Scientific Research Publishing

Open Journal of Obstetrics and Gynecology, 2025, 15(10), 1763-1794
https://www.scirp.org/journal/ojog
ISSN Online: 2160-8806
ISSN Print: 2160-8792

Health Care Providers' Perceptions of Respectful and Disrespectful Maternity Care in Facility-Based Births Worldwide: A Mixed Methods Systematic Review

Katherine Doughty Fachon[1], Sahana Narayan[1], Mary Greenwald[1], Annekathryn Goodman[1,2*]

[1]Department of Obstetrics and Gynecology, Massachusetts General Hospital, Boston, MA, USA
[2]Department of Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School, Boston, MA, USA
Email: *agoodman@mgh.harvard.edu

How to cite this paper: Fachon, K.D., Narayan, S., Greenwald, M. and Goodman, A. (2025) Health Care Providers' Perceptions of Respectful and Disrespectful Maternity Care in Facility-Based Births Worldwide: A Mixed Methods Systematic Review. *Open Journal of Obstetrics and Gynecology*, **15**, 1763-1794.
https://doi.org/10.4236/ojog.2025.1510149

Received: September 13, 2025
Accepted: October 27, 2025
Published: October 30, 2025

Abstract

Background: Respectful maternity care is critical to the health of birthing people and infants worldwide. However, there is global evidence of disrespectful or abusive care in childbirth, which negatively impacts maternal experiences and health outcomes. Maternal health care providers hold key insights into the dynamics of quality of care in childbirth. The aim of this systematic review is to synthesize the perspectives of health care providers' perceptions of respectful and disrespectful care in childbirth. **Methods:** We searched PubMed, CINAHL, HOLLIS (Harvard Medical Library), and Medline database for peer-reviewed quantitative and qualitative research studies examining health care providers' perceptions of respectful and disrespectful maternity care published between January 2014 and July 2024. Quantitative studies were summarized, and qualitative studies were synthesized thematically. A mixed-method summary integrated findings from both quantitative and qualitative findings. **Results:** Sixty studies (15 quantitative, 39 qualitative, and 6 mixed methods) were included. Prevalence of witnessing disrespect and abuse in childbirth ranged widely, from 21.9% to 93.2%. Types of respectful and disrespectful care witnessed and performed by maternal health care providers varied greatly. Four themes were identified from qualitative studies: 1—facility and structural issues, 2—clinician responsibilities, 3—hierarchy and power, and 4—(mis)understanding and interpreting the mother's experience. Both qualitative and quantitative studies identified three issues. Reduced staffing was a barrier to respectful maternity care. A lack of privacy was a key issue. Finally, providers expressed a need for training on respectful maternity care. **Conclusions:** This review found a wide variety of metrics quantifying respectful and disrespectful

maternity care, and a diversity of knowledge and perceptions held by health care providers. The global scope of the review revealed that the manifestation of respectful and disrespectful care varied greatly by cultural and institutional context, and that organizational resources significantly impacted quality of care.

Keywords

Respectful Maternity Care, Disrespect and Abuse, Childbirth

1. Introduction

Respectful, safe, and accessible obstetricalcare is a cornerstone for a functioning healthcare system and a stable and resourced society that values all its citizens. Maternal care includes all aspects of pregnancy-focused care, ranging from antepartum, intrapartum, and postpartum care. The intrapartum phase includes the dynamic and changing period of labor and delivery, where a birthing person and their infant are most vulnerable to medically critical and life-threatening events. A birthing person is a gender-neutral designation of someone who is pregnant or in the process of giving birth. The American College of Obstetricians and Gynecologists (ACOG) has identified the importance of establishing levels of maternal care that include basic care, specialty care, subspecialty care, and regional perinatal healthcare centers to reduce maternal mortality and severe maternal morbidity [1]. Maternal mortality is defined as deaths due to complications of pregnancy, delivery, or the first 42 days after delivery per 100,000 live births. Pregnancy-related deaths, a significant cause of death for women worldwide, have largely been due to lack of access to healthcare centers and unattended home deliveries. Hemorrhage, cardiovascular disease, and infection are the leading direct causes of maternal death in both high- and lower-income regions [2]-[4]. Enormous strides have been made in increasing access to skilled maternity care, especially during the World Health Organization's (WHO) Millennium Development Goal era (2000-2015) [5]. However, global progress in tackling maternal mortality has since stalled. The reasons are multifactorial. Gender biases deprioritize women's health care and stigma presents a barrier to comprehensive reproductive health worldwide [6]. Humanitarian crises strain health care systems. Inequities in race, income, and education put subpopulations at greater risk [6]. Currently, healthcare systems operate in the long shadow of the COVID-19 pandemic, with system deficiencies—some that predate the pandemic and some that were exacerbated by it—limiting the ability of maternal care facilities unable to provide quality care [7].

