maker	149	59.66±8.90			
Religion					
Hinduism	184	59.45±8.81	0.76	3/190	0.518^{NS}
Muslim	02	66.00±8.48			
Sikhism	04	56.50±5.25			
Christian	04	63.25±10.78			
Type of Family					
Joint	109	60.65±6.92	8.06	2/191	0.00*
Nuclear	76	57.02±10.35			
Extended	09	67.33±8.09			
Family Income Monthly (in Rupees)					
≤Rs.10,000	16	59.68±10.24	1.21	3/190	0.30^{NS}
Rs. 10,001-Rs. 40,000	89	59.75±8.52			
Rs.40,001-Rs. 70,000	60	60.51±9.03			
≥Rs. 70,001	29	56.79±8.13			
Source of Support					
Husband	132	58.76±8.08	2.07	3/190	0.10^{NS}
Mother-in-law	32	61.96±11.04			
Relative	29	60.82±8.66			
Friend	01	47.00±0.00			

*p≤0.05 (Significant), ^{NS} p≥0.05 (Not Significant)

Analysis of Obstetrical Variables showed (64.4%) postnatal mothers were in 37-38 weeks of gestation, followed by 24.2% at 39-40 weeks, 11.3% before 37 weeks, with none beyond 40 weeks. Regarding antenatal care, 54.6% attended more than four visits, 25.8% attended three, 9.8% attended four, 7.7% attended two, 1.5% attended one, and 0.5% had none. Female companions accompanied 94.6% of mothers, while 3.6% had male companions. Living areas reflected earlier data: 55.7% rural, 44.3% urban. Nurses constituted 76.3% of care providers, obstetricians 18.6%, midwives 4.6%, and others 0.5%. Most mothers saw three providers (44.3%), over three in 28.9%, two in 21.1%, and one in 5.7%. Labour duration was 11-15 hours for 55.2%, ≤10 hours for 32%, and ≥16 hours for 12.9%. Labour augmentation history was 52.6% yes, 47.4% no. Planned pregnancies accounted for 74.2%, unplanned 25.8%. Pain relief choices were: none (57.2%), sacral massage/therapy (34%), and epidural (8.8%). Lastly, 75.8% had no abortion history, while 24.2% did.

Item analysis showed majority postnatal mothers responded positively: 50-55% agreed that healthcare workers were kind, friendly, respectful, empathetic, communicative, addressed them by name, and responded professionally. Around one-third strongly agreed across positive domains. However, fewer (49.5%) felt free to practice cultural or religious traditions. For negative experiences, only a small minority strongly agreed to being mistreated slapped or pinched (2.1%), shouted at (4.1%), neglected (1.5%), monitored unsupervised (0.5%), or insulted due to personal characteristics (1%) though up to 27% acknowledged occasional mistreatment or verbal abuse. Most postnatal mothers reported positive experiences during labour: 77.3% felt the progression met expectations, 66.5% acknowledged unbearable pain, 76.3% felt scared yet 61.3% felt capable, and 83% experienced fatigue. Around 63-87% agreed providers communicated well explaining procedures, keeping them informed, understanding needs, and demonstrating competence fostering trust and security.

Table 3: **Association of Respectful Maternity Care (RMC) with Obstetrical Variables (N = 194)**

