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Transforming intrapartum care: Respectful maternity care

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A B S T R A C T

Respectful maternity care is recommended by the World Health Organization and refers to care that maintains dignity, privacy, confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth. In this paper, we review the evidence of respectful maternity care and discuss considerations for professional practice for health care providers. While there is limited evidence on what type of interventions can improve respectful maternity care, promising skills development for providers has included training on values, transforming attitudes, and interpersonal communication. Within a health facility, enabling environments may be created by setting up quality improvement teams, monitoring experiences of poor treatment, mentorship, and improved working conditions for staff. In order to provide respectful care, health facilities and health systems must be structured in a way that supports and respects providers, and ensures adequate infrastructure and organisation of the maternity ward.

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Introduction

Over the past several decades, women across the world have been encouraged to give birth in health facilities in order to ensure timely access to skilled care and referral if additional care needs arise [1]. Despite an increasing proportion of women giving birth in health facilities globally, expected reductions of maternal and newborn mortality and morbidity have not necessarily been met [2]. High rates of avoidable maternal and newborn mortality and morbidity are often due to poor quality of care [3], and increasing evidence suggests that disrespectful and undignified care is commonplace in many settings [4,5].

JCLP_press_logoThe World Health Organization (WHO) defines quality of care for women and newborns as "the extent to which health care services … improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable and people-centred" [6,7]. The WHO Framework for improving quality of care for women during childbirth highlights that women's experiences of care are equally important to clinical care provision [7]. Further, in a systematic review of high-quality clinical guidelines for maternity practice, Miller and colleagues (2016) noted that even the provision of evidence-based clinical care cannot be considered quality care unless the care is provided respectfully [8]. However, non-clinical intrapartum care practices, such as emotional support through labour companionship [9,10], continuity of carer [11], effective communication [12], and respectful care [13,14] are often not prioritised in many settings. These non-clinical practices are often inexpensive to implement and should complement any necessary clinical interventions to optimise quality of care for women and their families [15]. In this paper, we review the evidence of respectful maternity care and discuss considerations for professional practice for health care providers including obstetricians, midwives, nurses and trainees.

What is respectful maternity care?

The emphasis on quality care in nursing, midwifery, and medicine began formally in the 1960s and 1970s [16,17], and has used a variety of terms, such as quality care, humanized care, rights-based care, family-centred care, patient-centred care, woman-centred care, and respectful care. In maternity care, these concepts appeared in the 1970s along with the women's rights movement, which included women's health and rights, and impacted provider-thinking about provision of care. At the same time, nursing and midwifery journals published research on what we now label "evidence-based respectful care," such as evidence supporting birthing positions other than supine [18,19]. By the early 2000s, respectful maternity care began to appear in textbooks and training courses for midwives [20,21]. This included the American College of Nurse Midwives (ACNM) training on greeting and listening to the woman and her family, providing privacy and comfort measures, and explaining what will happen and answering questions.

Today, respectful maternity care has evolved to refer to "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth," and is recommended by WHO for all women [15]. WHO's recommendations on intrapartum care for a positive childbirth experience (2018) highlight that respectful maternity care is in accordance with human rights based approaches to maternity care, could improve women's experiences of labour and childbirth and address health inequalities [15]. Shakibazadeh and colleagues conducted a qualitative evidence synthesis (systematic review of qualitative research) and developed twelve domains of respectful maternity care from the perspectives of women and healthcare providers (Box 1) [14].

Box 1
Twelve domains of respectful maternity care [14].

