

Respectful maternity care in public health care facilities in Gujarat: A direct observation study

Hiral Raval¹, Tapasvi Puwar¹, Prakash Vaghela², Manshi Mankiwala³,
Apurva Kumar Pandya¹, Priya Kotwani⁴

¹Indian Institute of Public Health Gandhinagar, Gujarat, ²Department of Health and Family Welfare, Government of Gujarat, Gujarat, ³State Program Management Unit, National Health Mission, Government of Gujarat, Gujarat, ⁴Parul Institute of Public Health, Parul University, Waghodia, Gujarat, India

ABSTRACT

Introduction: Respectful maternity care (RMC) is not only the marker of quality maternity care but also ensures the protection of basic human rights of every child-bearing woman. This paper discusses the assessment of RMC services during the intrapartum period at public health care facilities in Gujarat state. **Material and Methods:** A cross-sectional research design was used for the study. The data were collected from three different levels of public health facilities such as primary health center (PHC), community health center (CHC), and district hospital (DH) in one of the districts in Gujarat. A standardized tool developed by the United States Agency for International Development based on the RMC charter was used for data collection. A total of 41 pregnant women across three public health facilities were observed during intrapartum care. **Findings:** Most women experienced disrespectful intrapartum care provided at the public health care facilities; however, at-least two performance standards of the RMC charter were met during intrapartum care at each public health care facility. Comparatively, the PHC demonstrated higher RMC performance compliance than DH and the CHC. Most often violations of RMC standards included beneficiaries were not greeted, privacy not maintained, they were not encouraged to ask questions, and support not provided during labor. **Conclusion:** Respectful maternity care is evidently not practiced in public health care facilities. Designing comprehensive behavioral training on RMC, especially for primary, secondary, and tertiary care physicians and nursing staff can improve the adaptation of RMC standards in respective public health care facilities. Positive experiences of intrapartum care can potentially improve the uptake of maternal care facilities. Further research is needed to understand local contextual factors, social norms, and patient-provider interactions.

Keywords: India, intrapartum care, public health care facilities, quality of care, respectful maternity care

Introduction

Disrespectful care is a barrier to pregnant women and their families accessing public health care services. Literature pertaining to respectful maternity care (RMC) highlighted disrespect and abuse in facility-based childbirth, including physical abuse,

nondignified care, nonconsented care, nonconfidential care, discrimination, abandonment of care, and detention in facilities.^[1]

RMC is protection from verbal and physical abuse, disrespect, and discrimination during care.^[2] It also aims to provide care to child-bearing women with dignity, privacy, and confidentiality.^[3] The WHO^[4] has acknowledged RMC as a fundamental right of every child-bearing woman and encourages health service provision to all women in a manner that maintains their dignity, privacy, and confidentiality. The WHO's "Recommendation on Respectful Maternity Care" ensures freedom from harm and

Address for correspondence: Dr. Hiral Raval,

13, Karnavati Society, Opp. Reliance Petrolpump, Bechraji,
District Mehsana, Gujarat, India.

E-mail: hiralraval1449@gmail.com

Received: 19-09-2020

Revised: 02-12-2020

Accepted: 25-12-2020

Published: 29-04-2021

Access this article online

Quick Response Code:



Website: www.jfmpc.com

DOI: 10.4103/jfmpc.jfmpc_1934_20

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: WKHLRPMedknow_reprints@wolterskluwer.com

How to cite this article: Raval H, Puwar T, Vaghela P, Mankiwala M, Pandya AK, Kotwani P. Respectful maternity care in public health care facilities in Gujarat: A direct observation study. *J Family Med Prim Care* 2021;10:1699-705.

mistreatment and enables informed choice and continuous support during labor and childbirth. Furthermore, the RMC Charter,^[5] developed by the White Ribbon Alliance, defines the universal rights of childbearing women and discusses the rights of childbearing women against disrespect and abuse across *seven* categories which have been adopted by many developing countries. Recently, the Government of India has adapted RMC under LaQshya to provide dignified care to pregnant women while in the health facility.^[6] However, RMC recommendations are often ignored and actions for their implementations are lagged to bring a paradigm change in maternal health practices. Ultimately, the insidious problem of negative interactions with pregnant women accessing health care services continues to exist.