Obstetrical Variables	Number of Subject	RMC Score Mean ± SD	F/t test	df	p value
Gestational Age					
<37 weeks	22	61.27± 6.56	4.87	2/191	0.00*
37-38 weeks	125	58.12±9.11			
39-40 weeks	47	62.48±8.03			
Total Number of Antenatal Visit					
0	01	73.00±0.00	2.02	5/188	0.07NS
1	03	59.33±14.29			
2	15	56.06±10.10			
3	50	58.38±7.55			
4	19	56.94±8.50			
More than 4	106	60.92±8.84			
Gender of Health Companion					
Male	07	65.28± 6.96	3.13	192	0.07NS
Female	187	59.32 ± 8.79			
Profession of Health Care Provider					
Obstetrician	36	59.50 ±7.84	0.06	3/190	0.98NS
Midwives	09	60.00 ± 8.55			
Nurses	148	59.54 ± 9.09			
Others	01	56.00 ± 0.00			
Number of Healthcare Provider					
1	11	55.09 ± 3.91	1.77	3/190	0.15NS
2	41	60.17 ± 8.70			
3	86	60.58 ± 7.88			
>3	56	58.35 ± 10.47			
Duration of Labor in Hours					
<10 hours	62	56.79 ± 9.70	5.99	2/191	0.00*
11-15 hours	107	60.25 ± 8.00			
>16 hours	25	63.32 ± 7.89			
Augmentation of Labour					
Yes	102	55.97 ± 8.47	43.26	192	0.00*
No	92	63.50 ± 7.34			
Nature of Pregnancy					
Planned	144	60.65 ± 7.99	9.31	192	0.00*
Unplanned	50	56.34 ± 10.18			
Types of Pain Relief Used					
None	111	59.24 ± 9.18	0.33	2/191	0.71NS
Epidural Anesthesia	17	61.11 ± 9.34			
Sacral Massage/Therapy	66	59.63 ± 8.02			
Abortion history					
Yes	47	59.61 ± 9.03	0.005	192	0.94NS
No	147	59.51 ± 8.74			

*p≤0.05 (Significant);NS p≥0.05 (Not Significant)

Conversely, emotional responses were mixed: only 31.4% felt happy, though 63.9% retained positive memories and most (59.3-60.3%) did not hold negative or depressive recollections. Choice was limited while 60.3% could move freely, fewer were allowed to choose their delivery position (40.7%) or pain relief method (45.4%) revealing areas needing improvement.

DISCUSSION

Present study showed majority of mothers 116 (59.8%) reported being highly satisfied, a substantial portion 74 (38.1%) expressed being moderately satisfied, followed only 42.1% of mothers were less satisfied. Similar findings were reported by Kaur R et al[18] in rural area of Northen, India that 88.7% women were satisfied with care during childbirth. Moreover, systematic review of 35 qualitative studies was conducted by Downe S et al[19] across 16 countries, including both high-income and low- and middle-income countries LMICs reveals 38.1% of mothers reported moderate satisfaction. Present study revealed that the majority of mothers 161 (83%) rated their childbirth experience as very good. A smaller proportion, 29 (14.9%) reported a good experience and only 4 (2.1%) of mothers had an average Childbirth Experience. Similar outcomes were reported by Maung TM et al[20] who did a cross-sectional study which found that 74.9% of women reported a positive childbirth experience, closely associated with effective communication, privacy, and emotional support during labor and delivery. Present study revealed that majority of the mothers 105 (54.1%) agree with the statement that healthcare workers cared for them with the kind approach. Similar outcomes were reported by Kene C et al[21] who conducted a cross- sectional study which found that 82% mothers agreed that healthcare provider provided care in a friendly manner.

Table 4: **Association of Child Birth Experience (CBE) with Socio Demographic Variables (N = 194)**

Socio Demographic Variables	Number of Subject	CBE Score Mean ± SD	F/t test	df	p value
Age in Years			5.95	2/191	0.00*
<18 years	02	36.50 ± 9.19			
19-26 years	102	50.97 ± 5.83			
27-34 years	90	50.86 ± 5.89			
≥35 years	00	00±00			
Educational Status of Postnatal Mother			0.62	4/189	0.64NS
Illiterate	05	49.00 ± 2.73			
Elementary	31	50.19 ± 7.73			
Secondary Education	75	50.78 ± 6.32			
Graduate	63	51.55 ± 4.62			
Above Graduation	20	49.60 ± 6.56			
Area of Residence			10.40	192	0.00*
Urban	86	52.30 ± 4.06			
Rural	108	49.55 ± 7.00			
Occupation of Postnatal Mother			0.89	4/189	0.46NS
Private Job	28	52.39 ± 2.52			
Government Job	05	48.60 ± 3.78			
Self Employed	10	50.10 ± 8.27			
Health Worker	02	54.00 ± 1.41			
Home Maker	149	50.54 ± 6.39			
Religion			0.48	3/190	0.69NS
Hinduism	184	50.75 ± 6.14			
Muslim	02	54.00 ± 2.82			
Sikhism	04	48.50 ± 3.31			
Christian	04	52.50 ± 2.38			
Type of Family			1.09	2/191	0.33NS
Joint	109	51.11 ± 5.40			
Nuclear	76	50.06 ± 2.87			
Extended	09	52.55 ± 2.87			
Family Income Monthly (in Rupees)			2.94	3/190	0.03*
<Rs.10,000	16	49.31 ± 6.69			
Rs.10,000-40,000	89	51.56 ± 5.92			
Rs. 40,001- 70,000	60	51.28 ± 5.14			
>Rs. 70,001	29	48.10 ± 7.03			
Source of Support			0.70	3/190	0.54NS
Husband	132	50.90 ± 6.32			
Mother-in-law	32	49.62 ± 6.29			
Relative	29	51.58 ± 4.11			
Friend	01	47.00 ± 0.00			