Lack of respectful maternity care has emerged as a critical byproduct of such healthcare systemic deficiencies. Birthing people who experience disrespect and abuse in childbirth are more likely to avoid or delay health care in the future, putting them at risk for poor outcomes [8]. Those who experience disrespect, abuse,

or violence during childbirth face the possibility of psychological trauma [9] [10], postpartum depression [11], and avoidance of health care services, leading to poorer maternal outcomes overall [12] [13]. The consequent decrease in rates of facility-based birth poses an additional barrier to reducing the rates of global maternal morbidity and mortality [14].

Though there is widespread observational evidence of birthing people's negative experiences, there is no standardized definition for disrespectful maternity care. A great deal of discourse exists regarding the conceptualization and terminology of the phenomenon. *Obstetric violence*, or violence against birthing people during childbirth, is conceptualized as an infringement of the human rights of birthing people and a dimension of gender-based violence [15] [16]. Several Latin American countries have developed a legal framework to criminalize such violence [16]-[18]. The most salient definition is found in the landmark 2007 Venezuelan law, "Organic Law on the Right of Women to a Life Free of Violence", which defines obstetric violence as follows:

> …*The appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women* [19].

However, the use of the term "obstetric violence" engenders controversy. The term may alienate health care professionals, who are vital stakeholders in the pursuit of respectful maternity care [20]-[22]. The currently preferred terminology, "*disrespect and abuse in childbirth*" and "*mistreatment in facility-based birth*", attempts to soften language and recruit obstetrical providers in efforts to improve care [15] [23]. Bohren *et al.* (2015) developed a framework of seven categories of mistreatment: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints [24]. Some dimensions of disrespect and abuse may be culture and context specific [25]. In a WHO-sponsored analysis of social determinants of health across the 53 Member States of the European Region, health inequities and mortality outcomes were tracked with socioeconomic status by country [26]. The resources of health systems correlated with national income, social development, and politics of each country [26]. In low- and middle-income countries, respectful maternity care has a direct association with the income of the country [27].

Recognizing that the absence of abusive care alone does not constitute quality care, the concept of "Respectful Maternity Care" (RMC) has recently gained traction. RMC aims to not only eliminate harm but also maintain and respect the birthing person's dignity, privacy, and confidentiality. As such, it is an important dimension of healthcare quality and can be operationalized by healthcare systems as part of quality improvement and safety initiatives [28]. Such debate and diver-

sity in conceptualization and terminologies regarding quality care in childbirth necessitate an inclusive review that encompasses respectful maternity care, disrespect and abuse in childbirth, and obstetric violence. As such, the term and concept of respectful maternity care is defined as medical care encompassing the rights, privacy, autonomy, and dignity of each birthing person during the delivery of maternity services [5].

Most studies in this realm focus exclusively on the experiences of birthing people [13] [24]. The perspectives of maternal healthcare providers have been comparatively unexplored, leaving a gap in the understanding of this topic. Providers can perpetrate violence and provide disrespectful care to vulnerable parturient people; they can also hold negative attitudes that translate into harmful patient interactions [29]. Additionally, providers can be subject to vulnerabilities themselves, such as punishing workloads in dysfunctional or under-resourced environments, which may lead to provider burnout and suboptimal care for patients [30] [31]. As both agents of and witnesses to these behaviors, providers are in a unique position to report on the personal, interprofessional, organizational, and system-level factors that impact delivery of respectful maternity care.

Consolidating evidence on provider perspectives on the full spectrum of childbirth care quality, ranging from obstetric violence to disrespectful and abusive care to respectful patient-centered care, is essential to addressing this gap. A review of literature on provider perspectives will facilitate the development of strategies to ensure that providers have the means and motivation to provide respectful maternity care.

2. Methods

This protocol used the Joanna Briggs Institute methodology for mixed-method systematic reviews [32]. A mixed-method review is well-suited to this subject matter because it allows for inclusion of varied study designs while retaining methodological rigor. A convergent segregated approach first synthesized quantitative and qualitative results separately, followed by an integration of all results. The study protocol was prospectively registered in PROSPERO (CRD42023477867). Findings follow guidance provided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) [33]. Quality was assessed using the Mixed Methods Appraisal Tool (MMAT) [34]. **Appendix A** lists the questions analyzed for the sixty studies.