1. Being free from harm and mistreatment
2. Maintaining privacy and confidentiality
3. Preserving women's dignity
4. Prospective provision of information and seeking informed consent
5. Ensuring continuous access to family and community support
6. Enhancing quality of physical environment and resources
7. Providing equitable maternity care
8. Engaging with effective communication
9. Respecting women's choices that strengthens their capabilities to give birth
10. Availability of competent and motivated human resources
11. Provision of efficient and effective care
12. Continuity of care

At the same time, mistreatment of women during childbirth is widely prevalent globally [5,13], and includes practices that may make a woman feel dehumanised, disempowered, or not in control of her birth [13]. Such practices may include physical or verbal abuse, discrimination, non-consented vaginal exams and/or procedures (e.g. caesarean section, episiotomy, induction of labour), lack of privacy, lack of supportive care, and neglect [4]. These mistreatment experiences may occur at the interpersonal level between the woman and the healthcare provider, or at the health facility or health system level [12]. It is important to note that certain components of respectful care can occur in the presence of mistreatment, and women may therefore experience elements of both respectful care and mistreatment throughout labour and childbirth.

Why is respectful maternity care important?

Respectful maternity care is an important component of quality of care [7]. When women feel supported, respected, safe, and able to participate in shared decision-making with their providers, they may be more likely to have positive childbirth experiences. However, when women experience disrespectful care, they may be less likely to use facility-based maternity care services in the future [22] and may be more likely to have negative birth experiences.

The value that women and their families place on different aspects of respectful care may vary across both settings and individuals. Therefore, it is important for healthcare providers to ask women about their values, needs, and fears, and support women in order to have positive childbirth experiences. For example, women in high-income countries may value shared decision-making more highly than women in lower-income countries [14], although this may also be impacted by health literacy, empowerment, and gender equality within a society.

Furthermore, providing respectful maternity care is a human rights issue [23,24]. All women have the right to freedom from harm and ill treatment, the right to provide informed consent and refusal to consent, and respect for choices and preferences, including companionship during maternity care [25].

Measurement

There is currently no core outcome set related to respectful care or mistreatment. The implications of no core outcome set are that researchers have used different methods, definitions, approaches, and tools for measurement, which complicates comparison across sites.

Measurement approaches

Attempts to measure respectful maternity care and mistreatment during childbirth to date have used the following quantitative approaches:

- **Direct observations of labour**: data collector either conducts 1:1 observation of woman throughout labour and childbirth, or conducts an observation of the maternity ward, labour room, or delivery room
- **Facility-based exit interviews:** surveys conducted with women after discharge from the health facility for childbirth
- **Community-based interviews**: surveys conducted with women during the postpartum period (ranging from several weeks to several years)

Qualitative research (including in-depth interviews, focus group discussions, open-ended survey questions) has also been conducted with many stakeholders including women, community members, obstetricians, junior doctors, midwives, nurses, and facility administrators to better understand the perceptions and experiences of respectful care and mistreatment [26–31].

Key measurement studies

There are a number of measurement studies conducted globally using labour observations and interviews with women [32–38]. In this section, we will focus on three recent tool development and measurement studies supported by formative and multi-country measurement phases.

WHO "How women are treated during facility-based childbirth" study

WHO led the development of two tools to measure the mistreatment of women during childbirth: (1) labour observation for one-to-one observations of women from admission to 2 h postpartum, and (2) community-based survey with women at up to eight weeks postpartum. The tools are openly available in eight languages [39]. WHO developed these tools in four countries (Ghana, Guinea, Myanmar, and Nigeria) and assessed the prevalence of different types of mistreatment in these settings.

In the labour observation component (n = 2016 women), over 40% of women had observed experiences of physical abuse, verbal abuse, or discrimination, 59% of women did not consent to their first vaginal examination, and 4.5% of women gave birth in a health facility without a provider present [5]. In the community-based survey (n = 2672 women), over 35% of women reported experiencing physical abuse, verbal abuse, or discrimination, and many women had unconsented procedures including caesarean section (11%), episiotomy (56%), and induction of labour (27%) [5].

The key strengths of this study are the use of an evidence-informed typology of specific acts that constitute mistreatment, an iterative tool design process, 24-h per day/7 days per week data collection for the labour observation, and the use of non-clinical data collectors which may reduce the risk of under-reporting [5]. However, one-to-one labour observations are resource intensive, and more work is needed to explore how observations of mistreatment and respectful care may be integrated into routine quality improvement or service assessment.