Disrespect and abuse to women during institutional childbirth services is one of the deterrents to the utilization of maternity care services.^[7-10] Mistreatment of women during labor and delivery negatively influences women's decisions to seek future obstetric care at health facilities and violates women's rights.^[11,12] There are limited India studies^[11,13-16] related to the respectful maternity care and disrespectful and abusive behaviors that pregnant women experience at public health facilities. Further, in the context of the LaQshya program – aimed at ensuring respectful maternity care – that is implemented under National Health Mission in India, it is pertinent to understand to what extent RMC practices have adhered to. The present study assessed the level of RMC practices in three public health care facilities, namely, Primary Health Center (PHC), Community Health Center (CHC), and District Hospital (DH) in one of the districts of the Gujarat state.

Material and Methods

A cross-sectional study was carried out across all three levels of public health care facility i.e., PHC, CHC, and DH of one district in Gujarat. The direct observation method was adopted to assess the delivery of respectful maternity care during the intrapartum period using a standardized tool developed by the United States Agency for International Development (USAID).^[2] The respectful maternity care was observed across seven parameters as mentioned below:

1. Physical harm or ill-treatment.
2. Right to information, informed consent, and protection of choice or preferences of the women.
3. Confidentiality and privacy.
4. Dignity and respect.
5. Equitable care free of discrimination.
6. Whether the woman is left without care.
7. Whether the woman is detained or confined against her will.

The setting for the present study was the labor room and maternity ward of a selected health care facility providing care during the intrapartum period in one of the districts in Gujarat. The samples for the present study comprised women delivering a child and health professionals of the selected health care facility.

Direct observation of 41 deliveries was conducted in 31 days. The observation of pregnant women started in the second/third stage of the labor and was continued till 2 h after delivery. The first author spent 14 days at DH, 10 days at CHC, and 7 days at PHC for observation of RMC practices. The days spent at each health care facility were proportionally distributed based on the reported delivery load in each facility. All the vaginal deliveries irrespective of the time of delivery were observed during the study period at each facility. The cases of abortion and cesarean section were excluded from the study.

Permission to undertake this study was obtained from the Health and Family Welfare Department, Gujarat, and clearance from the Institution's Ethics Committee of Indian Institute of Public Health Gandhinagar was obtained as well. Only those women or their family members who provided informed consent for the study were included in the study. A written consent from health care providers was also taken. The single blinding method was used, and the coding of the facilities, beneficiaries, and health care providers was known only to the researchers.

Results

The mean age of our study participants was 25.41 (\pm 1.87) years. Of all the women observed during intrapartum care, 92.7% of the women were Hindu, and the remaining 7.3% were Muslim with 68.3% of the women belonging to OBC (other backward class) category. Around 83% of the women were multiparous.

The unit of analysis was an observation that represents the practices adopted by the health care providers in the care of women during labor across seven performance standards. Each of the seven performance standards has various subitems as shown in Table 1.

Out of the total 41 deliveries observed, 19 were observed at the DH where 8 health care providers were present. The CHC recorded 8 deliveries, and 5 health providers were present, whereas at the PHC 14 deliveries were recorded with the presence of 2 health care providers.

Respectful maternity care performance standards

Table 2 highlights the frequency of events for each of the seven performance standards. While comparing *three* facilities, it was observed that Standards II (right to information, informed

Table 1: Details of the RMC Charter

Seven performance standards of Respectful Maternity Care	Subitems in each performance standard
Physical harm and ill-treatment	6
Right to information, informed consent, and preferred Choice	9
Confidentiality and privacy	2
Dignity and Respect	2
Provision of equitable care, free of discrimination	2
Left without care	3
Detained or confined against the will	1

consent, and choice) and III (protection of confidentiality and privacy) were the most violated standards across all types of facilities, followed by I (protection from physical harm or ill-treatment), and VI (not left without care). Standard IV (treated with dignity and respect), V (received equitable care free of discrimination), and VII (never detained against will) were least violated. DH had violated *five* standards (standard I, II, III, IV, and VI) more often, whereas CHC and PHC were observed with noncompliance of *four* standards (namely, standard I, II, III, and VI).

Table 3 highlights the compliance across each subitem for all *seven* performance standards across three types of facilities. For example, within standard I, 100 percent compliance was observed for *two* indicators (never uses physical force or abrasive behavior and does not deny food or fluid to a woman) at both CHC and PHC. Compliance with other subitems was ranging from 42 to 84 percent for standard I.