Arksey and O'Malley's methodological framework was used to conduct the review. The framework consists of five steps: 1) identification of the research question; 2) identification of relevant studies; 3) selection of studies; 4) data extraction; and 5) compilation, summary, and reporting of results [35].

Step 1: Identification of the Research Question

The questions guiding this review are:

1) How do maternity care providers practice disrespectful and respectful maternity care in facility-based birth?

2) How do maternity care providers perceive disrespectful and respectful maternity care in facility-based birth?

Step 2: Identification of Relevant Studies

Inclusion Criteria. The Population-Concept-Context (PCC) framework guided the inclusion and exclusion criteria, detailed in Table 1.

Table 1. Inclusion and exclusion criteria.

Strategy	Inclusion Criteria
Population	Studies whose population include maternity healthcare providers: physicians, midwives, nurses, skilled and traditional birth attendants, doulas, clinical students, health administrators, and specialists who provide intrapartum care.
Concept	Studies that address perceptions of experiences providing or witnessing care of intrapartum birthing people along the continuum of quality: encompassing obstetric violence, disrespectful and abusive care, and respectful care.
Context	Studies that address the provision of care during labor and childbirth in hospitals and facility-based health settings worldwide.
Other Criteria	Include: • Full-text articles. • Peer reviewed primary qualitative or quantitative studies. • Studies in English. • Studies that include provider perspectives and other perspectives may be included only if the provider-side data can be separately analyzed. • Studies that include an observational component along with a survey/interview/focus group component may be included only if the survey/interview/focus group data can be separately analyzed. • Studies published from January 2014-July 2024. Exclude: • Synthesis studies (meta-syntheses or meta-analyses). • Observational studies that focus on observing providers' behavior without directly eliciting their input. • Studies that include provider perspectives primarily as part of a pre- and post-intervention evaluation. • Studies that include provider perspectives and other perspectives, where the provider-side data cannot be separately analyzed. • Studies that focus primarily on technical or procedural aspects of intrapartum care. • Articles where the full-text version cannot be obtained.

Search Strategy. The research strategy focused on the search for peer-reviewed publications. Primary quantitative and qualitative research studies of any type were included to focus on recent research. Articles from January 1, 2014 through July 1, 2024 were eligible.

Electronic databases PubMed, CINAHL, HOLLIS (Harvard Medical Library), and Medline were searched. The search strategy (**Appendix B**) used Boolean operators to align with the PCC framework. The search strategy tool was modified according to specifications of each database.

Step 3: Study Selection

Studies were selected based on the inclusion criteria detailed above. Duplicate studies were removed by organizing the articles in EndNote citation manager software. In the first phase of selection, titles and abstracts were screened to identify eligibility. Full-text articles were then read to assess eligibility and inclusion in the

review. The selection process for the studies is detailed in a PRISMA flow diagram below (**Figure 1**) [33].

