

Review Article

Exploring the status of respectful maternity care: A mixed-method systematic review

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ABSTRACT

Introduction: Receiving respectful maternity care (RMC) is the right of pregnant women on humanitarian grounds; however, disrespect and abuse are more prevalent at all levels across the world. Thus, this review sought to assess the current state and most prevalent forms of disrespectful maternity care experienced by pregnant women in India.

Material and Methods: A comprehensive review of multiple databases was conducted systemically. Following the quality review, twelve quantitative research and two qualitative studies were included.

Results: Study revealed that physical and verbal abuse is the most frequently encountered form of disrespect faced by pregnant women. Regardless of the type of healthcare setting—whether primary, secondary, or tertiary, and across both government and private sectors—disrespectful care was reported in various regions, including Northern, Eastern, Northeastern, and Western India. The lack of dignity, delivery by unqualified staff, a loss of privacy, the demand for informal fees, additionally, there is significant deficiency in basic infrastructure, cleanliness, and sanitation, were other factors that were noted. We also found that the situation of women has even worsened during the COVID-19 pandemic period.

Conclusion: RMC should be prioritized to give great care to pregnant mothers. To do that a sustainable change in policy level is needed. It is critical to facilitate women-centric care, enhance infrastructure, train healthcare staff on a regular basis, and educate pregnant women about RMC.

Keywords: Dignity, Respectful maternity care, Right of pregnant women

INTRODUCTION

The term “maternal health” encompasses a woman’s health before, during, and immediate after pregnancy. Following pregnancy and childbirth, every pregnant woman needs excellent antenatal care, skilled labor and delivery care, and postpartum support. Institutional delivery has increased in India during the past few decades, rising from 40.8% in 2005–2006 National Family Health Survey (NFHS 3) to 88.6% in 2019–2021 (NFHS 5).^[1] Despite these advancements, accessibility to high-quality services is not always assured. Globally, attention is being drawn to the link between poor treatment and unfavorable consequences for mothers. The global burden of maternal morbidity and mortality could be greatly diminished if everyone had access to safe, acceptable, and high-quality sexual and reproductive health care. Disrespectful maternity care is a worldwide concern, affecting the treatment of mothers before, during, and after childbirth. Unfortunately, in low middle-income countries, such experience often leads to

delay or avoidance of essential maternity care.^[2,3] A recent declaration by the World Health Organization (WHO) seeks to prevent and eliminate disrespect and abuse during facility-based deliveries.^[4]

The concept of Respectful Maternity Care (RMC), as emphasized by the recently launched Labour Room Quality Improvement Initiative (LaQshya), recognizes that women's experiences during childbirth are an integral part of quality healthcare. RMC focuses on respecting women autonomy, dignity, emotion, privacy, choices and ensuring they are free from mistreatment and coercion. It also considers individual preferences such as allowing companionship during maternity care. Beyond promoting positive outcomes for both mother and newborn, RMC also contributes to cognitive development for babies later in life.^[5]

Mistreatment and abuse, therefore, have an impact on health outcomes, enhance patient satisfaction, and increase the likelihood of mothers choosing to give birth at a facility, both in the present and for future deliveries.^[6] Mistreatment and abuse in the past may dissuade women from seeking treatment, even if they are experiencing difficulties.^[7] Inadequate treatment adds to maternal mortality, *i.e.*, a review of all maternal deaths at tertiary care institutions in Sri Lanka discovered that most maternal deaths were preventable, with 79% related to inadequate care.^[8] A study conducted in rural India during the pandemic period revealed that harassment and abuse were among the obstacles preventing people from accessing and utilizing healthcare.^[9] However, the most effective approaches to quantify mistreatment are still unknown, despite the fact that research in this area is rapidly expanding and efforts are being done to gauge the problem's prevalence. Therefore, the objective of the current review is to assess the prevalence and most common form of disrespect of maternity care experienced by pregnant women in India.

MATERIAL AND METHODS

Search strategy

In this systematic review, research that had been previously published on disrespect and abuse during childbirth in India was included. The searches utilized several databases, including PubMed, Web of Science, Google Scholar, and Scopus, which were used for the search, which was updated in May 2023. The search process adhered to the standard set forth by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses standards [Figure 1]. For this each of these topics, the search keywords included "respectful maternity care (RMC)," "prevalence of disrespect and abuse," "India," and other similar terms. To identify related articles, asterisks were utilized [Annexure 1]. To organize citations, remove duplication, and speed up the review process, the papers were saved in Mendeley Desktop V1.19.5 software. The date

of publishing was not constrained. To find more studies, the reference lists of the pertinent papers were also examined.