Person-centred maternity care in low-income and middle-income countries

Similarly, Afulani and colleagues developed a scale to measure person-centred maternity care, and explored the prevalence of person-centred maternity care in Ghana, India, and Kenya [40]. The scale includes 30-items across three domains: dignity and respect, communication and autonomy, and supportive care [40]. They found that the lowest scores were in communication and autonomy, including that over 60% of women in Ghana and India reported that providers did not explain the purpose of examinations or procedures [40]. The key strengths of this study centred on the use of a validated tool across three countries, and the use of both objective and subjective questions to better understand the both contextual- and individual-level factors that affect women's experiences of care [40]. Owing to the inherent differences in interpretation of both the questions and responses, more work is needed to develop public health and maternity care responses that can action the more subjective measures into better care for individual women.

The giving voice to mothers study

In the United States, Vedam and colleagues (2019) measured lived experiences of maternity care across diverse populations in the United States [41]. They found that women of colour and poorer women were more likely to experience mistreatment compared to white or richer women, including loss of autonomy, being shouted at or threatened, or being ignored [41]. These findings demonstrate that the mistreatment of women during childbirth is not just a phenomenon in lower-income countries and much work remains to be done in high-income settings, particularly for women of colour. The key strengths of this study are the participatory approach to measurement, as the researchers and study population (women) co-designed and validated quantitative indicators, as well as the oversampling from under-represented communities [41]. Applying the tools from this study at a population-level may help to provide additional insights into discrimination and racism faced in maternity care.

Other measurement studies have contributed to understanding the conceptualisation and manifestations of elements of respectful maternity care and/or mistreatment during childbirth. However, validated measures have typically not been used, thus complicating comparability across study contexts.

Assessing women's experiences of care

Indicators measuring quality of maternity care have typically focused on assessing the coverage of life-saving interventions (e.g. proportion of births with skilled attendance, proportion of births by caesarean section) and health outcomes (e.g. maternal death, postpartum haemorrhage, pre-eclampsia/eclampsia). However, increasing attention is now being given to quality of care indicators related to the woman's experience [3]. Measuring and reporting on women's experiences of intrapartum care are important to better understand quality and their interactions with health services. However, much remains to be done to ensure that women's experiences of maternity care are integrated into research, monitoring, and audit and feedback mechanisms. For example, a Cochrane review of continuous support for women during childbirth found that only 41% of randomised controlled trials (11 out of 27 trials) reported on women's experiences of continuous support, which was one of the primary outcomes of the review [9,10]. The other 59% of randomised controlled trials measured clinical outcomes only (such as mode of birth and use of interventions) but did not report on women's experiences [9,10].

Larson and colleagues provide guidance on measuring person-centred care as part of quality improvement or research initiatives [42]:

- **Defining the purpose** of measurement is important to ensure that appropriate indicators are used. For example, patient experience measures can be used to evaluate quality of care, while satisfaction measures can track patients' responses to care. Both measures are important for accountability and quality, but serve different purposes: patient experience relates to providing high quality of care, while patient satisfaction refers to the responsiveness of care to the expectations of the population.
- **Addressing subjectivity** is important to understand how the phrasing of questions, response choices, and whether the questions account for expectations may influence the results.
- **Validated tools** should be used to standardise measurement to ensure that the approach used is measuring what it is intended to measure.

The Quality, Equity, and Dignity Network, supported by WHO, United Nations Children's Fund (UNICEF), and United Nations Population Fund (UNFPA) is leading efforts to standardise indicators for measuring respectful maternity care and mistreatment during childbirth across Ministries of Health currently in eleven low- and middle-income countries [43]. Shared learning resources and access to country data is available via the Network website [https://worldhealthorg-my.sharepoint.com/Users/millers/Desktop/www.qualityofcarenetwork.org].