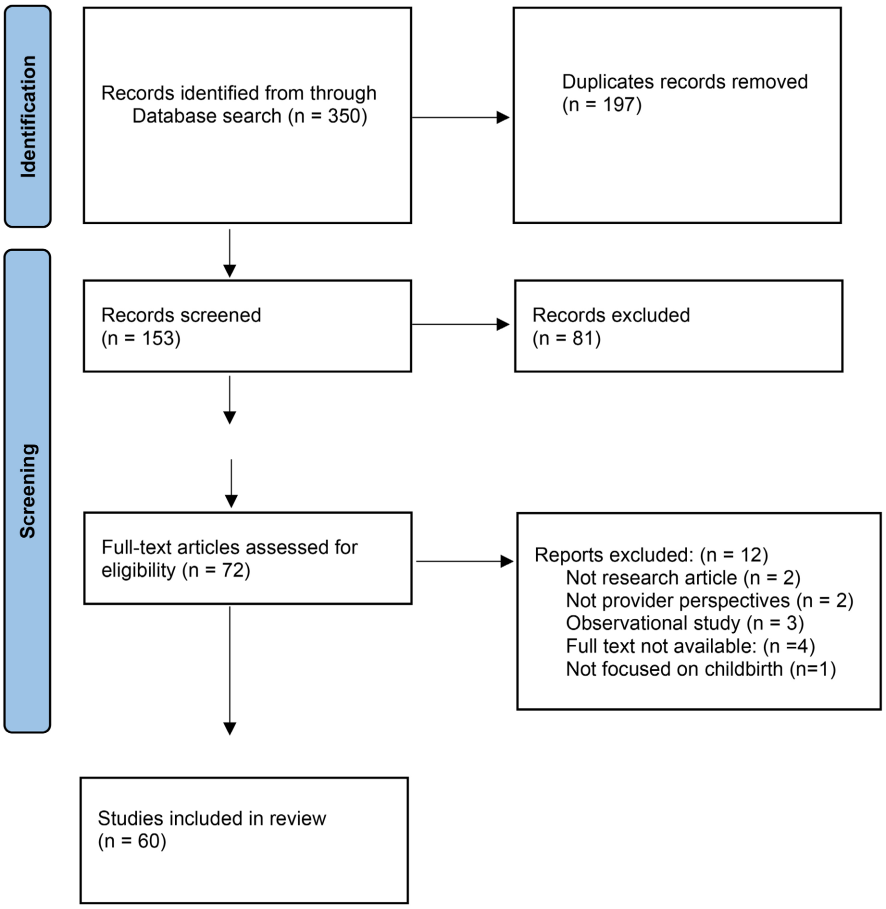

Figure 1. PRISMA diagram showing the study selection process.

Step 4: Data Extraction

The following information was collected from each eligible study. Reference management software and Excel were used to organize the data extraction.

- Citation (Author, Year).
- Number and profession of participants.
- Geographical location of study.
- Study methods.
- Prevalence of witnessed/perpetrated disrespect or RMC.
- Predictors/drivers of D&A.

Step 5: Compiling, Summarizing and Reporting the Results

Quantitative studies were summarized with descriptive results in a table format. Qualitative findings were synthesized thematically using methodology detailed by Thomas and Harden [36]. The results sections of selected papers were coded in Dedoose version 9.0.107 (stage one); descriptive themes were developed from the codes (stage two); and analytical themes were developed (stage three).

3. Results

The search identified 60 studies eligible for inclusion: 15 quantitative studies, 39 qualitative studies, and 6 mixed-method studies [37]-[98]. Of these, 36 were from Africa [37] [39] [41] [42] [51]-[55] [57] [59]-[61] [63]-[70] [72] [73] [75]-[79] [82]-[85] [88] [90]-[92] [96], 1 from East Asia [47], 2 from North America [50] [63], 4 from South America/Caribbean [81] [89] [93] [98], 3 from Europe [58] [80] [86], 6 from South Asia [43] [44] [71] [87] [94] [95], 4 from the Middle East [38] [46] [49] [74], 1 from Australia [48], 1 from both South Asia and the Middle East [45], and 2 global studies. Three studies also focused on the impact of COVID-19 [40] [56] [58]. Study participants included midwives, physicians, clinical officers, nurses, health officers, nursing/midwifery students, as well as clinical support staff and doulas.

3.1. Quantitative Study Results

Table 2 summarizes the quantitative study results.

Table 2. Summary of studies with quantitative components.

Author and Year	Number/Profession of Participants	Geographical Location of Study	Study Methods	Prevalence of Witnessed/ Perpetrated Disrespect or RMC	Predictors/Drivers of D&A
Afulani *et al.* (2020) [37]	7 clinical officers/doctors 25 nurse/midwives 35 support staff	Kenya	Mixed methods: survey and interview	53% of respondents witnessed and 45% perpetrated verbal abuse. 37% of respondents witnessed and 35% perpetrated physical abuse.	(Integrated in qualitative synthesis below)
Alzyoud *et al.* (2023) [38]	231 nurses and midwives: 146 nurses, 85 midwives	22 countries	Quantitative: survey questionnaire	NA	Gender, number of hours worked per week, and organizational/structural factors were all predictors of disrespect and abuse, with organizational/structural factors as the strongest predictor.
Asefa *et al.* (2018) [39]	57 health professionals: 13 clinical nurses, 25 midwives, 16 medical doctors, 2 health officers, 1 gynecologist/obstetrician	Ethiopia	Quantitative: survey questionnaire	Most commonly reported elements of witnessed RMC were responding promptly and politely to mothers (63.2%), using curtains or barriers to protect mothers' privacy (60%), and explaining procedures and birth expectations to women (58.9%). Most commonly reported elements of witnessed D&A were lack of privacy protection during labor and delivery (34%), physical force or abrasive behavior (25.9%), and detention in facility against the mothers' will (18%).	NA