Data extraction and management

Each work was reviewed by two authors. If disagreement was encountered about the selection of an article, two of the co-authors discussed it to reach a decision. A third co-author was consulted to review and assist in determining whether to include the study if there was a disagreement between the two main reviewers concerning the publication's eligibility. The following data were then collected from each source article from the eligible articles: The name of the author, the location of the study, the year of publication, the study design, the number of participants, the type of disrespect, the prevalence of disrespect, and other baseline characteristics and important information.

Inclusion and exclusion criteria

This paper included studies conducted in India that focused on the elements of RMC, as well as those that described participants in the study, sample size, and form of disrespect, abuse, or mistreatment during childbirth, and those that were published in English. Both authors consented to the screening and inclusion of the studies for the systematic review. After retrieving every full-text article, a literature search revealed 34 full-text papers. This evaluation covered a total of (12 quantitative and 2 qualitative) 2 studies after determining their eligibility.

Quality assessment

The Joanna Briggs Institute (JBI) quality-assessment tool was used to evaluate the qualitative studies' quality, with the following domains being evaluated: Objectives, methodology, recruitment, design, data collection, reflexivity, data analysis, ethical considerations, research contribution, and findings.^[10] JBI quality assessment tools for observational studies were modified to evaluate the quantitative studies' quality, and the evaluation covered the following areas: Participant characteristics, eligibility criteria, method of variable assessment, reporting of summary measures/outcome events, as well as discussion regarding sources of bias and/or imprecision.^[10]

Assessment of qualitative studies

For qualitative studies, the following criteria were considered:

- Research design and objectives: Clarity of study objectives and appropriateness of the qualitative methodology.
- Participant selection and recruitment: Justification of recruitment strategy and representation of diverse perspectives.
- Data collection and reflexivity: Suitability of data collection methods (*e.g.*, interviews, focus groups) and

