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Review Article

Obstetrics and Gynaecology Section

Respectful Maternity Care: A Narrative Review

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ABSTRACT

Respectful Maternity Care (RMC) is a fundamental right of every childbearing woman. It is aimed at lessening disparities in medical care and assists in achieving an optimal outcome for both mothers and newborns. However, studies have shown that Disrespect and Abuse (D&A) are extremely widespread in low socio-economic countries and that care quality has been neglected at all levels. To minimise disrespectful Maternity Care, we must create situation-specific, proof-based interventions as well as strategies and plans of action. RMC needs a lot more than the ending of misconduct. Care should be provided to all women in a way that safeguards their respect, privacy, and confidentiality. They should not be ill-treated and constant support should be provided at the time of labour and childbirth. Respectful treatment should not be dependent on the social status of the mother. The implementation of RMC through the labour and delivery process is a complicated procedure that demands that healthcare providers possess both interpersonal and scientific abilities. In this regard, it is crucial to recognise the probable hurdles and execute efficient approaches for implementing RMC into action. The present review aimed to further focus the discussion around the creation of RMC policies for various healthcare settings. The authors emphasise the value of RMC and highlight that poor treatment and disrespectful care are issues that are essential to be addressed across all research fields, including community health, quality assurance, administration, and human rights.

Keywords: Childbearing, Labour, Healthcare, Newborn

INTRODUCTION

Pregnancy and childbirth are phases when a woman is most vulnerable. A woman's safety during this period is related not only to maternal mortality but also to the quality of care provided. Every childbearing woman possesses the essential and universal right to Respectful Maternity Care (RMC). RMC includes respect for women's autonomy, privacy, feelings, choices, and preferences. She should also have the right to choose her companion during maternal care, labour, and childbirth. Her companion can ensure no ill-treatment is given to her and a known face staying around will comfort her [1]. In multiple settings around the world, especially among the less fortunate population, disrespectful care is common. This refers to physical cruelty, non consented care, non dignified care, non confidential treatment, unfairness, neglect or rejection of care, and confinement in facilities [2]. Including the antepartum, intrapartum, and postpartum periods, RMC applies to all phases of pregnancy. A woman deserves to be treated with the same respect during all phases. But the institutions and society in which we live don't necessarily ensure research-based treatment. Let us take an example of a woman who is in labour and goes to a hospital for high-quality obstetric treatment. She would anticipate a certain kind of care and demand timely attention to detail. It should be made clear to her by a compassionate healthcare professional about what to anticipate and why. Acknowledging herself as a protagonist and active decision-maker in her birthing process, providing her the freedom to agree to or decline any interventions after knowing entirely what they are likely to involve [1,2].

Nevertheless, such immediate and polite obstetric care is not followed in many healthcare environments across the world. This leads to disparity, giving providers the upper hand and encouraging obstetric violence. Ineffective communication among members of the care team may result in differences in treatment quality. According to a 2014 World Health Organisation (WHO) statement, "Every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth." The statement also called for the prevention and elimination of Disrespect & Abuse (D&A) during childbirth. WHO also urged governments, programmers, researchers, advocates, and communities to rally around RMC [3].

Unfortunately, there was an important aspect lacking. Despite the sharp rise in hospital deliveries, there hasn't been a parallel improvement in the labouring experience for women. Giving birth in hospitals rather than at home has helped enhance access to life-saving care for medical emergencies, but it also brought with it new difficulties, such as congestion in amenities, overcrowding of facilities, and over-medicalisation of delivery. Birthing process depends on high-quality, considerate, evidence-based care [4]. Women's decisions to seek maternity care are impacted by the poor quality of care offered, particularly the fear of D&A inflicted by health professionals. Physical abuse, non consented care, non confidential care, non dignified care, discrimination, and abandonment in facilities are examples of common D&A expressions. Privacy violations, denial of access to medical facilities, failure to provide care to women during childbirth results in life-threatening problems that could be prevented, and the detention of women and their newborns in facilities, because they are unable to pay, are also abusive. It can be quite difficult to use maternity care services when there is little respect shown for women in the birthing environment [5]. Thus, pregnant women need to have a good relationship with maternity service providers because women's interactions with carers during pregnancy and childbirth can have a positive or negative effect on them. Their emotional pain or comfort may result from this event, which could boost or diminish their self-confidence [5].