Continued

Asefa *et al.* (2022) [40]	1127 health professionals: 280 midwives/ nurse-midwives, 242 obstetrician-gynecologists, 219 other MD, 316 nurses, 70 other	Global	Mixed methods: survey questionnaire and	29.6% reported ability to provide RMC was about the same during COVID; 46.8% reported better, 17% reported lower.	(Integrated in qualitative synthesis below)
Bakker *et al.* (2020) [41]	391 midwifery students	Ethiopia	Quantitative: survey questionnaire	NA	Younger age, more stress, and more observation during education were significantly associated with positive appraisal of mistreatment of women during childbirth.
Burnett-Zieman (2023) [42]	302 health professionals: 31 physicians, 72 nurses/ midwives, 179 nurse/ midwife technicians, 20 community midwife assistants	Malawi	Quantitative: survey questionnaire	NA	PTSD scores were associated with increased burnout and depression scores, but not with RMC scores. Positive relationships with facility managers were significantly associated with increased RMC scores.
Datta *et al.* (2023) [43]	78 health professionals: 20 nurses58 resident doctors	India	Quantitative: survey questionnaire	Providers reported that practices of RMC in their workplace were generally favorable, except introducing themselves to patients (15.4% always performed), encouraging companions (2.5% always performed), and allowing labor position of choice (5.2% always performed).	Training status was the strongest predictor of RMC perception, with trained personnel less likely to report that favorable RMC practices were implemented.
Deki and Choden (2018) [44]	83 nurse-midwives	Bhutan	Quantitative: survey questionnaire	Most frequently practiced RMC was providing privacy (97.6% always performed) and allowing support people (97.6% always performed.) Least frequently practiced was allowing birth position of choice (24.1%).	Commonly cited barriers to RMC included need for training (96.8%) and lack of adequate staffing (73.5%).
Dhakal *et al.* (2022) [45]	171 Nepalese nursing students 105 Jordanian midwifery students	Nepal and Jordan	Quantitative: survey questionnaire	Most frequently reported types of D&A witnessed in Nepal: allowing uninvolved people to be present at birth (43.9%), treating women in unfriendly manner (42.7%). Most frequently reported types of D&A in Jordan: performing procedure without consent (100%), leaving women exposed (97%).	Provider age and duration of clinical placement were significant predictors of RMC scores.
Haghdoost *et al.* (2021) [46]	130 midwives	Iran	Quantitative: survey questionnaire	Performance of RMC: 30.8% Good, 51.5% Fair, 17.7% Weak.	Negative association of job satisfaction and RMC performance; positive association of work experience plus Master's degree and RMC performance.

Continued

Huang *et al.* (2024) [47]	733 nursing and midwifery students	China	Quantitative: survey questionnaire	21.9% of respondents who had witnessed at least one birth reported witnessing D&A. The most common forms of D&A were physical restraint (9.8% witnessed) and failure to explain examinations (8.2%).	Students who were female, Han Chinese, enrolled in a midwifery major, and achieved higher grades were more likely to have higher RMC scores.
Kasaye *et al.* (2024) [48]	148 health professionals: 99 midwives, 25 nurses, 10 OBGYNs, 6 health officers, 5 general practitioners, 3 integrated emergency surgical officers	Ethiopia	Quantitative: survey questionnaire	93.2% of providers reported witnessing D&A, and 75.6% reported perpetrating D&A. The most common types of mistreatment were privacy violations (44.6%), physical abuse (37.1%) and verbal abuse (35.8%).	Positive perception of work environment was associated with less mistreatment.
Moridi *et al.* (2022) [49]	250 midwives	Iran	Quantitative: survey questionnaire	Giving emotional support: 88% reported knowledge, 86% reported practice. Providing safe care: 94% reported knowledge, 90% reported practice. Preventing maltreatment: 78% reported knowledge, 68% reported practice.	The strongest predictive factor or RMC knowledge was age, and the strongest predictive factor of RMC practice was work experience.
Morton *et al.* (2018) [50]	2781 nurses and doulas	United States and Canada	Quantitative: survey questionnaire	65.4% witnessed a failure to provide informed consent occasionally or often; 19.8% witnessed racially or sexually demeaning language occasionally or often; 18.0% witnessed procedures against patient wishes occasionally or often.	Respondents who expected to leave their job within three years were more likely to report witnessing most types of disrespect. Respondents of color were more likely to report witnessing racial discrimination.
Moyer *et al.* (2021) [51]	43 maternity care providers: 22 midwives 2 doctors 1 anesthetist 18 nurses	Ghana	Mixed methods: survey questionnaire, interview, and observation	38.9% reported verbally abusing women. 26.4% reported treating women differently because of personal attributes.	(Integrated in qualitative synthesis below)
Nankamba (2021) [52]	217 midwives	Zambia	Mixed methods: survey, interviews	40.1% have perpetrated D&A; 68.7% have witnessed D&A.	There was a positive association between midwives' perception of D&A and their practicing disrespectful behavior.
Okedo-Alex *et al.* (2020) [53], Okedo-Alex *et al.* (2021) [54] and Okedo-Alex (2022) [55]*	156 health professionals: 40 midwives, 116 doctors	Nigeria	Mixed methods: survey, interviews, focus groups	39.1% reported treating patients disrespectfully. 73.1% witnessed disrespectful treatment.	(Integrated in qualitative synthesis below)
Pokharel *et al.* (2023) [56]	278 health professionals	Nepal	Quantitative: survey questionnaire	NA	Respectful maternity care scores decreased during the COVID pandemic. Client-provider ratio was negatively associated with RMC practice.