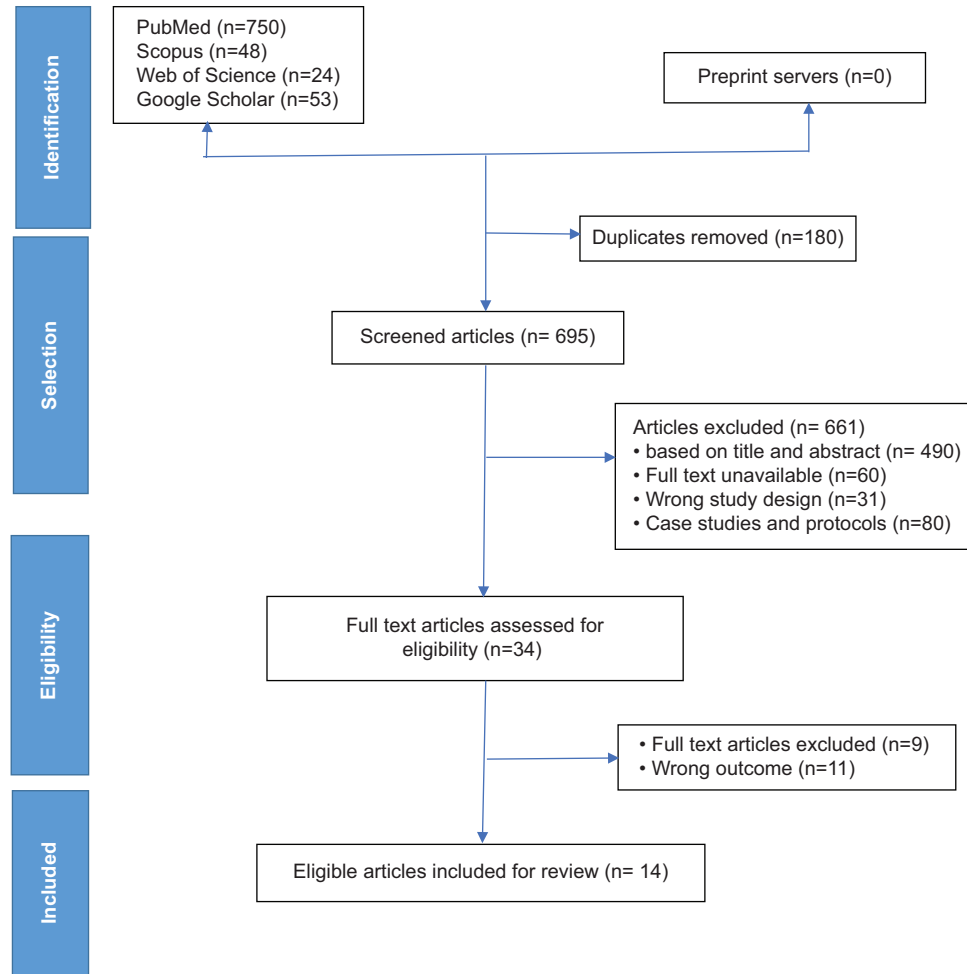


Figure 1: PRISMA flow diagram for systematic review

researcher reflexivity.

- Data analysis and interpretation: Transparency in coding, thematic Assessment of Qualitative Studies.

For cross-sectional and observational studies, the modified JBI checklist for analytical cross-sectional studies was used, covering:

- Eligibility criteria and sampling: Clear inclusion/exclusion criteria, appropriate sampling methods, and study population representativeness.
- Measurement of variables: Definition and assessment of disrespect and abuse in maternity care, with preference for validated tools (*e.g.*, WHO mistreatment framework).
- Bias and confounding control: Consideration of social desirability bias, recall bias, and statistical adjustments for confounders.
- Outcome measures and statistical analysis: Clarity in reporting prevalence rates, confidence intervals, statistical significance analysis, and data saturation.

The comprehensive quality rating of “high,” “medium,” or “low” was determined by two autonomous evaluators, with

disagreements resolved through discussion until a consensus was reached. The quality assessment did not lead to the exclusion of any studies; rather, instead the methodological rigor of each contributing study enhanced the confidence in the assessments of each review finding.

RESULTS

This review synthesized findings from fourteen Indian studies [Table 1]. We attempted to cover studies conducted in the north, east, and west of India. All of this research was published between 2016 and 2023. This review includes ten cross-sectional studies, two mixed-method studies, and three qualitative investigations. Eleven studies were hospital/health facility-based, while three were community-based. The total number of participants across all studies was 6114, with a sample size ranging from 41 to 2639 individuals. The data collection method includes interviews, observations, and focus group discussions. In this review study, we attempted to summarize the research under the Bowser and Hill landscape analysis categories of disrespect and abuse during childbirth.^[11]

Table 1: Summary of quantitative studies.

Author	YOP	Setting (Urban/Rural)	Number of participants	Type of Participants	Study design	Type of Disrespect	Prevalence
Yadav <i>et al.</i> ^[12]	2023	Tertiary health center-Odisha	246	Postpartum women	Cross-sectional study	Physical abuse, Discriminated because of ethnicity, race, and economic situation	66%
Gogoi <i>et al.</i> ^[13]	2022	Majority from rural, 55 from urban	401	Women aged 18 years or more who had a live birth within the past 2 months of data collection	Cross-sectional study	Physical abuse nonconsented care, nonconfidential care nondignified care, discrimination, Abandonment of care, detention in facility, disrespect and abuse in child birth	Mean score of 13.5±5.9
Sharma <i>et al.</i> ^[14]	2019	Rural	150	Women aged 18-49 years with institutional delivery	Cross-sectional study	Physical abuse: pushing, slapping, pinching, or any gesture towards slapping or hitting during examination and delivery. Non-confidential care and non-consented care, Abandonment or denial of care Birth companion in labour room not allowed-	100%
Rajkumari <i>et al.</i> ^[15]	2021	Rural-Manipur	231	Women with children<2 years, undergone institutional deliveries and accessing immunization clinics	Cross-sectional study	Physical abuse, verbal abuse, non supportive care, Lack of privacy and confidentiality, lack of transparency.	96.5%
Raval <i>et al.</i> ^[16]	2021	Rural- Gujrat	41	Pregnant women started in the second/third stage of the labor and was continued till 2 h after delivery	Cross-sectional study	Physical harm or ill-treatment, choice of birth position, non-confidential care	Not mentioned

(Contd...)