The objective of this review is to bring attention to the topic of developing RMC policies for various healthcare settings in India. We emphasise the value of RMC and highlight that poor treatment and disrespectful care are issues that need to be addressed all across research fields, public health, quality assurance, administration, and human rights. RMC depends on number of factors, including structural inputs, procedures, policies, and programs, perspectives from the user and supplier, as well as requirements and expectations [6].

DISCUSSION

A systemic search on electronic databases (PubMed, Web of Science, and Google Scholar) was initiated. Articles on RMC were explored using the following keywords- RMC, labour, healthcare, intervention, and newborn. Around 450 articles were found relevant to the studies and screened for inclusion and exclusion criteria. For inclusion criteria articles up to date, relevant to studies and on maternity care were included and articles not in English, non-peer-reviewed were excluded. Original articles and review articles published in the English language were included in the study. Finally, around 35 references were imported to Zotero and cited in the present review article.

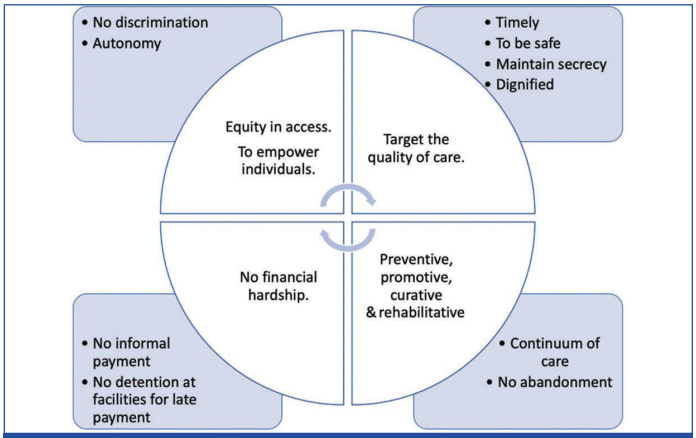
Importance of RMC

Women's experiences at this vulnerable time may play a significant role in empowering them or leading to developing negative feelings, resulting in low confidence and self-esteem. These experiences remain with the mother for the rest of her life. Furthermore, they impact the mother's and the baby's well-being. Access to high-quality medical care can lower rates of maternal mortality and morbidity and aid in detecting, managing, and treating health issues that complicate pregnancy. It can also lower the risk of adverse health outcomes. It's critical to have access to respectful care, as much as it is to address concerns like continued perinatal assistance and health insurance coverage. For lowering stillbirths and maternal and neonatal fatalities, RMC is a practical and effective technique. The lack of RMC proves a significant system failure in the health system. Factors including limitations in the health system and system breakdowns are crucial to assure the quality of care. Doctors, nurses, doulas, midwives, and community health workers should all be a part of the care teams. They need to have sufficient training in cultural humility so they can approach every patient with an honest desire to listen and learn. Furthermore, they must be held responsible for delivering fair, discrimination-free, high-quality treatment [7,8].

Respectful Maternity Care (RMC) in Developed and Developing Countries

According to recent research and comprehensive reviews, women are subjected to mistreatment and abuse. According to the study, women are subjected to various forms of violence, including physical assault, verbal abuse, stigma, neglect, and threats. They are also detained, denied privacy, offered bribes, and deprived of essential medical supplies in hospitals worldwide [7,8]. According to reports, D&A are prevalent to a respective extent of 19% and 98% in Tanzania and Nigeria [8]. According to the Heshima Project in Kenya, one in five women report feeling humiliated, and nine out of ten doctors believe that women are not treated empathetically [9]. According to a comprehensive review from Ethiopia, the pooled prevalence of disrespect and maltreatment was 49.4% [10]. One of the pioneering initiatives in the world, Heshima evaluated the prevalence of D&A during childbirth and came up with solutions based on the baseline survey findings. Heshima researchers and implementers used an iterative, participatory learning-by-doing process throughout all phases of the Project's conception, implementation, and assessment to gather data and carry out several interventions that cross the boundaries of policy, facilities, and communities. According to international human rights treaties and relevant governmental legislation and laws, the intervention should identify and address disparities, discriminatory practices, and power imbalances between service providers and clients. Women's access to high-quality maternity care in Ethiopia could be hindered by cultural and social obstacles such as mistrust of medical institutions, financial constraints, and a lack of transportation to medical facilities. The end consequence is a preference for home births despite the risks associated with that choice [9,10].