Continued

Shimoda *et al.* (2020) [57]	439 nurses, midwives, nursing assistants	Tanzania	Quantitative: survey questionnaire	96.1% of participants reported enacting at least one form of D&A. The most common reported forms were not draping for vaginal exams (66%), not obtaining consent for episiotomy (46.2%) and conducting deliveries in the presences of students or many staff (43.1%).	More working hours per week and taking breaks during evening shift were associated with higher D&A scores. Supervision of new nurse-midwives was associated with lower D&A scores.

*Three articles report the results of the same study.

3.2. Qualitative Synthesis Results

Four themes emerged from the qualitative papers' results: 1—facility issues, 2—hierarchy and control, 3—(mis)understanding and interpreting the mother's experience, and 4—clinician responsibilities.

3.3. Facility and Structural Issues

Qualitative studies nearly universally identified poor staffing and corresponding high workload as a major barrier to providing respectful care [24] [37] [40] [52] [54] [58]-[71] [73] [76].

Providers noted two ways that high workload leads to disrespect. First, it makes providers less available to birthing people as patients. With many patients and competing priorities, it can be impossible to attend to all of them. One provider recounts:

> "*If you are dealing with three patients and one has eclampsia, another needs a caesarean section and the third suddenly has a hemorrhage, for sure one will be abandoned.*"—*Midwife, Mozambique* [68]

Second, it adds to their stress, which in turn makes them less responsive to mothers' needs. Providers reported lashing out at patients because of burnout and compassion fatigue.

> "*Whenever there is burnout then you just find yourself not giving the clients the best that you should, you just find yourself treating the patients as if they are the cause of the burnout.*"—*Clinician, Kenya* [77]

Facility infrastructure presented an additional barrier. Facilities may lack sufficient supplies and have limited bed space, which was especially common in lower-income countries [54] [60] [61] [63] [64] [70] [72] [76] [78]. Even as some of these countries, including Ghana and Kenya, endorse a policy of free maternity care, patients of these hospitals are expected to bring their own supplies such as sheets or sanitizer. Clinicians reported that patients who did not bring these supplies evoked provider frustration and were sometimes scolded [37] [60] [77]. Lack of proper equipment constrains the options for different birthing positions, while lack of space makes privacy impossible and prevents the presence of birth companions [65]

[68] [78] [79].

> "*Some women ask for their husband. But we cannot let them enter because we only have one corridor. Women walk half-naked and have contractions in the corridor. A man cannot see all that.*"—*Midwife, Mozambique* [68]

The COVID-19 pandemic exacerbated facility constraints. Protocols disallowed visitors, masking hindered communication, and infection control measures took time from an already overburdened staff [40] [58]. COVID restrictions also limited interactions between mother and infants, in the case of preterm delivery, or if the mother tested positive for COVID [58]. Providers also acknowledged the relationship between these restrictions and potential poor outcomes for newborns and the long-lasting effects on partners, due to their inability to support both the mother and infant [58].

> "*We have less information regarding the protocols, which are still changing. Different protocols in different areas: for example, in the emergency room if clients do not have COVID-*19 *symptoms, service providers do not use a gown or screen, in the maternity ward they do.*"—*Midwife, Spain* [80]
> "*Like I say, we've got lots of incidences where we've got women in and they're going to end up being in five days and their partner can't see them. Now that's a huge chunk of life, and it's really traumatizing for a lot of the partners.*"—*Midwife, UK* [58]

The designation of some facilities as teaching hospitals, with staff-in-training being a part of routine care, was also mentioned as another characteristic that worsened maternity care [64].

> "*Yeah, women feel disrespected due to the teaching environment that leads to too frequent vaginal examination that is performed less than* 4 *hours apart. However, vaginal examinations are recommended every hour during labor.*"—*Midwife, Ethiopia* [64]

3.4. Clinician's Responsibilities

Providers' responsibilities are multifaceted: they aimed to provide respectful, continuous care and emotional support, support family involvement, counsel their patients, and complete administrative tasks. Specialized roles, such as doulas, focus mainly on emotional and physical support of the birthing mother [81].

Responsibility to provide respectful care.