Table 1: (Continued)

Author	YOP	Setting (Urban/Rural)	Number of participants	Type of Participants	Study design	Type of Disrespect	Prevalence
Nawab <i>et al.</i> ^[17]	2019	Rural Community	305	Women at 4-6 weeks postpartum	Cross sectional study	No consented services, Abandonment/neglect during childbirth, physical abuse, discrimination, detention in the health facility	84.3%
Sharma <i>et al.</i> ^[18]	2019	Rural Facilities (26 Public and private Health facilities)	275	Women during labor and childbirth	Mixed-method study	Disrespect on choice of birth position, manual exploration of the uterus after delivery, physical abuse , verbal abuse , birth companion not allowed, non-confidential care	100%
Bhattacharya and Sundari Ravindran <i>et al.</i> ^[19]	2018	Rural community of Uttar Pradesh	410	Women who delivered at the health facility	Community based cross-sectional study	Physical abuse, neglect or abandonment, Non-confidential care	28.80%
Singh <i>et al.</i> ^[20]	2018	New Delhi	63 health professionals	The second stage of labor to 2 hours post-delivery	Quantitative non-experimental research study	Physical abuse, discordance between patients and providers, non-confidential care and non-consented care, Financial demand No greeting by health care workers	98%
Dey <i>et al.</i> ^[21]	2017	Rural, UP	875	Women delivering in public health facilities interviewed 2-4 weeks post-delivery	Cross-sectional study	Non-consensual care or inadequate information provisions regarding treatment or care for them or their child. Mistreatment, forcefully pushing, physical abuse including women beaten/slapped by provider Provider applying force to pull the baby during delivery	77.3%

(Contd...)

Table 1: (Continued)

Author	YOP	Setting (Urban/Rural)	Number of participants	Type of Participants	Study design	Type of Disrespect	Prevalence
Raj et al. ^[22]	2017	Rural, UP	2639	Women delivered at the health facility, interviews conducted an average of 4.5 weeks postpartum	Cross-sectional study	Verbal abuse, Stigma and discrimination, non supportive care, denial of treatment, non consent care	20.9%
Sudhinaraset et al. ^[23]	2016	Urban	392	Women with a child under the age of 5, delivered in a health facility	Mixed-method study	Physical abuse, Verbal abuse, Lack of information, no Choice of position, birth Companion not allowed, Requested payment or bribe, separation from baby	54.7%

YOP: Year of publication

Quantitative synthesis

Among the 12 quantitative studies, there were 10 cross-sectional studies and two mixed-method studies. The prevalence reported in each study ranged from 20.9% to 100%. Notably, four of the ten cross-sectional studies specifically investigated the abuse of women during childbirth at healthcare institution as a primary objective. We present comprehensive results from nine studies that directly examined women's abuse below [Table 1].

Bhattacharya and Sundari Ravindran^[19] explored the type of mistreatment experienced by women seeking institutional delivery at rural health facilities in North India reported that improper monetary demands were prevalent at 90.5%, while the overall prevalence of any abusive behavior was 28.8%. The reported abuses included non-dignified care, which encompassed verbal abuse and derogatory remarks about the women's sexual behavior 19.3%, physical abuse 13.4%, neglect or abandonment 8.5%, non-confidential care 5.6%, and feeling of humiliation due to inadequate cleanliness with described as nearly filthy 4.9%.

Nawab et al.^[17] assessed prevalence and sociodemographic determinants of disrespect and abuse among women residing in the rural population of North India. It reported that 257 out of 305 women, 84.3% experienced some form of disrespect and abuse. The most common types included non-confidential care 62.35 and the provision of services without consent is 71.1%. After giving delivery, 10.2% of women experienced abandonment or neglect; 9.2% said that they had experienced abusive treatment; 5.9% had experienced physical abuse; 3.3% had been held in a medical facility; and 3.9% had experienced prejudice.

Sharma et al.,^[14] assessed mistreatment and quality of care among the mothers attending a tertiary care center in Central India and reported that nearly 100% of the participants experienced disrespectful care during their pregnancy journey. In addition, 103 (68.67%) participants noted a lack of physical comfort throughout the intranatal stage. Moreover, half of the women, or 82 (54.67%), reported experiencing physical abuse or force of some kind from medical personnel during examination and delivery. This included pushing, slapping, pinching, or making any motion that looked like slapping or hitting. There were 145 (96.67%) in total.

On the contrary, one study conducted in the tertiary center of eastern India reported A good RMC by more than one-third of the study samples.^[12]

Indirect relevance to this review was provided by the other five papers that contained pertinent quantitative data. From the nine studies that included quantitative data, Table S1 shows the quantitative measures of abuse of women during childbirth.