In Latin America, where conventional gender and societal norms are particularly prevalent, women frequently defer to their husbands or partners when making decisions which reduces their autonomy during childbirth. Improving RMC in this area requires educating partners and families on the value of women's autonomy, empowering women to make informed choices about their care, and creating a climate where they can speak up for themselves [10]. One should note the following components of RMC to be kept in mind as stated below [Table/Fig-1].



[Table/Fig-1]: Components of RMC. Adapted from [11].

RMC: The Indian Scenario

Institutional deliveries have been encouraged to mitigate maternal mortality and morbidity by offering mothers financial rewards. Womens in India benefit financially from a government programme called the Janani Suraksha Yojana (JSY) in India [11]. The JSY is the most significant conditional cash transfer initiative ever implemented globally. Promoting more deliveries at hospitals in India primarily aimed to lower mother and infant mortality. The JSY has also reduced out-of-pocket costs for issues related to delivery and improved antenatal care [11,12].

The most common complaints mentioned by patients and providers were the lack of medication and provisions, access to water and energy, the lack of female and specialised doctors, poor communications, and post-delivery psychotherapy. The prevalent issues noted by providers included poor referral management, vacant jobs resulting in a shortage of human resources, insufficient incentives, inadequate infrastructure, the lack of blood banks, and terrible user collabouration [13,14]. According to a study done in New Delhi, there are communication gaps during the intrapartum period of care and providers with poor communication skills. No healthcare worker greeted any women who had come for delivery, and many women had poor interactions with providers and needed to be better informed about their care [15].

To address this issue, the WHO's standards for improving the quality of maternal and newborn care in health facilities sufficiently highlight the significance of effective communication that is responsive to the specific needs and preferences of women and their families, providing care with respect and dignity, staff members' motivation and competency, and the appropriate physical environment as critical components of quality care [16].

Susceptible Population

The rights of child-bearing women are presented in [Table/Fig-2] [17]. According to studies, women who are economically underprivileged, illiterate, from a caste considered backward, migrants from rural localities, who experience co-morbid conditions, who are teenagers, and who are not married are more likely to face disrespectful RMC. Language and religious discrimination against women both exist [18]. The tacit acceptance of any treatment, lack of desire for quality care, fear of asking questions, and self-blame are all characteristics of underpowered women.

Category of disrespect and abuse	Corresponding rights
• Physical abuse	Freedom from harm and ill treatment
• Non consented case	Right to information, informed consent and refusal.
• Non confidential care	Confidentiality, privacy
• Non dignified care	Dignity, respect
• Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
• Detention in facilities	Liberty, autonomy, self-determination and freedom

[Table/Fig-2]: Rights of a childbearing women.
Adapted from [18]

Goals

Following are some suggestions for delivering multifactorial RMC:-

We should increase awareness of RMC among various stakeholders, including women, healthcare providers, regulators, and legislators, by involving public health experts as educators and advocates. Consulting experts for assistance in handling the issue of disrespect could be helpful. Implementing regulatory policies and programmes, consistent protocols, efficient plans, and strategies must be developed for varied health settings to ensure the autonomy and empowerment of women by putting in place accountability systems informed by their experiences [17,18]. A lack of resources shouldn't hinder implementing RMC in alternative ways; one should address it to overcome infrastructure obstacles. One must insist on greater accountability from staff providing healthcare. Possess a monitoring and assessment system to monitor the input, output, effects, and benefits of programmes and policies. Developing complaint and resolution centres in each hospital should be done on a priority basis. Carrying out audits, holding exit interviews, and gathering consumer feedback to pinpoint obstacles and evaluate service utilisation and quality is a must. We can improve the standard through community involvement and collaboration. Coordinating efforts are needed amongst a range of stakeholders, including decision-makers, government officials, the United Nations, non-profit organisations, public and commercial health amenities, and women's organisations, to assist RMC in reaching the desired standard [18].