Compliance of subitems underperformance standard II varied from 5 to 86 percent, standard III, varied from 0 to 71 percent;

Table 2: Observation of respectful maternity care performance standards across facilities

Standard	Performance Standards	DH n=19 (f)	CHC n=8 (f)	PHC n=14 (f)
I	The Woman is protected from physical harm or ill-treatment	2	2	3
II	The Woman's right to information, informed consent, and choice/preferences are protected.	0	0	0
III	Confidentiality and privacy are protected.	0	0	0
IV	The Woman is treated with dignity and respect	5	6	10
V	The woman receives equitable care free of discrimination	13	8	14
VI	The woman is never left without care.	1	3	4
VII	The woman is never detained or confined against her will	18	8	13

Table 3: Observation of respectful maternity care across each sub-item of performance standard

Performance Standards	Sub-Items	DH (n=19) f (%)	CHC (n=8) f (%)	PHC (n=14) f (%)
1. The Woman is Protected from physical harm or ill-treatment	Never uses physical force or abrasive behavior with the woman, including slapping or hitting	16 (84%)	8 (100%)	14 (100%)
	Never physically restrains woman	11 (58%)	4 (50%)	9 (64%)
	Touches or demonstrate caring in a culturally appropriate way	10 (53%)	4 (50%)	10 (71%)
	Never separates woman from her baby unless medically necessary, breastfeeding within 1 h	8 (42%)	6 (75%)	8 (57%)
	Does not deny food or fluid to the woman in labor unless medically necessitated	19 (100%)	8 (100%)	14 (100%)
	Provides comfort/pain-relief as necessary	11 (58%)	6 (75%)	8 (57%)
2. The Woman's right to information, informed consent, and choice/preferences is protected.	Introduces self to woman and her companion	1 (5%)	0 (0%)	0 (0%)
	Encourages companion to remain with woman whenever possible	12 (63%)	3 (37%)	4 (28%)
	Encourages woman and her companion to ask questions	3 (16%)	1 (12%)	0 (0%)
	Responds to questions with promptness, politeness, and truthfulness	6 (31%)	5 (62%)	10 (71%)
	Explains what is being done and what to expect throughout labor and birth	2 (10%)	3 (37%)	8 (57%)
	Give periodic updates on status and progress of labor	4 (21%)	0 (0%)	4 (28%)
	Allows the woman to move about during labor	5 (26%)	3 (37%)	12 (86%)
	Allows a woman to assume a position of choice during birth	2 (10%)	1 (12%)	11 (78%)
3. Confidentiality and privacy is protected.	Obtains consent or permission prior to any procedure	15 (79%)	5 (62%)	12 (86%)
	Uses curtains or another visual barrier to protect a woman during exams, birth, procedures	5 (26%)	6 (75%)	10 (71%)
4. The Woman is treated with dignity and respect.	Uses drapes or covering appropriate to protect woman's privacy	0 (0%)	0 (0%)	0 (0%)
	Speak politely to woman and companion	5 (26%)	6 (75%)	11 (78%)
5. The woman receives equitable care, free of discrimination	Never makes insults, intimidation, threats, or coerces woman or her companion	12 (63%)	6 (75%)	11 (78%)
	Speaks to the woman in a language and at a language-level that she understands	17 (89%)	8 (100%)	14 (100%)
6. The woman is never left without care	Does not show disrespect to a woman based on any specific attribute	15 (79%)	8 (100%)	14 (100%)
	Encourages woman to call if needed	2 (10%)	3 (37%)	8 (57%)
	Comes quickly when woman calls	4 (21%)	5 (62%)	11 (78%)
7. The woman is never detained or confined against her will	Never leaves woman alone or unattended	12 (63%)	7 (87%)	11 (78%)
	The facility does not have the policy to detain a woman who does not pay	18 (95%)	8 (100%)	13 (93%)

standard IV, from 26 to 78 percent. Overall, standard V (89 to 100 percent) and Standard VI 10 to 87 percent; and standard 7 (93 to 100 percent) were more complied compared to others. Table 3 also highlights that comparatively, PHC demonstrated higher RMC performance compliance than DH and CHC facilities.