Sudhinaraset et al.^[23] conducted a mixed-method study among the rural women of North India revealing that the most frequently reported form of mistreatment was verbal abuse 28.6%, followed by the demand of contribution or bribes 24.2%.^[23] Other common forms of disrespect or abuse included not allowing partner to accompany the women 19.6%, discrimination 16.8%, and physical abuse 15.5%. Approximately 10% of participants reported threat to withhold treatment, experiences of abandonment or being ignored, delivering alone, or being denied their preferred position. The least common behavior reported was lack of information 4.6% and unnecessary separation from the child is 4.3%.

Table 2: Summary of qualitative studies.

Review finding	Contributing Studies	Confidence in Evidence	Explanation of Confidence in the Evidence Assessment
Physical assault, verbal abuse, and sexual violence.			
Beating with hands or dirty socks to using derogatory statements	Rajbangshi <i>et al.</i> ^[24] Shrivastava <i>et al.</i> ^[25]	High	All the studies reported the same with minor to moderate methodological limitations. High Coherence
Health system condition and constrain			
Long waiting periods which, in many cases, led to referral to another hospital or denial of admission. Visited multiple facilities before being provided with any maternity care.	Shrivastava <i>et al.</i> ^[25]	High	One study with minor to moderate methodological limitations. High Coherence
Lack of privacy and cleanliness	Rajbangshi <i>et al.</i> ^[24]	High	One study with minor to moderate methodological limitations. High Coherence
Failure to meet professional standard			
Discrimination against pregnant muslim women, denying them admission at the facility.	Shrivastava <i>et al.</i> ^[25]	High	One study with minor to moderate methodological limitations. High Coherence
Neglect and lack of promptness to attend labor pain	Rajbangshi <i>et al.</i> ^[24]	High	One study with minor to moderate methodological limitations. High Coherence
Unassisted childbirth in wards, where women were taken to the labor room after the child's head was out.	Rajbangshi <i>et al.</i> ^[24]	High	One study with minor to moderate methodological limitations. High Coherence

Sharma *et al.*,^[18] reported a high incidence of disrespectful practices in both private and public institutions, with 92% of participants indicating that they were not allowed to choose their position and 80% experiencing routine manual probing of the uterus.

Qualitative synthesis

Two qualitative studies were included in this review. The main objective of this study was to explore the experiences of the pregnant women attending the institutional facilities. However, one of the studies conducted a content analysis of online news reports to assess the challenges faced by pregnant women during lockdown and reported a lack of RMC^[16] [Table 2].

Rajbangshi *et al.*,^[24] reported experiencing inadequate facilities, unclean conditions, and a lack of medication. Many expressed feelings of abandonment during labor and highlighted instances of obstetric abuse in the labor room. In addition, the lack of prompt care was identified as significant concern.

Another qualitative study by Shrivastava *et al.*^[25] analyzed online news report to access the challenges faced by pregnant

women during COVID-19 lockdown. The finding revealed that health professional denied admission to muslim women, withheld essential medical supplies, and failed to communicate adequately with patients and families.

Study findings on the elements of disrespectful maternity care

Various forms of disrespect and abuse were reported in the studies. Physical abuse and verbal abuse are the most commonly reported forms of disrespect across all studies. Studies^[12,13,17-19] have consistently indicated that these types of mistreatments occur in various regions of India.

Physical abuse commonly involves pushing, slapping, pinching, or forceful handling of women during labor. Sharma *et al.*^[14] found that 100% of the participants at tertiary care centers in central India experienced some form of disrespect with 54.67% reporting physical mistreatment. Verbal abuse encompasses the use of offensive or abusive language, making judgmental or accusatory remarks, and threatening individuals with negative consequences or withholding care. Nawab *et al.*^[17] found that 71.1% of rural women were subjected to service without their consent,

while 62.3% faced non-confidential care. In addition, studies conducted in rural health facilities in North India have reported that non-consented care is considered the most form of abuse,^[13,17,18] revealing that the procedures such as episiotomy and other minor procedures were conducted without prior consent; however, another study conducted in the same setting revealed that procedures like per vaginal examinations were performed without prior information.^[18]