*p≤0.05 (Significant);NS p≥0.05 (Not Significant)

Present study revealed that 129 (66.5%) agree with the statement that they felt unbearable pain during labour. Similar results were reported by Yang J et al[22] who conducted a qualitative study which revealed that 70% of the women experience unbearably intense pain during child birth.

Present study revealed that the correlation coefficient r = 0.488 between RMC and CBE indicates a moderate positive relationship. This means that as the quality of increases, the childbirth experience tends to improve as well. Similar study was done by Afulani PA et al[23] conducted a cross-sectional study demonstrated that higher levels of perceived respectful care were strongly associated with improved childbirth satisfaction β = 0.63, p <0.001. Also, a similar study was conducted by Sudhinaraset M et al[9] showed, respectful care 4.6 times greater with childbirth services AOR = 4.6, p <0.001.

Present study showed that educational status of mothers significantly influenced mean scores (F = 3.58, df = 4/189, p = 0.00), and mothers residing in urban area scored higher than rural (t = 3.71, df = 192, p = 0.05). A cross-sectional study done by Beraki GG et al[24] on 304 postpartum mothers showed that educational level was significantly associated with knowledge of postnatal care (χ^2 = 7.7, p = 0.021). Similarly, residence (urban vs rural) showed a significant association with maternal knowledge (χ^2 = 6.3, p = 0.012), with mothers residing in urban area demonstrating higher knowledge than rural. Further, present study revealed that type of family had a highly significant effect (F = 8.06, df = 2/191, p = 0.00), with mothers from extended families scoring highest. A comparable finding comes from a 16-culture study by Georgas J et al[25] which reported for extended vs nuclear family differences in geographic proximity, frequency of meetings and contact.

Table 5: **Association of Child Birth Experience (CBE) with Obstetrical Variables (N = 194)**

Obstetrical Variables	Number of Subject	CBE Score Mean ± SD	F/t test	df	p value
Gestational Age					
<37 weeks	22	48.40 ± 6.49	2.21	2/191	0.11^{NS}
37-38 weeks	125	51.28 ± 5.79			
39-40 weeks	47	50.51 ± 6.28			
≥40 weeks	00	00±00			
Total Number of Antenatal Visit					
0	01	57.00 ± 0.00	1.10	5/188	0.36^{NS}
1	03	51.66 ± 5.03			
2	15	49.33 ± 7.02			
3	50	51.00 ± 5.59			
4	19	48.42 ± 7.25			
More than 4	106	51.20 ± 5.85			
Gender of Health Companion					
Male	07	51.85 ± 3.89	0.23	192	0.62^{NS}
Female	187	50.73 ± 6.10			
Profession of Health Care Provider					
Obstetrician	36	47.63 ± 6.49	4.18	3/190	0.00*
Midwives	09	51.22 ± 4.11			
Nurses	148	51.50 ± 5.81			
Others	01	51.00 ± 0.00			
Number of Healthcare Provider		51.72 ± 0.78			
1	11	52.83 ± 3.87	2.38	3/190	0.07^{NS}
2	41	49.98 ± 6.88			
3	86	50.26 ± 6.21			
>3	56				
Duration of Labor in Hours					
<10 hours	62	49.16 ± 6.70	6.05	2/191	0.00*
11-15 hours	107	50.96 ± 5.88			
>16 hours	25	53.96 ± 2.85			
Augmentation of Labour					
Yes	102	50.01 ± 5.79	3.39	192	0.06^{NS}
No	92	51.60 ± 6.20			
Nature of Pregnancy					
Planned	144	51.72 ± 5.35	15.05	192	0.00*
Unplanned	50	48.02 ± 7.02			
Types of Pain Relief Used					
None	111	49.94 ± 6.19	2.58	2/191	0.07^{NS}
Epidural Anesthesia	17	51.29 ± 4.42			
Sacral Massage/Therapy	66	52.03 ± 5.96			
Abortion History					0.18^{NS}
Yes	47	51.78 ± 4.88	1.75	192	
No	147	50.44 ± 6.33			