Many providers demonstrated knowledge of the ethical principles of respectful maternity care. In addition to rights-based ethical concepts like bodily autonomy and informed consent, they noted the importance of privacy, communication, and polite interactions. Providers denounced disrespectful and abusive care. They noted that poor experience in facility-based birth erodes trust in the health care system and indirectly contributes to maternal and infant mortality [82]. Abusive care was perceived as a violation not only of professional ethics but also of personal moral

responsibility:

"*It is unethical* [*to withhold care*]. *How would you sleep at night peacefully after abandoning a laboring mother?*"—*Midwife*, *Ethiopia* [69]

"*In my understanding, this should sound bad like beating a pregnant woman. She is in pain and this pain is observed even from her appearance. So, I think we cannot cause harm to her, like shouting on her, even beating her. This is against the midwives' practices.*"—*Midwife*, *Rwanda* [83]

However, even as mistreatment was denounced on its face, the perceived line between acceptable and unacceptable actions differed depending on the individual respondent and the different global cultural contexts within which they operate. For example, one physician believed that physical abuse was unacceptable, but verbal abuse could be justified:

"*You can effectively yell, but don't hit. When you can yell, is only if the woman closes her legs when she is in complete* [*cervical*] *dilation.*"—*Doctor*, *Guinea* [76]

Providers' awareness of the principles of respectful maternity care did not guarantee its practice.

"*If we want to do anything for them, we obtain a consent, informed consent, we inform about the procedure and respectful ask for their consent whether they want the procedure to be performed on them especially vaginal examinations, we explain the procedure. I'm not saying that is what we practice but that is how it is supposed to be because by the time we have like* 4 *or* 5 *patients to attend to and you will want to use* 4 *or* 5 *minutes to counsel a patient you know time is fast spent.*"—*Midwife*, *Nigeria* [84]

Responsibility to ensure survival.

Even as providers valued respectful care, they believed it could conflict with ultimate responsibility to ensure their patients' survival. Delivering respectful care was secondary to safety, especially as providers grapple with the need to ensure the survival of not one but two patients—mother and baby.

"*We are not doing this to harm the mother but to save the life of the baby.*"—*Support Staff*, *Kenya* [85]

Abuse could be perceived as justified if the provider believed it was being done to "encourage" a patient or save the baby [60]-[62] [64] [67]-[69] [73]. This reasoning was used to justify verbal abuse, physical abuse, or threats:

"*I mean, sometimes you've got to be a little rough … We're not really supposed to, but sometimes that's what you got to tell them … 'If you do this, if you leave against our medical advice, your baby's going to die'.*"—*Nurse*, *United States* [62]

"*Myself and a few of my colleagues at our workplace are nicknamed com-*

mandos because when we are on shift, we never end up with birth asphyxia. We are very tough with women during labour. If women fail to collaborate, they could be slapped, pressure applied to rescue her life and that of a child."—*Midwife, Tanzania* [61]

"*Women don't know why we scream sometimes. We're all shouting at them to save their lives and the unborn baby… but they don't understand us.*"—*Midwife, Ethiopia* [67]

Consequences of failing responsibilities.

The risk of maternal and fetal mortality weighs heavily on providers, not only for their patients' sake but also for their own: providers face social and professional consequences if their patients die [54] [61] [68] [69] [73] [86]. Midwives especially noted how blame for death fell differentially on them, especially when compared to doctors [54] [68] [69] [73].

"*When I look back to when I would always stick with the protocols and all the time refer to the obstetrician, well that was not because I thought that it was the best thing for mother and child.* […] *It was because… because I don't know how it ends either. And if it doesn't end well, I hang. I hang.*"—*Midwife, Netherlands* [86]

"*The women don't cooperate, they refuse to bear and some will be like they are tired and if you are tired the baby will die and if the baby dies they will be like, the midwife has killed my baby.*"—*Midwifery student, Ghana* [73]

Contributing to or witnessing the mistreatment of birthing people, even unintentionally and/or when constrained by policies, negatively impacts their job satisfaction and causes moral distress.

"*Our staffing was so cr*p we were really almost working at absolute minimum care, certainly on the postnatal wards* […] *sounds awful and it is, and it was, you know, you'd come home from the shift crying.*"—*Midwife, UK* [58]

"*I get a sense of disappointment as though the system has failed this young woman* [*the patient*]."—*Midwife, Jamaica* [75]

3.5. Hierarchy and power

Societal hierarchy.