It is seen that health care providers of DH fail to explain what is being done and what to expect throughout labor and birth, let women assume the position of choice during birth, and use drape or cover the women. While in the case of CHC and PHC, health care providers did not introduce themselves to women and her companion, did not give periodic updates on the status and progress of labor, and failed to use drapes or cover the women to protect their privacy.

Pearson's Chi-Square test was used to assess the association between the violation of performance standards and level of health care facility. Table 4 presents the Pearson Chi-Square results.

A significant association was found between the violation of performance standards and level of health care facility (P -value = 0.016) suggesting women delivering in DH are more likely to experience disrespectful maternity care. Examples of disrespectful maternity care were as follows: Women were not greeted (100%), not encouraged to ask questions (93%), and no privacy maintained (100%) nor support provided (76%) during labor. These negative treatments to women were exerted by staff nurses and support staff i.e., known as *aaya* (93%).

Out of all the 41 deliveries observed, 58.5% of the deliveries happened at night. Association between experiencing violations of RMC and various independent variables such as time of delivery, caste, and parity of the women were insignificant.

Discussion

In the present study, findings reported practices adopted by health care providers about RMC. Overall, compliance with RMC standards I, II, III, IV, and VI needs to be strengthened across the three facilities. We find that disrespectful care of patients during labor and delivery – particularly verbal and physical abuse – are common. This finding is largely consistent with those from recent studies on disrespectful care in maternity services.^[7-10] Some studies identified some other constructs of disrespectful care of women in various health facilities in India.^[11,13,14,17] Recent systematic review revealed the pooled prevalence of disrespectful maternity care as 71.31%^[18] A study conducted by Sharma and colleagues established that at least one indicator of disrespectful

care was present during childbirth at both the public and private health facility.^[15] Another Indian study^[11] revealed that 98 percent of women faced disrespect and abuse during childbirth in public and private health facilities. At the extreme, one Indian study^[16] reported discrimination based on religious and socioeconomic status during intrapartum care. However, not surprisingly, there have been reports of treating disrespectful maternal care as “normal” as part of the health care procedure by health care providers and also by women undergoing such care.^[17] A study conducted by Sando *et al.* reported “normalization” of disrespect and abuse in their study conducted in urban Tanzania.^[19] Such normalization contributes to the increased prevalence of the problem as well as creates an “iceberg phenomenon” by not recognizing it as a problem.

In this study, nonconsented care was also the most common practice which was also reported in Indian studies.^[11,16,17] Health care providers assume to perform care as the need arises in the best interest of the patients and do not consider informing patients. Okafor *et al.*^[20] have also reported nonconsented care to be the most prevalent type of disrespect and abuse among females of Nigeria. Reportedly, landscape review conducted at Harvard University^[21] presents that data from Latin American countries, Sub-Saharan Africa, and Eastern Europe regions have reported a lack of routine, patient information-communication, and consent protocols for obstetric procedures in their respective settings, including the widespread practice of episiotomy without patient notification or consent.

In the present study, privacy was not maintained and service providers did not introduce themselves to women and companions. Women and her companion were not encouraged to ask questions. A similar study conducted in New Delhi^[11] reported a lack of encouragement and positive communication between women and health care professionals, none of the women delivering babies was greeted by health care professionals. International studies^[12,22-24] reported similar findings. In our study, many women experienced poor interaction with providers and were not well informed about their care. It certainly indicates communication gaps during intrapartum period care and poor communication skills of providers. To address this problem, the WHO's standards for improving the quality of maternal and newborn care in health facilities^[25,26] adequately emphasize the importance of effective communication that is responsive to specific needs and preferences of women and their families, providing care with respect and dignity, staff's motivation and competency, and appropriate physical environment as critical components of quality care.

Table 4: Grading of violations of respectful maternity care

Violation of RMC	DH (n=19) f (%)	CHC (n=8) f (%)	PHC (n=14) f (%)	Pearson Chi-Square P*
Violation of upto 3 performance standards	2 (10.5)	4 (50)	5 (35.7)	0.016
Violation of 4 to 5 performance standards	10 (52.6)	5 (50)	9 (64.3)	
Violation of 6 to 7 performance standards	7 (36.8)	0	0	

*At 5% level of significance ($\alpha=0.05$)

Studies indicate that higher patient load, inadequate infrastructure, staff shortage, and work stress are barriers to provide RMC.^[16,27,28] Hygiene practices of health workers were compromised. In a study,^[29] hand washing after the examination of each patient was observed to be inadequate. Besides, only 15 percent of the facilities followed immediate wiping off the floor after delivery.