*p≤0.05 (Significant), ^{NS} p≥0.05 (Not Significant)

In this study gestational age had a highly significant association with RMC (F = 4.87, df = 2/191, p = 0.00), with mothers delivering at 39-40 weeks reporting the highest scores. A similar result was found by Athira Cet al[26] who reported obstetric complications related to preterm and post-term gestations were significantly associated with lower RMC scores (p < 0.05). In contrast, Jafari Eet al[27] found that no significant difference in childbirth satisfaction across gestational ages (p = 0.687), and Fentie TA et al[12]also reported that gestational age did not significantly influence RMC (p > 0.05). Further, present study revealed that duration of labour was significantly associated with RMC and mothers experiencing labour durations of >16 hours reporting the highest mean scores (F = 5.99, df = 2/191, p = 0.00). A similar result was reported by CarlhällS et al[28] who found that longer durations of active labour was significantly associated with a negative CBE with an AOR of 2.39 (95% CI: 1.98-2.90) for primiparous women and 2.23 (95% CI: 1.78-2.79) for multiparous women. In contrast, Kempe P et al[29] reported that the duration of labour had an independent, statistically significant negative impact on women's satisfaction with their labour and delivery experiences. The study found that longer labour durations was associated with lower maternal satisfaction, a p-value of 0.05 indicating a significant negative correlation between labour duration and maternal satisfaction.Present study showed that augmentation of labour was significantly associated with RMC, with mothers who did not receive augmentation reporting higher mean scores (t = 43.26, df = 192, p = 0.00). A similar result was reported by Kempe P et al[29] who found that oxytocin augmentation was significantly related to lower maternal satisfaction with the birthing experience (p

<0.05). In contrast YouseﬂuS et al[30] reported that oxytocin induction was strongly associated with higher RMC scores, indicating a positive relationship between labour augmentation and RMC (p < 0.05). Further, present study showed the nature of pregnancy was significantly associated with RMC with mothers who had planned pregnancies reporting higher mean scores (t = 9.31, df = 192, p = 0.00; 60.65 ± 7.99 vs 56.34 ± 10.18). A similar result was reported by Silesh M and Lemma T[31] who found that planned pregnancies were significantly associated with higher maternal satisfaction with intrapartum care AOR = 2.25, 95% CI: 1.21-4.16). In contrast Nelson HD et al[32] reported that unintended pregnancies were significantly associated with higher odds of maternal depression during pregnancy and postpartum AOR = 1.59, 95% CI: 1.35-1.92), indicating a negative relationship between unintended pregnancies and maternal mental health.