The Problems and Challenges

It is difficult to calm stakeholder concerns and implement context-specific programmes and policies in a varied nation like India, where D&A are prevalent in all contexts [18]. 'The RMC' term is being conceptualised differently in different settings. Inconsistent approaches have been used to explore RMC. The key hurdles are RMC's definition, assessment, and measurement [18]. There aren't any recommendations that are evidence-based and context-specific. Only the tip of the iceberg regarding disrespect, abuse, and neglect is officially reported. Implementing RMC is complicated by underdeveloped healthcare systems, inadequate staff, a shortage of supplies, poor infrastructure, and low compensation for doctors and nurses [19].

Which Policies and Programmes Improve RMC?

Communication, cultural awareness, and technology are just a few ways to help improve RMC. For instance, India examined the use of mobile apps to enhance communication and information sharing between healthcare workers and women during childbirth. The majority of the study's participants, who were midwives, expressed satisfaction with the app for several reasons, including its meticulous evidence and reciprocal interaction. An emphasis on community listening is a frequent trait of effective RMC policies. The Labour Room and Quality Improvement Initiative (LaQshya) in India demonstrates how empowering women's voices can improve the labour and delivery process. The effort started in 2016 aims to guarantee RMC for all pregnant women using public health facilities while minimising maternal mortality and enhancing labour room care. Its success was primarily attributed to listening. Three hundred thirty-five thousand women participated in the White Ribbon Alliance (WRA) India programme "Hamara Swasthya Hamari Awaaz," which sought to boost maternal and reproductive health. Based on survey data from women who requested that they be treated with respect, dignity, and non-discrimination while seeking care, the campaign inspired the "What Women Want" movement and the need for RMC [19].

The Government subsequently incorporated these requests into the LaQshya rules. A policy change brought about the requirement for RMC in facility-based labour and post-partum care, resulting in considerable training and curriculum revisions. Similarly, two essential methods introduced in 2020 to assess the quality of Government-sponsored reproductive, maternity, and neonatal healthcare services have made women's voices a central component. The first intervention was a toolkit for assessment that uses questions about women's experiences with care to gauge the efficacy of maternity services in Government-run facilities. The second intervention was the auditing and accountability tool, which is how regulatory agencies assess health institutions when they inspect them. Both devices consider women's top requests, such as privacy, better access to water, sanitation, and cleanliness, and considerate, prompt, and attentive care. They also put women's requirements for high-quality care, opening up new avenues for holding decision-makers responsible for better meeting those needs [20].

Key Principles of RMC

Respect and dignity: Women need to be treated with decency, respect, and kindness throughout their experience in obtaining maternity care. Health professionals should work harmoniously and involve the pregnant woman in making decisions.

Autonomy and informed choice: Every woman has the right to make choices regarding her care supported by accurate and unbiased information [20,21].

Continuity of care: Continuity of treatment is crucial to foster trust and guarantee a positive experience. Including prenatal, intrapartum, and postpartum care, women should have access to continuous, coordinated care throughout their pregnancies [20].

Emotional support: During pregnancy, labour, and the postpartum period, every woman should receive emotional support. Healthcare providers, partners, family members, or skilled birth companions can all offer this assistance. Women can feel more confident and comfortable receiving compassionate and understanding treatment [21].

Safe and respectful physical care: Women should receive treatment that is secure, supported by science, and considerate of their physical health.

Non-discrimination: Regardless of age, marital status, ethnicity, social situation, or any other factor, every woman has the right to maternity care without discrimination. Healthcare professionals should guarantee that all women have fair access to their choice of care. Healthcare professionals should actively listen to women's questions and concerns and answer them in a language and format that they can understand [21].

Future Directions to Improve RMC

First and foremost, they should deepen our comprehension of RMC over the entire spectrum of care, including newborn and immediate postpartum care, prenatal and postnatal care, sexual and reproductive health, and family planning. Both healthcare providers and the community they serve need to understand the significance of RMC and the rights of women and patients to respectful treatment. Also, essential are initiatives to support healthcare personnel who are under stress. Healthcare workers can suffer from mental health issues due to the stress and pressure they work under, especially in

emergencies, making it harder for them to treat patients with respect. Finally, initiatives to enhance RMC must be supported by data. It is essential to create standard metrics that appropriately reflect what is important to women and their families and to incorporate them into common measurement frameworks [22].