Considerations for practice

There is limited evidence on what type of interventions can improve respectful maternity care. A systematic review of interventions to promote respectful maternity care [44] was conducted for the WHO recommendation on respectful maternity care [15] and identified five interventional studies (all conducted in Africa and none conducted in high income countries). Most of the interventions were multi-component and included both community engagement and quality improvement for providers. Types of components included [15,44]:

- Training in values and transforming attitudes
- Training in interpersonal communication skills
- Setting up quality improvement teams
- Monitoring experiences of mistreatment
- Mentorship for healthcare providers
- Improving privacy in maternity wards (e.g. with curtains or partitions between beds)
- Improving working conditions for staff
- Hosting maternity open days (for women and their families to visit the maternity unit and interact with providers)
- Mediation/alternative dispute resolution
- Counselling of community members who experienced mistreatment during childbirth
- Improving accountability by setting up complaint mechanisms
- Educating women and girls about their rights

Women in the respectful care intervention groups were more likely to report experiencing respectful care and not report experiencing mistreatment, compared to women without the intervention [44].

Depending on the characteristics of the woman and/or her community, there may be additional considerations for improving respectful care and inclusive services. For example, evidence from Indigenous Australian communities demonstrates that “Birthing on Country,” (Indigenous women giving birth on ancestral land) reduced the risk of preterm birth [45], improved cultural safety [46], and was highly valued [46]. Similarly, refugee and migrant women in high-income countries who had labour and childbirth support from a community-based doula (someone from their ethnic or cultural background) reported improved experiences of culturally responsive care [10,47]

Health policy and systems considerations

In order to provide respectful care, health facilities, and health systems must be structured in a way that supports and respects providers, and provides adequate infrastructure and organisation of the maternity ward space. Table 1 depicts some of the ways that maternity care can be structured to provide a more supportive environment for both healthcare providers and women [15].

The International Childbirth Initiative (ICI) is a consortium of professional associations (including the International Confederation of Midwives (ICM), International Federation of Gynecology and Obstetrics (FIGO), the International Childbirth Education Association (ICEA)) universities, and other international organizations). ICI has developed a process for facilities to improve and ensure respectful care in childbirth, provide a healthy and positive birth environment, promote wellness, support women's choices and autonomy, and to use evidence-based maternity services ("ICI Principles and 12 Steps") [48]. Their unique, underlying foundation is to approach childbearing, birth, immediate postpartum, and care of the newborn as applied to a triad: the mother-baby-family. The ICI Principles and 12 Steps Initiative includes guidance for policy makers and providers, and gives specific details for how to achieve the steps and indicators for demonstrating adherence (https://www.internationalchildbirth.com).

Table 1
Structuring health policies and environments to provide respectful maternity care. Adapted from the WHO recommendations for intrapartum care for a positive childbirth experience [15].

Resource	Description
Policies	• Developing and implementing policies to provide respectful care to all women including (but not limited to): – Allowing all women to have at least one person of their choice present as a labour companion (spouse/partner, family member, friend, or doula) – Promoting midwifery continuity-of care models • Establishing policies and governance to ensure that training, staffing, supervision and monitoring, supplies, equipment, and infrastructure are adequately addressed to support the provision of respectful care.
Training	• Healthcare facility administrators: sensitised and orientated to respectful care and how to develop and apply respectful care in their setting • Healthcare providers: regular practice-based training on providing respectful maternity care that meets the needs (social, cultural, linguistic) of the women accessing services, supported by pre-service training and orientation of new staff • Outreach staff: training for effective community engagement, focusing on including women's voices and providing opportunities for community interaction with healthcare providers (for example, through maternity open days) • Users: orientation sessions for women, their families, and potential companions so that users know what to expect from their maternity care
Staff	• Adequate numbers of competent, trained, and supervised healthcare providers with appropriate skills mixes • Appropriate and reliable remuneration for providers
Supervision and monitoring	• Regular supportive supervision by labour ward or facility lead • Staff meetings to review respectful maternity care processes • Easily accessible mechanisms for service users and providers to submit complaints (e.g. complaints box) • Establishment of accountability mechanisms for redress in the event of mistreatment or violations • Establishment of standardised informed consent procedures
Supplies	• Written, up-to-date standards and benchmarks outlining clear goals, and operational and monitoring plans for respectful maternity care • Adequate provisions for staff in the maternity wards, such as refreshments • Health education materials in an accessible format (written or pictorial) and in the languages of the communities served • Standard informed consent forms and consent processes including communicating results of any procedures or examinations to the woman and/or her family • Information on what to expect for the woman and her supporters • Essential medicines for labour and childbirth available in sufficient quantities at all times in the labour and childbirth areas
Equipment	• Basic and adequate equipment for labour and childbirth available in sufficient quantities at all times in the labour and childbirth areas
Infrastructure	• Adequate physical environment to support respectful care including: – Rooming-in to allow women and their babies to stay together – Clean, appropriately lit, well-ventilated labour, childbirth, and neonatal areas that are adequately equipped and maintained – Privacy measures such as private rooms, or consistent use of curtains or partitions in shared areas – Continuous energy supply – Clean and accessible bathrooms for women to access during labour and after birth – Safe drinking water for women and hand hygiene station with soap/alcohol-based hand sanitizer – Sufficient bed capacity for the patient load – Facilities for labour companions or family support people to use, including physical private space for the woman and her companions • On-site pharmacy and medicine/supplies stock management that is managed by a trained pharmacist or dispenser