In present study age was significantly associated with CBE, mothers aged 19-26 years reporting the highest mean scores (F = 5.95, df = 2/191, p = 0.00; 50.97 ± 5.83 vs 36.50 ± 9.19 for <18 years). A similar result was reported by YouseﬂuS et al[30] who found that younger mothers (<20 years) had significantly lower CBE scores compared to mothers aged 20-30 years (p < 0.05). In contrast, Athira C et al[26] reported no significant association between maternal age and CBE (p > 0.05) indicating that age did not always influence maternal perceptions of childbirth satisfaction. Further,present study showed that area of residence was significantly associated with childbirth experience, with urban mothers reporting higher mean CBE scores than rural mothers (t = 10.40, df = 192, p = 0.00; 52.30 ± 4.06 vs 49.55 ± 7.00). A similar finding was reported by Silesh M and Lemma T[31] who found that mothers living in urban areas had significantly higher childbirth satisfaction compared to rural mothers (AOR = 2.18, 95% CI: 1.34-3.55, p < 0.01). In contrast, Jafari E et al[27] reported no significant difference in CBE between urban and rural mothers (p = 0.12) indicating that residence does not always influence maternal perceptions of care. Present study revealed that family income was significantly associated with CBE, with mothers in Rs. 10,000-40,000 income group reporting the highest mean scores (F = 2.94, df = 3/190, p = 0.03; 51.56 ± 5.92 vs 49.31 ± 6.69 for <Rs. 10,000 and 48.10 ± 7.03 for >Rs. 70,001). A similar finding was reported by Silesh M and Lemma T[31] who found that highe income was significantly associated with greater maternal satisfaction with intrapartum care (AOR = 1.85, 95% CI: 1.12-3.05, p = 0.02). In contrast, Jafari E et al[27] reported no significant association between family income and CBE (p = 0.15.

Present study showed that the profession of the health care provider was significantly associated with CBE with mothers attended by nurses reporting the highest mean scores (F = 4.18, df = 3/190, p = 0.00). A similar finding was reported by Jafari Eet al[27] who found that women attended by skilled birth attendants such as nurses/midwives reported significantly higher maternal satisfaction compared to those attended by less experienced providers (p < 0.01. In contrast, Athira Cet al[26] reported no significant difference CBE based on the profession of the attending provider (p = 0.18) suggesting that provider profession may not always influence maternal perceptions. Further, present study showed that the duration of labour was significantly associated with CBE with mothers experiencing labour>16 hours reporting the highest mean scores (F = 6.05, df = 2/191, p = 0.00). A similar finding was reported by CarlhallS et al[28] who found that longer labour durations were significantly associated with higher maternal satisfaction and CBE with AOR of 2.39 (95% CI: 1.98-2.90) for primiparous women and 2.23 (95% CI: 1.78-2.79) for multiparous women (p < 0.05). In contrast, Kempe P et al[29] reported that labour duration did not significantly affect maternal satisfaction in some settings, with a negative but statistically non-significant association (p = 0.08). The current study found a strong relationship between CBE and the kind of pregnancy, with mothers reporting higher mean scores for planned pregnancies than for unexpected ones (t = 15.05, df = 192, p = 0.00; 51.72 ± 5.35 vs 48.02 ± 7.02). A similar finding was reported by Silesh M and Lemma T[31] who found that planned pregnancies were significantly associated with higher maternal satisfaction during childbirth AOR = 2.25, 95% CI: 1.21-4.16, p = 0.01). Conversely, Nelson HD et al[32] reported that unplanned pregnancies were associated with a higher risk of negative maternal mental health outcomes, including lower satisfaction with CBE (AOR = 1.59, 95% CI: 1.35-1.92, p <0.05).

Conclusion

The study came to the conclusion that RMC plays a crucial part in improving delivery experiences. It is crucial to have policies and procedures that support courteous, compassionate care, such as making sure there is enough staffing, good communication, emotional support, and pain management. Maternal happiness and the standard of care during childbirth can be significantly raised by addressing modifiable labour - related factors and carer consistency.

The study's strengths include its thorough evaluation of several aspects of RMC and the birthing experience, use of validated tools, and reference to international studies for comparison. The cross-sectional design, which precludes drawing conclusions about causality, and the possible recall bias brought on by the use of self-reported survey data are drawbacks, though.

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drafted methods, analysis, and collected data. **T** contributed to ethics, literature review, and summaries. **SB** handled the pilot study, first chapter, and references. **JK** guided overall research and thesis development. Several team members aided in Hindi translation, Excel prep, and final presentation.

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