Recommendations

First, there needs to be an organised and context-specific effort to quantify abuse in public and private facilities in India's high-burden states. Second, a training campaign to introduce the fundamentals of RMC to all maternity care staff would be helpful. Third, there is a need for creative ways to increase accountability for RMC. Fourth, it would be beneficial to encourage RMC with community and health system interventions. Finally, we point out that health systems require persistent, long-term investment to provide front-line health workers with supportive work conditions. If there is no increase in the standard of care given by healthcare personnel, particularly for various aspects of RMC, efforts to improve the quality of facility-based maternity care for women under the LaQshya programme are unlikely to provide the intended results. We should make concrete recommendations to guarantee RMC practices at all levels of public health facilities [23].

Access: Even when maternal health services are culturally acceptable, researchers found that financial and geographic constraints frequently prevent women from specific ethnic groups from using them. In some situations, access was further hampered by gender-based travel limitations, poor levels of education or literacy, a lack of social support or child care, a lack of knowledge of health services, and gender-specific knowledge gaps [23].

Community participation: The success of treatments depended on fostering respect among communities and health personnel through collaboration and communication. Certain programme implementers emphasised the necessity of building community ownership over interventions. Community-based participatory research is a promising strategy that incorporates communities in programme creation from the start [24].

Person-centered care: Poor interactions between patients and carers were a significant problem; many women complained of carers' rudeness, prejudice, and unfavourable attitudes. Hiring workers from comparable linguistic or cultural backgrounds to women seeking care was the most widely used tactic to address these problems [24].

Continuum of care: Collaboration between various healthcare professionals is crucial to ensure that women received services during pregnancy, birth, and the postpartum period that were culturally acceptable.

Promote adherence to RMC standards in public healthcare facilities: Structured, context-specific planning, monitoring, and supervisory mechanisms, as well as instruments to evaluate disrespectful maternity care practices, can support RMC practice. The development of contextual tools to assess and track RMC practices in public and private healthcare facilities is urgently needed in this direction [25].

Women-centric maternal care: When choosing a birthing location, privacy-ensuring draperies and curtains, and a birthing partner, is essential to consider the mother's preferences. Additionally, companions should receive education about their responsibilities since knowledgeable companions may better meet the emotional requirements of the women, which will improve how well-adjusted pregnant women perceive intrapartum care [25].

Enhancing the capacity of primary care staff on RMC: Periodic in-service behavioural training for medical professionals, especially support personnel, may help close RMC gaps. Incorporating RMC into preservice training and medical and paramedical courses may be the most effective way to improve the labour ward's culture [25].

Encouraging RMC practice across healthcare facilities: The State or District authority's "reward and recognition" of intrapartum care personnel can encourage responsibility and inspire employees to provide considerate, woman-centered maternity care in their healthcare facilities. A thorough behavioural training intervention that tackles the underlying causes and supports RMC would be worthwhile to design and evaluate for success [25].

Long-term, sustained investment in infrastructure, work-culture, and research: We observe that upgrading the infrastructure and health systems requires ongoing, long-term investment. We can only achieve RMC standards by establishing settings that empower and support front-line health workers and encourage public accountability. Health institutions should set up a responsive redressal procedure to handle and address complaints [26,27].

Being free from harm and mistreatment: Women and healthcare professionals from many nations agree that speaking to women in a warm and measured way, without excessive excessive volume is a sign of respect. Women stated that access to tools and technologies and expert care contributed to their sense of security. A safe and secure atmosphere for women was seen by medical experts as an essential component of humanised care [28].

Maintaining privacy and confidentiality: Women and healthcare professionals everywhere cited upholding secrecy and privacy as examples of humane treatment. Women hid themselves from male staff members, visitors, or other women during physical tests and procedures to convey their need for solitude by controlling the number of employees and guests [28].