As observed in this study, disrespectful care was perpetrated by health care providers which is echoed in earlier studies as well.^[19,29] In a country like India, where the majority of women from rural areas where childbirths are mostly provided by health care providers at CHC or DH while auxiliary nurse midwife (ANM) at PHC, not by a qualified doctor,^[17] child-bearing women become vulnerable to disrespect and abuse. Higher RMC practice at PHC indicates positive treatment by a health care provider. A systematic review^[30] on midwife-led models of care for childbirth in high-income countries showed that midwife-led care was beneficial particularly for normalizing and humanizing childbirth. It is appreciable that better compliance with RMC at the PHC facility indicates positive interaction with pregnant women.

The need for dignified obstetric care i.e., high-quality, equitable, and respectful maternity care in all health facilities is beyond the prevention of mortality and morbidity. In this line, the WHO's vision for quality of Reproductive Health care for women and newborns emphasizes the importance of both the "provision of care" and "experience of care."^[25] Thus, promoting RMC is crucial to improve the quality of maternal care and institutional deliveries.

Meaghan *et al.*^[31] have developed a framework of generating awareness on RMC for global health network for effective planning, optimal use of resources, and creating conducive environment that can be adapted to promote RMC in the country. These efforts can unquestionably improve the uptake of maternal health care services including institutional deliveries.

Recommendations

Efforts to improve the quality of facility-based maternity care for women under the LaQshya program are unlikely to achieve the desired gains if there is no improvement in the quality of care provided by health care providers, especially for different elements of RMC. Based on the study, the author proposes a few specific recommendations to ensure RMC practices across all levels of public health facilities.

Promote adherence to RMC standards in public health care facilities

First, there is a need to promote RMC standards, especially those *five* RMC standards (mentioned Table 2) in public health care facilities. RMC practice can be promoted through systematic, context-specific planning, monitoring, and supervision

mechanism as well as tools to assess disrespectful maternity care practices. In this direction, developing contextual tools to measure and monitor RMC practices in public and private health care facilities is the need of the hour.

Women-centric maternal care

The preferences of the woman should be kept in mind regarding the choice of birth, curtains, and drapes to ensure privacy, choice of a companion during childbirth. Further, companions should be educated about their roles as companions with knowledge of their roles can address the emotional needs of the women that in turn can positively impact pregnant women's experience of intrapartum care. Field staff can orient both mothers and companions on the procedure using culturally relevant "information education communication" materials.

Enhancing the capacity of primary care staff on RMC

In-service periodic behavioral training of health care providers including support staff can potentially help reducing gaps in RMC. Incorporation of respectful maternal care during preservice training as well as medical and paramedical course (especially, Auxiliary Nurse-Midwifery and General Nursing and Midwifery course) curriculum can be the key strategy to change the culture in the labor ward.

Encouraging RMC practice across healthcare facilities

The "reward and recognition" of intrapartum care staff by the State or District authority can not only promote accountability but also motivate staff to exercise respectful, woman-centered, maternity care in their respective health care facilities. Designing and assessing the effectiveness of a comprehensive behavioral training intervention that addresses root causes and promote RMC would be worthy.

Long-term, sustained investment in infrastructure, work-culture, and research

We note the need of a long-term, sustained investment is needed for strengthening infrastructure and health systems. Without creating supportive and enabling work-environments for front-line health workers and fostering accountability to the public RMC standards cannot be materialized.

Health institutions should establish a responsive redressal mechanism to handle and address complaints. Further, more research in this domain, such as documenting beneficiary and providers' perspectives on RMC practice, innovative behavioral approaches to enhance the quality of intrapartum care should be promoted both in academia and practice.

Strengths and limitations of the study

A strength of this study is that it is one of the few that has explored RMC practice standard compliance and disrespectful

care of women through observation. Most studies conducted on RMC used women's exit interviews, which may underestimate actual practice due to recall bias. The investigator who observed provider-client interactions was trained and experienced in participant observation. Another strength of this study was that it covered three levels of public health care facilities.