Box 2
The International Childbirth Initiative (ICI) 12 Steps to safe and respectful mother-baby-family maternity care [48]. Reprinted with permission.

1. Provide respect, dignity and informed choice
2. Provide free or affordable care with cost transparencies
3. Routinely provide Mother-Baby-Family maternity care
4. Offer continuous support
5. Provide pain relief measures
6. Provide evidence-based practices
7. Avoid harmful practices
8. Enhance wellness and prevent illness
9. Provide emergency care and transport
10. Have a supportive human resource policy
11. Provide a care continuum
12. Promote breastfeeding and skin-to-skin contact

Health provider considerations

Currently there are a few systematic reviews of respectful care clinical practices and how to make evidence-based clinical care respectful [8,49]. A systematic review for the Lancet's Midwifery Series [49] reported that women valued clinical interventions as well as timely and pertinent information and support, which help them to maintain control and dignity. The series resulted in the development of a Quality, Maternal and Newborn Care framework centred on needs of mothers and newborns.

Table 1 mainly focuses on what the facility and health systems can do to provide an enabling environment for health providers themselves to be treated respectfully and for health providers to deliver respectful care. The ICI 12 Steps (Box 2) contain broad and specific recommendations for policymakers and providers. There are also some considerations for individual providers to self-check if they are providing quality, respectful care. Some research has also been conducted on "what matters to women". The White Ribbon Alliance's "What Women Want" campaign reached out to 1.2 million women across 114 countries to discover what women wanted in reproductive health care [50], with considerations for health care providers. Further, some national clinical guidelines and recommendations for best practices for providers have been published which emphasise respectful care [51–54].

In Lancet's Maternal Health Series, Miller and colleagues (2016), used a systematic review approach to report recommended and not recommended clinical practices in a framework of respectful care [8]. In their review of 51 high quality, evidence-based guidelines, they identified interventions for respectful care across all phases of maternity care services. The advice for clinical providers for intra- and post-partum included:

Intrapartum.

- offer women the possibility of being cared for by a midwife; provide one-to-one continuous supportive care
- allow and encourage women to have their choice of a birth companion
- treat every woman with respect, provide her with information, ask her about her expectations, and involve her in decisions about her care
- consider women's psychological and emotional needs
- assess labouring women's pain level and desire for pain relief (nonpharmacological and pharmacological)
- allow and encourage women to drink and eat lightly
- encourage and help women to move and adopt any position, except supine
- inform women that they should push when they feel the urge to push
- inform women that active management of the third stage prevents PPH

- encourage women to have skin-to-skin contact as soon as possible after birth
- avoid separating women and newborns in the first hour after birth
- encourage and support breastfeeding in the first hours after birth

Postpartum.