Preserving women's dignity: Women from various backgrounds highlighted the value of a welcoming environment in the labour ward by emphasising its relevance. Women liked healthcare professionals who were patient, considerate, pleasant, smiling, and friendly. They also favoured those who spent time with them [28]. Women and healthcare professionals emphasised the need to respect women's traditions, values, and beliefs. Women, primarily Muslims, indicated their strong desire for a female birth attendant during labour or delivery in several nations [29].

Prospective provision of information and seeking informed consent: Women expressed a desire for education on labouring procedures, such as breathing, pushing, and relaxation techniques, as well as how to mentally and physically be ready for childbirth. According to healthcare professionals, explaining the interventions that women will soon be undergoing was reportedly a part of RMC [29].

Ensuring continuous access to family and community support: Most women and certain healthcare professionals underlined the value of family support and the presence of labour companions of choice and viewed these as fundamental rights for all women. The family's involvement in the women's treatment and connection with them was highly recognised by healthcare professionals [29]. Some laws and regulations, such as those prohibiting labour companions, were identified by healthcare professionals and women as obstacles to humanising childbirth [30].

Enhancing the quality of the physical environment and resources: Women and medical professionals agreed that offering delivery conditions that were cozy, hygienic, and soothing while imposing strict visiting hours helped foster RMC. Healthcare professionals in India believed that better physical environments-including a waiting room, cleanliness, appropriate bedding, and a steady supply of water, power, and medications were necessary to humanise birth [30].

Providing equitable maternity care: It was emphasised that services were accessible to everyone, regardless of age, ethnicity, sexual orientation, religion, or other subgroups, and that treating all women equally was considered respectful [30].

Engaging with effective communication: Women and medical professionals worldwide stressed the significance of efficient communication as a crucial element of RMC. Women valued the verbal encouragement and support they received from midwives and the emotional support they received while in delivery [30].

Respecting women's choices that strengthen their capabilities to give birth: Health experts and women spoke in various contexts about respecting and empowering women's choices. Cultural circumstances impact whether or not women were given the chance to choose how they gave birth. Healthcare professionals often feel that women follow other people's decisions. In the opinion of midwives, being an effective advocate depends on ensuring that women are included in decision-making and considering their right to free choice and participation [31].

Availability of competent and motivated human resources: RMC depended on the workforce's competence and sufficiency. Women believed establishing a trusting relationship required midwives' professional expertise and competence. Because midwives felt pressured to prove that they were following protocols, they explored how using guidelines and protocols might reduce women's dignity in some regions [31].

Continuity of care: Women worldwide value receiving care from a dependable midwife. Most women found the constant staff assistance comforting and sought it during and after labour. Some nurses say humanised delivery is "being with the woman and being available on demand." Women worldwide expressed a desire to stay in the hospital with their babies [32].

In some humanitarian and fragile settings, the use of RMC has been noticed, and more research is required to determine how well these interventions are implemented and how well they benefit various populations, including host communities, refugees, internally displaced people, young mothers, and other vulnerable groups. The Global Respectful Maternity Care Council's (GRMCC) Newborn Working Group recently finished a modified Delphi exercise that resulted in developing a prioritised list of research questions about the respectful care of newborns, designating parents and infants living in humanitarian crises as priority populations. This study generates a ranked list of research questions focused on providing respectful care for babies and provides the first global consensus of experts around a working description of this concept. The Delphi survey and the RMC technical brief provide compelling evidence for advancing RMC in humanitarian and vulnerable settings. The RMC technical brief explains why and how to improve RMC in humanitarian situations, and the Delphi survey identifies the most critical areas for further research on improving respectful neonatal care. Understanding the viability and effectiveness of incorporating RMC-promoting programs/interventions into humanitarian health programmes would be enhanced by doing implementation research. We encourage aid organisations to assess their RMC services, identify gaps or potential areas for improvement, choose at least one RMC intervention to include in their response strategy, evaluate the intervention with the assistance of research partners as necessary, and share their findings with the larger aid community field [33].