While this study was conducted with rigor and provides important insights into respectful maternity care, some limitations should be acknowledged. First, the study was conducted at three different public health care facilities in only one district. Therefore, cultural diversity across regions may not be captured. Second, these facilities were purposively selected considering operational feasibility and time constraint which has not allowed the incorporation of facilities that are better or worse in terms of RMC practices. Third, this study used an observational study designed to capture elements of RMC practices for normal labor and childbirth, c-section and high-risk deliveries were excluded from the study. Future studies should include these groups as well. The fourth limitation was the possible Hawthorne effect, in which providers will show acceptable behavior during service provision because they know that they are being observed. Thus, health care providers would try to minimize their lack of respectful care when speaking to women and other health care providers. This may have been minimized by rapport building with the staff. The researcher was trained in communication skills to ease health care workers' anxiety related to participant observation. Besides, all attempts were made to ensure confidentiality, and the participants were informed that their names as well as of the facility will be deidentified in the report and during publication. Also, they were assured that their responses would not be shared with their superiors. Despite these limitations, the study revealed a real practice scenario that limited respectful maternal care, suggesting that participants were honest in their practice. Nevertheless, findings should be interpreted with some caution as conducting participant observation at the health facility may lead to a risk of "courtesy bias."

Conclusion

The findings of our study provide valuable insight into the current perceptions and practices by health care personnel from primary, secondary, and tertiary level public health care facilities. Respectful maternity care is evidently not practiced in public health care facilities. Positive experiences can improve the uptake of public maternal care facilities. Further research is needed to understand local contextual factors, social norms, complex patient-provider interaction which may provide insights on enhancing RMC. Longitudinal research is needed to identify the reason for the superior RMC performance of primary health center than community- health centers and district hospitals and staff nurses and midwives compared to other professional cadres.

Acknowledgements

Authors thank all the participants of the study and health staff for their co-operation.

Ethics approval and consent to participate

Ethics approval was sought from the Institutional Ethics Committee of the Indian Institute of Public Health Gandhinagar. A written consent from participants was obtained.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Pileggi VN, *et al.* Respectful care during childbirth in health facilities globally: A qualitative evidence synthesis. *BJOG* 2018;125:932-42.
2. Moving Respectful Maternity Care into Practice in Comprehensive MCSP Maternal and Newborn Programs Operational Guidance DRAFT, USAID, Maternal and child survival program. 2018. Available from: https://www.mcsprogram.org/wp-content/uploads/2018/05/M_CSPR_MCOperationalGuidanceDraft.pdf.
3. White Ribbon Alliance. Effective accountability for disrespect and abuse experienced by women during maternity care: Evidence and recommendations submitted to the iERG by White Ribbon Alliance on behalf of members of the Global Respectful Maternity Care Community of Concern. May 15, 2015. Available from: https://www.who.int/woman_child_accountability/iERG/reports/12_WRA_on_behalf_of_RMC_evidence_submitted_iERG_2015.pdf?ua=1. [Last accessed on 2020 Mar 18].
4. WHO. Recommendations on respectful maternity care. [Internet] 2018. Available from: <https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/who-recommendation-respectful-maternity-care-during-labour-and-childbirth>.
5. RMC Charter. Universal rights of childbearing women. White Ribbon Alliance. [Internet]. Available from: https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf. [Last accessed on 2020 Mar 18].
6. LaQshya: National labour room & maternity OT quality improvement initiative. National Health Mission. Government of India. [Internet]. [Last accessed on 2020 Mar 18]. Available from: <https://laqshya.nhp.gov.in/>.
7. Van Den Broek NR, Graham WJ. Quality of care for maternal and newborn health: The neglected agenda. *BJOG* 2009;116(Suppl 1):18-21.
8. Hodgins S. What happens after women come through the door? *Glob Health* 2011;10:12.
9. Shiferaw S, Spigt M, Godefrooij M, Melkamu Y, Tekie M. Why do women prefer home births in Ethiopia? *BMC Pregnancy Childbirth* 2013;13:5.
10. Balde MD, Bangoura A, Diallo BA, Sall O, Balde H, Niakate AS, *et al.* A qualitative study of women's and health providers' attitudes and acceptability of mistreatment during childbirth in health facilities in Guinea. *Reprod Health* 2017;14:4. doi: 10.1186/s12978-016-0262-5. [Last accessed on 2020 Mar 18].
11. Singh A, Chhugani M, Merlin MJ. Direct observation on