We made an effort to highlight the types of discrimination experienced by Indian pregnant women in the various wards of the medical facility. In the operation theater, the most common types of mistreatment included the failure to administer anesthesia, delays in treatment, and confinement within the facility. The lack of curtains or screens resulted in intolerable exposure for the patients. According to two studies, unclean gloves, unsterilized equipment, and soiled clothing examined the women, further contributing to their discomfort and sense of disrespect.^[18-20]

The conditions are severe in the labor room. Rajbangshi *et al.*^[24] Unclean rooms with stray animals, particularly dogs and cats, were present. Studies also reveal that women were not given the choice of or allowed to be in the delivery position. The most frequent problems, as opposed to those in private facilities, were delivery made by inexperienced staff and the demand for informal payments faced by 90.5%.^[18-20] However, studies conducted in North-eastern part reported that lack of medication, left unattended during the labor process, and lack of prompt care were also identified as one of the major issues.^[24]

RMC during COVID-19 pandemic

In this review, we also tried to highlight the status of RMC during pandemic period.

Study conducted by Sharma *et al.*, conducted study between October 2021 and March 2022 reported that during their labor, childbirth, or postnatal period at the hospital, 100% of women experienced at least one form of disrespect.^[14]

Shrivastava *et al.*, conducted a content analysis of the online news reported that pregnant women underwent inadequate treatment during the lockdown for a variety of reasons. Before administering care to pregnant patients, health professionals urged the patients' families to gather essential medical equipment including gloves. In addition, the personnel did not discuss the pregnant women's health concerns with their families or the pregnant women themselves. Health care providers (HCPs) discriminated against Muslim expectant mothers by refusing to admit them to the facility.^[25]

Determinants of disrespect

Socioeconomic status, religion, cast, and tribal affiliation significantly contribute to the mistreatment experienced by

pregnant women. Research has also indicated that factors such as timing of admission, nature of complications, type of healthcare provider, and the classification of healthcare facilities are critical determinants of violence within health institutions.^[16,19,20] Study conducted in a tertiary health facility reported that age, less education, occupation, and income of the women were associated with RMC,^[15] however, age of the healthcare provider also plays an important role.^[21] In addition, Sharma *et al.*^[18] reported a high incidence of disrespectful practices in both private and public institution, with 92% participants indicating they were not allowed to choose their delivery position and 80% experiencing routine manual probing of the uterus.

DISCUSSION

The objective of this review is to evaluate the prevalence and most common forms of disrespect experienced by women in both rural and urban health facilities throughout India. A total of fourteen studies were included in this review, reported that irrespective of the type of health facilities, the situation is almost the same all over India, which is in line with findings from a study conducted in five countries.^[26]

The present study reported that physical and verbal abuse were the most common form of disrespect faced by pregnant women in the healthcare setting, which is in line with a report presented by the WHO.^[27] The review also brings out the fact that demand for unethical money for the services provided in the government sector as well as forcing them to buy some consumables from outside of the hospital is the common practices. However, studies conducted in the eastern India reported that women prefer government hospitals to reduce their out-of-pocket burden; rather, they face violence and discrimination, which in other ways restrict them from assess government facilities.^[9,28]

This study also highlighted the condition of labor room in public health facilities. There is a lack of equipment, no given choice of delivery positions, and no birth companion during delivery. However, a study conducted in North India among healthcare professionals revealed that most healthcare personnel were aware about the multiple benefits of birth companions during labor, but despite this awareness, only 40% agreed to practice this in the actual setting.^[29]

The review also analyses the determinants of not providing RMC such as lack of basic infrastructure, age, parity, specific cast, religion, untrained personnel, and socioeconomic status of pregnant women. However, this study also tried to find the condition of RMC during the COVID-19 pandemic. COVID-19 pandemic has worsened a number of detrimental practices that were previously prevalent in the context of prenatal, intrapartum, and postpartum care, including lack of information, denial or interruption of care, neglect, abandonment, and various forms of abuse. A global survey

of healthcare workers also revealed that multiple aspects of providing RMC were adversely impacted by the COVID-19 pandemic. Less family involvement, lessening of emotional and physical support for women, an uptick in medically unnecessary cesarean sections, staff being overloaded by rapidly changing guidelines, and increased infection prevention measures were the six main themes that were found, which is in line with the current study findings.^[30]