Maathru Samman Pants

The RMC is a new strategy within the National Health Mission that offers services to improve pregnant women's satisfaction while in the medical institution. A new innovative programme called Maathru Samman Pants addresses the emotional and physical needs of expectant mothers and their families during labour. "Maathru Samman" Pants are pants that stretch from the waist to the ankles on both legs. There is a vulval opening that is the right dimension to do procedures such as vaginal assessments, episiotomies, forceps applications, ventouse usage, bladder catheterisation, and delivery of the baby and placenta. In the supine position, when the expecting mother is on the labour table, the front flap of the pants covers the opening. The pant's back flap hides the opening when walking and standing in a hospital ward or labour room. The trousers have very little room for pollutants to hide, such as buttons, zips, etc. Maathru Samman Pants offers pregnant women numerous benefits during childbirth. Having the remainder of the women concealed gives pregnant women privacy as they wait in the labour room. Providing sterile cover also gives expectant women security and comfort while doctors perform thorough procedures and give birth. Doing so reduces the inconvenience of dressing and undressing after each treatment and vaginal inspection. It reduces the quantity of time required that is intended for treatments and deliveries [34].

Using cleaned and autoclaved trousers in the delivery room helps reduce mothers' infections. In addition, reducing exposure to an unsterile environment lowers the newborn's risk of contracting illnesses. Implementing Maathru Samman Pants in the Indian healthcare system is viable. The market has plenty of the fabric needed for clothing. In most states, the textile material is frequently utilised in public hospitals. According to daily delivery loads, one may provide hospitals with Maathru Samman Pants. The Maathru Samman Pants may be conveniently cleaned and sterilised using the equipment found in government hospitals and the staff already on hand. Both their upkeep and reusability are simple. Pregnant women can wear them without any extra assistance, and they are simple to wear. The maternity care standards have substantially improved during the past few decades. To address patients' thoughts, the field is still in its infancy. The Maathru Samman Pants are the first of their type in India for pregnant women going through routine labour. RMC guidelines must be developed in concert with patient viewpoints. To secure the protection of women's fundamental human right to dignity, which goes past preventing humanity and morbidity, Maathru Samman Pants gives a chance [35]. A summary of all the articles included in this review is listed in [Table/Fig-3].

Place	Authors	Year	Findings
India	Ansari H and Yeravdekar R, [1]	2019	Policies and programmes should be implemented to reduce disrespectful maternity care in developed and developing countries.
UK	Briscoe L et al., [2]	2016	Analysing the concept of vulnerability and how it is currently acknowledged concerning pregnancy and birth.
India	Tunçalp O et al., [3]	2015	Quality, provision and experience of care followed by the healthcare system across countries during pregnancy.
India, USA	Stanton ME and Gogoi A, [4]	2022	Achieving RMC at the policy, facility, and community levels.
USA	Miller S et al., [5]	2016	Evidence-based clinical practice for antenatal, intrapartum, and post-natal care.
USA, Argentina	Belizán JM et al., [6]	2020	Recommendations and actions taken to reduce home births and encourage birth in facilities.
Iran	Shakibazadeh E et al., [7]	2018	The approach of conceptualisation of RMC and demonstrating a broader concept towards the same.
Tanzania	Bohren MA et al., [8]	2020	Improving RMC, transforming attitudes, improving and developing interpersonal skills of providers.
Kenya	Warren CE et al., [9]	2017	Activities taken into notice to better understand if the Heshima Project can be implemented successfully in different regions.
Ethiopia	Kassa ZY and Husen S [10]	2019	A meta-analysis on violation of fundamental rights in Ethiopia and producing a pooled prevalence of the same.