- respectful maternity care in India: A cross-sectional study on health professionals of three different health facilities in New Delhi. *Int J Sci Res* 2017;7:5.
12. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, *et al.* Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy Childbirth* 2015;15:306. doi 10.1186/s12884-015-0728-4.
 13. Sudhinaraset M, Treleaven E, Melo J, Singh K, Diamond-Smith N. Women's status and experiences of mistreatment during childbirth in Uttar Pradesh: A mixed-methods study using cultural health capital theory. *BMC Pregnancy and Childbirth* 2016;16:332. doi: 10.1186/s12884-016-1124-4.
 14. Dey A, Shakya HB, Chandurkar D, Kumar S, Das AK, Anthony J, *et al.* Discordance in self-report and observation data on the mistreatment of women by providers during childbirth in Uttar Pradesh, India. *Reprod Health* 2017;14:149.
 15. Sharma G, Penn-Kekana L, Halder K, Filippi V. An investigation into mistreatment of women during labour and childbirth in maternity care facilities in Uttar Pradesh, India: A mixed-methods study. *Reprod Health* 2019;16:7.
 16. Reddy BV. MaathruSamman Pants: An initiative towards "Respectful Maternity Care". *J Family Med Prim Care* 2019;8:1821-3.
 17. Nawab T, Erum U, Amir A, Khaliq N, Ansari MA, Chauhan A. Disrespect and abuse during facility-based childbirth and its sociodemographic determinants - A barrier to healthcare utilization in rural population. *J Family Med Prim Care* 2019;8:239-45.
 18. Ansari H, Yeravdekar R. Respectful maternity care during childbirth in India: A systematic review and meta-analysis. *J Postgrad Med* 2020;66:133-40.
 19. Sando D, Abuya T, Asefa A, Banks KP, Freedman LP, Kujawski S, *et al.* Methods used in prevalence studies of disrespect and abuse during facility-based childbirth: Lessons learned. *Reprod Health* 2017;14:1-18.
 20. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. *Int J Gynecol Obstet* 2015;128:110-3.
 21. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Report of a landscape analysis. Boston: USAID-TRAction Project, Harvard School of Public Health. 2010. [Last accessed on 2020 Mar 18]. Available from https://www.ghdonline.org/uploads/Respectful_Care_at_Birth_9-20-101_Final1.pdf.
 22. Bohren MA, Tunçalp Ö, Miller S. Transforming intrapartum care: Respectful maternity care. *Best Pract Res Clin Obstet Gynaecol* 2020;67:113-26.
 23. Hajizadeh K, Vaezi M, Meedy S, Charandabi SM, Mirghafourvand M. Respectful maternity care and its relationship with childbirth experience in Iranian women: A prospective cohort study. *BMC Pregnancy Childbirth* 2020;20:1-8.
 24. Pathak P, Ghimire B. Perception of women regarding respectful maternity care during facility-based childbirth. *Obstet Gynecol Int* 2020;2020:5142398. doi: 10.1155/2020/5142398.
 25. WHO. Standards for Improving the Quality of Maternal and Newborn Care in Health Facilities. Geneva: World Health Organization; 2016.
 26. Tunçalp Ö, Were WM, MacLennan C, Oladapo OT, Gülmezoglu AM, Bahl R, *et al.* Quality of care for pregnant women and newborns-the WHO vision. *BJOG* 2015;122:1045-9.
 27. Bohren MA, Hunter EC, MuntheKaas HM, Souza J, Vogel JP, Gülmezoglu A. Facilitators and barriers to facility-based delivery in low and middle-income countries: A qualitative evidence synthesis. *Reprod Health* 2014;11:7188.
 28. Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OMR, Feigl AB, *et al.* Quality maternity care for every woman, everywhere: A call to action. *Lancet* 2016;388:2307-20.
 29. Saxena M, Srivastava A, Dwivedi P, Bhattacharyya S. Is quality of care during childbirth consistent from admission to discharge? A qualitative study of delivery care in Uttar Pradesh, India. *PLoS One* 2018;13:e0204607.
 30. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev* 2016;4:Cd004667.
 31. O'Connor M, McGowan K, Jolivet RR. An awareness-raising framework for global health networks: Lessons learned from a qualitative case study in respectful maternity care. *Reprod Health* 2019;16:1.