To meet the Sustainable Development Goal with the goal of reducing maternal mortality to <70/1000000 live births,^[31] it is imperative that all pregnant women have access to quality, equitable, and accessible care. However, to ensure high-quality care, the Indian government also introduced a range of initiatives, namely Ayushman Bharat and LaQshya initiatives. The RMC is among the crucial components of LaQshya certification.^[5] In this country, where most births are performed by midwives rather than doctors, it is of the utmost significance to conduct periodic training and behavioral change communication among healthcare personnel at all levels, from subcenter to tertiary center. However, to achieve universal health coverage, it is essential to strengthen health and wellness centers (HWCs) under Ayushman Bharat. HWCs are specifically designed to provide health services to pregnant women, children, and adolescent girls. In addition, there is an urgent need for the involvement, dedication, and investment of government authorities in participatory accountability mechanisms such as social audits, community scorecards, and other similar tools, which ensure that women's experiences and perceptions of care are acknowledged and that respectable maternity care standards are upheld.^[32]

The present study yields a few recommendations for the policy makers. The authors advocate that comprehensive, context-specific planning, monitoring, and supervisory mechanisms, along with measures to assess disrespectful maternity care practices, can play a vital role in promoting RMC practice. Periodic behavioral change training given to healthcare workers in-service, including support staff, may aid in closing RMC gaps and staff is critical to providing accessible, high-quality, and compassionate treatment to all beneficiaries to ensure the future growth of India. In addition, to establish strategies for improvement for RMC, it is crucial to comprehend how the various involved stakeholders view the problems with the health system, and to identify these factors, a further research is needed.

Strength and limitations

In the present review, the authors tried to incorporate different regions of India and tried to highlight the status of RMC in different parts of maternity ward such as labor room and operation theater. The authors also tried to compare the status of RMC during and after COVID-19 pandemic.

Despite of the comprehensive nature of this review, several limitations should be acknowledged. The included studies use diverse methodologies, which introduce variability in the findings. The scales, instruments, and methods used for data collection and study design (cross-sectional, mixed method, etc.) varied. There was no data on the care of women who had to terminate their pregnancies due to abnormalities or maternal health complications. This omission may result underestimation of mistreatment as women who experience medical termination may face unique challenges in accessing RMC.

Limited healthcare infrastructure and varying provider attitude across states and facility type affects the generalizability of finding, *i.e.*, study from tertiary hospitals may not fully reflect the challenges faced in lower tier hospitals, where access to resources and RMC training is often inadequate.

Furthermore, the reviewed studies rarely included healthcare provider's prospective which are crucial for understanding barriers to RMC implementation.

Nevertheless, the study still uncovers several crucial points and suggestions for giving pregnant women a respectable, safe, and memorable delivery experience.

CONCLUSION

It is evident the RMC is often lacking in public healthcare institutions. Positive interactions can increase the use of public maternal care facilities. Therefore, in conclusion, there is a need for the entire country to pay attention to the standard of care provided at the medical facilities. This can be done by creating focused interventions and putting policies and programs in place that guarantee RMC in all settings.