India	Chaturvedi S et al., [11]	2015	A cash transfer programme- Janani Suraksha Yojana (JSY), which is beneficial to the population.
India	Issac A et al., [12]	2016	Components of out-of-pocket expenditure of families during delivery.
India	Sharma G et al., [13]	2019	Context-specific efforts to measure mistreatment in high-burden states and improve accountability towards the same.
India	Coffey D, [14]	2014	Study documents important emotional and psychological costs to women of delivering in the hospital.
India	Chattopadhyay S et al., [15]	2018	Maternal health interventions are aimed at reducing maternal mortality by boosting institutional deliveries. This is usually achieved by providing financial transfers to mothers who give birth in hospitals and incentivising local health workers to record births.
India	Jha P et al., [16]	2017	Improving interpersonal interaction with nurse-midwives, ensuring privacy during childbirth and hospital stay, and improving women's childbirth experience.
India	Bohren MA et al., [17]	2015	A comprehensive, evidence-based typology of the mistreatment of women during childbirth in health facilities at the health facility and health system levels, and develop measurement tools and inform future research, programmes, and interventions.
India	Bhattacharyya S et al., [18]	2018	The study aims to examine pregnant women's expectations of high-quality care in public health facilities and to contrast this with provider's perceptions of the same, as well as the barriers that limit their ability to provide high-quality care.
USA	Bohren MA et al., [19]	2014	Providing a valuable framework for better understanding on how various factors influence the decision-making process of pregnant women.
India	Ansari H et al., [20]	2020	Sociocultural and environmental factors were identified as determinants of ill-treatment. Ill-treatment was in the form of non-consent, verbal abuse, threats, physical abuse, and discrimination.
India	Chatterjee P, [21]	2018	Health protection schemes to get improvements and better the quality of services provided.
India	Hajizadeh K et al., [22]	2022	To provide comprehensive guidelines for policymakers and planners to formulate plans through the RMC promotion approach.
Africa	Downe S et al., [23]	2018	Multi-component RMC policies to reduce women's overall experiences of D&A.
USA	Butler MM et al., [24]	2020	This study demonstrates the need for new regulations to ensure that all government hospitals adhere to a minimal set of requirements for high-quality care delivery and to make government health facilities more welcoming and easily accessible to patients.
USA	Silan V et al., [25]	2014	To identify essential competencies for midwifery practice and the knowledge, skills, and professional behaviours that should be hallmarks of RMC practices among the global community of midwives.
USA	Paxton A et al., [26]	2005	Evidence for the effectiveness of emergency obstetric care (EmOC) interventions in reducing maternal mortality.
India	Ansari H and Yeravdekar R, [27]	2021	Effects of RMC on breastfeeding.
India	Association of Women's Health, Obstetric and Neonatal Nurses [28]	2022	Enhance and encourage the need for RMC.
USA	Birtwell B et al., [29]	2015	To nurture prenatal attachment relationships, which play a protective role, by helping us establish the foundations for secure mother-infant relationships in the future. Meeting similar women and engaging in ordinary, supportive conversation reduced feelings of isolation and stigma.
India	Afulani PA et al., [30]	2020	Opportunities to routinely capture and improve RMC during facility-based childbirth include Quality Improvement (QI) initiatives, community-based monitoring efforts through community scorecards (CSC), and performance-based financing (PBF) initiatives.
India	Hulton LA et al., [31]	2007	Assessing care provided in urban slums by institutional maternity services.
Africa, USA	Adam T et al., [32]	2005	Evaluating the suitability of present tactics and future planning to achieve the Millennium Development Goals, it is necessary to ascertain the costs and benefits of maternal and newborn health interventions.
USA	Austad K et al., [33]	2017	Care navigation is a potential way to break down the "humanistic barrier" to hospital service.
India	Reddy BV, [34]	2019	Maathru Samman Pants is the first of its kind in India for pregnant women in normal labour and should be introduced to promote a shy-free environment for women.
USA	Bruce J, [35]	1990	Analysing the quality of family planning services.

[Table/Fig-3]: Details of articles cited in the review [1-35].

CONCLUSION(S)

Implementing tailored treatments, policies, and programmes is crucial to ensure RMC nationally. Maternity care delivery should adapt through interventions that are uniquely suited to the requirements of each area or community. Develop programmes that are mindful of these local contexts and consider women's unique preferences and needs. Precise guidelines and requirements that emphasise RMC's fundamental tenets should be established. These regulations should set specific criteria and procedures for medical facilities and practitioners to ensure patients are consistently treated respectfully. Policies may address a variety of subjects, including informed consent, confidentiality and privacy, pain management, emotional support, and redressing discriminatory practices. Healthcare providers, midwives, and other key staff members might need to participate in training courses to improve their ability to deliver caring, evidence-based care. RMC activities and programmes should be periodically reviewed and evaluated for effectiveness.

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