- provide individualized, culturally and contextually appropriate care that is responsive to changing needs and based on individual care
- facilitate rooming-in, and promote parent participation in educational activities on newborn health
- promote exclusive breastfeeding

In 2018, WHO published recommendations on intrapartum care for a positive childbirth experience with a priority question focusing on what matters to women [15,44]. This question was cross-cutting, a required criterion for inclusion of clinical practices in their recommendations. Table 2 outlines the WHO recommendations focused on a positive childbirth experience for the woman, her family, and the newborn.

The companionship during labour and childbirth recommendation was primarily based on a Cochrane intervention review of continuous support during childbirth and a Cochrane qualitative evidence synthesis on labour companionship [9,10]. The findings from the Cochrane intervention review of 26 published randomised controlled studies with nearly 16,000 women demonstrated that women with continuous support are more likely to have a) spontaneous vaginal births, b) positive feelings about their childbirth, and c) shorter labours [9]. Women with continuous support were less likely to have a) baby with low 5-min Apgar, b) use intrapartum analgesia, c) have a caesarean birth, d) use regional analgesia, and e) have an instrumental birth [9].

Recognising that there is no standardized definition of "effective communication," WHO made recommendations on how to achieve effective communication between maternity care providers and women/families, which included the following [12,15]: Providers should introduce themselves to the woman and her companions, call the woman by her name, offer the woman/her companions information in clear, short messages in their language, communicate positively, support her needs empathetically and compassionately, support her to understand that she has choices, explain all procedures and receive consent (verbal or written), encourage her to express her needs/preferences, keep the woman/companions updated on the process of labour, ensure confidentiality, make sure the woman/companions are aware of how to address complaints (suggestion boxes, formal complaint mechanisms), and to interact with the companions with clear explanations on how to better support the woman during the childbirth experience.

Furthermore, WHO outlined key areas where providers should counsel women about what to expect from the process of labour and childbirth, as well as any interventions, including [15]:

1. Discuss with women how there are no definitive answers to the length of the latent stage of labour and inform them of the usual parameters of first and second stages of labour. This discussion will aid women and their families to make decisions about any suggested interventions and care.
2. Discuss with women how routine cardiotocography is not recommended for assessment of foetal health in healthy women in spontaneous labour, and that intermittent auscultation is recommended.
3. Discuss with and provide women with their choice of non-pharmacologic and pharmacologic pain relief.
4. Discuss with and help women assume their choice(s) of labouring positions.
5. During the second stage, discuss with women that they only need to push when they feel the urge to push.
6. Discuss with women how routine or liberal use of episiotomy is not recommended for women with spontaneous vaginal births.
7. Discuss with women the importance of skin-to-skin contact and provide them and their newborns with skin-to-skin contact in the first hour after birth.

Table 2
WHO recommendations for intrapartum care for a positive childbirth experience [15].

Care option	Recommendation	Category of recommendation
Care throughout labour and birth		
Respectful maternity care	Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended.	Recommended
Effective communication	Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.	Recommended
Companionship during labour and childbirth	A companion of choice is recommended for all women throughout labour and childbirth.	Recommended
Continuity of care	Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well-functioning midwifery programmes.	Context-specific recommendation
First stage of labour		
Maternal mobility and position	Encouraging the adoption of mobility and an upright position during labour in women at low risk is recommended.	Recommended
Oral fluid and food	For women at low risk, oral fluid and food intake during labour is recommended.	Recommended
Perineal/pubic shaving	Routine perineal/pubic shaving prior to giving vaginal birth is not recommended.	Not recommended
Enema on admission	Administration of enema for reducing the use of labour augmentation is not recommended.	Not recommended
Epidural analgesia for pain relief	Epidural analgesia is recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Opioid analgesia for pain relief	Parenteral opioids, such as fentanyl, diamorphine and pethidine, are recommended options for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Relaxation techniques for pain management	Relaxation techniques, including progressive muscle relaxation, breathing, music, mindfulness and other techniques, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Manual techniques for pain management	Manual techniques, such as massage or application of warm packs, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.	Recommended
Second stage of labour		
Fundal pressure	Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended.	Not recommended
Episiotomy policy	Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth.	Not recommended