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REFERENCES

1. IIPS. National Family Health Survey (NFHS-5), 2019–21: India.

2. Kyei-Nimakoh M, Carolan-Olah M, McCann TV. Access barriers to obstetric care at health facilities in sub-Saharan Africa-a systematic review. *Syst Rev* 2017;6:110.
3. Lusambili A, Wisofsch S, Shumba C, Obure J, Mulama K, Nyaga L, *et al.* Health care workers' perspectives of the influences of disrespectful maternity care in Rural Kenya. *Int J Environ Res Public Health* 2020;17:8218.
4. International Federation of Gynecology and Obstetrics (FIGO). The prevention and elimination of disrespect and abuse during facility-based childbirth. Available from: <https://www.who.org/figo-committee-and-working-group> [Last accessed on 2023 May 13].
5. NHM-MoHFW. LaQshya-labour room quality improvement initiative; 2017. Available from: https://nhm.gov.in/new_updates_2018/nhm_components/rmnc_h_guidelines/laqshya-guidelines.pdf [Last accessed on 2023 May 13].
6. Kruk ME, Paczkowski M, Mbaruku G, De Pinho H, Galea S. Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *Am J Public Health* 2009;99:1666-72.
7. Miller S, Lalonde A. The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother-baby friendly birthing facilities initiative. *Int J Gynecol Obstet* 2015;131:S49-52.
8. Wagaarachchi PT, Fernando L. Trends in maternal mortality and assessment of substandard care in a tertiary care hospital. *Eur J Obstet Gynecol Reprod Biol* 2002;101:36-40.
9. Manna S, Basu S. It cost us all of our savings to deliver our baby: A qualitative study to explore barriers and facilitators of maternal and child health service access and utilization in a remote rural region in India during the COVID-19 pandemic. *Cureus* 2023;15:e35192.
10. Joanna Briggs Institute (JBI). Checklist for qualitative research. Available from: https://view.officeapps.live.com/op/view.aspx?src=https%3a%2f%2fjbi.global%2fsites%2fdefault%2ffiles%2f2021-10%2fchecklist_for_qualitative_research.docx&wdorigin=browselink [Last accessed on 2023 May 19].
11. Bowser D, Hill MPH. Exploring evidence for disrespect and abuse in facility-based childbirth report of a landscape analysis. USAID-TRAction Project. Harvard School of Public Health and University Research Co., LLC; 2010.
12. Yadav P, Smitha M, Jacob J, Begum J. Intrapartum respectful maternity care practices and its barriers in Eastern India. *J Family Med Prim Care* 2022;11:7657-63.
13. Gogoi A, Manoranjini M, Ravi T, Kaur M, Gupta M, Rajagopal V. Determinants of respectful maternity care in India: A cross-sectional study. *WHO South East Asia J Public Health* 2022;11:3-9.
14. Sharma S, Smith, L, Gupta R, Mehta P. Data collection methods in maternal care research: A review of interviews, observations, and focus group discussions. *Int J Reprod Health Res* 2019;15:134-42.
15. Rajkumari B, Devi NS, Devi LA. Assessment of respectful maternity care among women attending immunization clinics in Bishnupur district, Manipur. *Indian J Public Health* 2021;65:11-5.
16. Raval H, Puwar T, Vaghela P, Mankiwala M, Pandya A, 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.
17. Nawab T, Erum U, Amir A, Khalique N, Ansari M, 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. 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.
19. Bhattacharya S, Sundari Ravindran TK. Silent voices: Institutional disrespect and abuse during delivery among women of Varanasi district, northern India. *BMC Pregnancy Childbirth* 2018;18:338.
20. Singh A, Chhugani M, Mary James M. 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* 2018;7:821-5.
21. Dey A, Shakya HB, Chandurkar D, Kumar S, Das AK, Anthony J, *et al.* Discordance in self-report and observation data on mistreatment of women by providers during childbirth in Uttar Pradesh, India. *Reprod Health* 2017;14:149.
22. Raj A, Dey A, Boyce S, Seth A, Bora S, Chandurkar D, *et al.* Associations between mistreatment by a provider during childbirth and maternal health complications in Uttar Pradesh, India. *Matern Child Health J* 2017;21:1821-33.
23. 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 Childbirth* 2016;16:1-12.
24. Rajbangshi P, Srivastava A, Nambiar D. Women's experiences with maternity care in public health facilities of Assam, India. *WHO South East Asia J Public Health* 2022;11:61-64.
25. Shrivastava S, Rai S, Sivakami M. Challenges for pregnant women seeking institutional care during the COVID-19 lockdown in India: A content analysis of online news reports. *Indian J Med Ethics* 2021;6(3):202-11.
26. Rosen HE, Lynam PE, 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.
27. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, *et al.* The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Med* 2015;12:e1001847.
28. Jha P, Christensson K, Svanberg AS, Larsson M, Sharma B, Johansson E. Cashless childbirth, but at a cost: A grounded theory study on quality of intrapartum care in public health facilities in India. *Midwifery* 2016;39:78-86.
29. Sarwal T, Sarwal Y, Shakun Tyagi M, Sarwal R. Opinion of health care providers on birth companions in obstetrics department of a tertiary care hospital in North India. *medRxiv*; 2021. Available from: <https://www.medrxiv.org/content/10.1101/2021.06.24.21259462v1> [Last accessed on 2023 May 18].
30. Asefa A, Semaan A, Delvaux T, Huysmans E, Galle A, Sacks E,

- et al.* The impact of COVID-19 on the provision of respectful maternity care: Findings from a global survey of health workers. *Women Birth* 2022;35:378-86.
31. SDG Target 3.1 Maternal mortality: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births. Available from: <https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality> [Last accessed on 2023 May 18].
32. Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwiga C, Warren CE, *et al.* Defining disrespect and abuse of women in childbirth: A research, policy and rights agenda. *Bull World Health Organ* 2014;92:915-7.

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