Table 2 (*continued*)

Care option	Recommendation	Category of recommendation
Birth position (for women with and without epidural analgesia)	For women with and without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.	Recommended
Care of the newborn		
Skin-to-skin contact	Newborns without complications should be kept in skin-to-skin contact with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding.	Recommended
Breastfeeding	All newborns, including low-birth-weight babies who are able to breastfeed, should be put to the breast as soon as possible after birth when they are clinically stable, and the mother and baby are ready.	Recommended
Bathing and other immediate postnatal care of the newborn	Bathing should be delayed until 24 h after birth. If this is not possible due to cultural reasons, bathing should be delayed for at least 6 h. Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of hats/caps. The mother and baby should not be separated and should stay in the same room 24 h a day.	Recommended

8. All newborns, including low-birth-weight babies who are able to breastfeed, should be put to the breast as soon as possible after birth when they are clinically stable, and the mother and baby are ready.

Adherence to clinical guidelines, including not performing interventions and procedures which are "not-recommended," such as applying fundal pressure, routine episiotomy, and enema on admission, can help providers to deliver evidence-based, respectful care.

Besides clinical evidence-based guidelines resources, there are organizations and initiatives that are devoted to helping mothers and families understand their rights in childbearing. Further, they also help health care providers to understand what constitutes respectful maternity care and how providers can implement respectful maternity care in their practices [50].

Summary

Respectful maternity care is recommended for all women throughout labour, childbirth, and postpartum periods, and refers to care organized for and provided to all women "in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth," [15]. Despite clear guidance about what constitutes respectful care, global evidence suggests that not all women receive this type of care. Furthermore, the provision of respectful care may not be prioritised in the same way as the provision of clinical care. More work is needed to understand how respectful care can be provided, particularly in lower-resource contexts, and how non-recommended practices can be removed from clinical settings.

Practice points

Key practice points are listed below, and (*) indicates points recommended by WHO [13].

Respectful maternity care should be provided to all women*

- Treat all women and their families with dignity, respect, and confidentiality, regardless of their low, average, or high maternal risk status, abilities, differences, ethnicity, age, marital status, or if they have co-morbidities, such as infectious diseases.
- Be culturally humble: encourage women to engage in culturally appropriate birthing practices, and address women in a culturally appropriate manner. For example, in some cultures it is considered rude to look directly into the eyes of the person you are speaking to, particularly if the care provider is male; in other cultures, it is a sign of honesty and sincerity to look directly at the woman and her family members.

Effective communication between maternity care providers and women in labour should be provided*

- Inform women and their families about: evidence, risk, and benefits of procedures, processes, and use/non-use of technologies and strategies during maternity care.
- Use effective, respectful, two-way communication techniques; speak respectfully, but also listen respectfully to women and their families.
- Partner with women and families on decision-making, respecting their individual/family/cultural preferences.

A companion of choice is recommended for all women throughout labour, childbirth, and postpartum*

Midwife-led continuity of care should be for pregnant women in settings with well-functioning midwifery programmes*

Encourage women to mobilise, use upright or preferred positions, and have access to oral fluids and food (low-risk women)*

Depending on women's preferences, facilitate use of appropriate pain relief measures including epidural analgesia, opioid analgesia, relaxation measures, and manual techniques*

Provide evidence-based, recommended care and avoid non-recommended practices such as routine enemas, episiotomy, fundal pressure, perineal/pubic shaving, or separating mother and baby*

Do no harm: Do not harm women physically or emotionally and do not engage in harmful practices, unnecessary practices, or practices not recommended based on evidence. Do not coerce women or force them or their families to pay bribes to receive care.

Research agenda

- Behavioural change interventions to de-implement clinical practices that are commonly practiced but not recommended (e.g. manual fundal pressure, routine perineal shaving)
- Multi-component strategies to ensure implementation and sustainability of respectful maternity care within well-functioning health systems.
- Measurement methods for respectful maternity care for routine use in audit and feedback or quality improvement initiatives.

Declaration of Competing Interest

None.

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