Providers acknowledged that bias and preferential treatment at the birthing person's bedside mirror larger societal inequities. Many reported particular frustrations with and subsequent disrespect for social groups with barriers to health literacy (such as those in poverty, with low literacy, first-time mothers, and younger people), who were perceived to lack knowledge of childbirth [74] [75] [87]. Differential treatment of racial and ethnic groups was another common theme. Birthing people of higher socioeconomic status tended to be treated better [37] [54] [62] [65] [70] [73] [77] [87] [88].Facility policies such as detaining birthing people

in facilities if they are unable to pay [37] [54] [65] or mandating drug screens for those who miss appointments only exacerbated bias against vulnerable groups [62].

> "*She will have to listen to a lot of comments if she is poor. There is a lot of ignorance too. If someone is rich or from better income society, then every staff behaves very patiently, and respectful maternity care pours out of them. They know how to do it, just depends on whether you are worthy of respect.*"—*Nursing/midwife leader, India* [87]

Birthing people who were language-discordant with their provider were also treated poorly, which was sometimes attributed to poor provider behavior and other times attributed to an inherent lack of clear communication due to the language barrier [51] [58] [62] [66] [70] [73] [86] [99].

> "*Those* [*non-English-speaking patients*] *require more work. And it's not that it's difficult work. But when your staffing ratios are terrible, it's harder…it's a time-suck. And you have other patients.*"—*Nurse, United States* [62]
>
> "*She was so scared, and I said to the midwife, 'I know it's evening, but can't we get an interpreter to translate?'* [...] *But the midwife said, 'You know, just do it'. And then I said, 'But she doesn't understand it.' You know, I'm not going to just put my fingers in someone, while someone doesn't understand, I think just really that that is a form of rape. I notice that when people are foreign and do not speak Dutch, they also use the opportunity to just do it, to let the student practice more.*"—*Midwife, Netherlands* [86]

Some providers frowned upon traditional birthing customs, including the use of uncertified birth attendants or traditional herbs [37] [79]. The global power dynamics of Western medicine over other traditions plays out in facility-based births, according to one African provider:

> "*I work as I was trained.* (…) *I take the medical training that I received is of European norms and principles. So, we take that understanding expecting mothers who has come to the hospital for treatment or childbirth has left her traditions and customs at home. She has agreed with European norms.*"—*Skilled health personnel, Tanzania* [79]

A few clinicians ascribed poor treatment of birthing people in childbirth to the poor status of women in society [80] [82] [87].

> "*Globally, women are of low status, not treated with respect or regarded as equal citizens, not valued. Little girls grow up thinking she is not as important as her brother, not likely to get educated, not encouraged to question. Women accept their lower place in the society. When they come to give birth, many of them did not choose to be pregnant, they did not have access to birth control. Married off very young. Arranged marriages, child brides. These all take away their empowerment. You find it difficult to stand up for yourself. When*

she is in labour, the last thing you want is fighting for yourself. You are so caught up in the psychological process that is happening, that makes you vulnerable as well."—Nursing/midwife leader, India [87]

"[*B*]*irth is a reflection of how society perceives women and until society respects women, I don't think that we're going to see a change."—Midwife, Australia* [89]

Interprofessional hierarchy.

Midwives in particular noted negative impacts of being in "the lowest rank in the hospital" [68]: they reported being blamed for negative patient outcomes and disrespected by patients and doctors [34] [60] [68] [69]. In contexts where men are more represented in higher-ranking positions (doctors) and women are more represented in lower-ranking provider positions, interprofessional hierarchy can intersect with gender hierarchy [68] [87].

"[*The patients*] *might just slap or scratch you when you are working. You think they would do the same to a man? I don't think so. It is just because we are women."—Midwife, Mozambique* [68]

"*One time, nurses and midwives were being held as witches. It's like a trail of under-representation that leads to disrespect and abuse of women and midwives. This increased in the* 80*'s and* 90*'s as the male medical model marginalised midwives."—Nurse/Midwife leader, India* [87]

Ranking of professionals (by seniority, academic rank, and leadership position within the department) can also be a barrier to respectful maternity care. Younger clinicians often lack the power to challenge disrespectful senior clinicians or facility cultures [61] [68] [75] [87] [89]. One midwife leader observed how a high-ranked abusive clinician can shift an entire organizational culture to one of normative abuse:

"*It's like a ripple in the pond. You have got an abusive person at the centre of that* (…) *The person at the centre becomes powerful and in order to maintain that power builds relationships and slowly people change their behaviour to fit into that way of being. The longer that person is able to stay in one place* (*centre*) *the culture* (*of abuse*) *grows stronger."—Nurse/Midwife leader, India* [87]

Conversely, hierarchy can also facilitate respectful care. The presence of a respected senior clinician provides accountability that prevents disrespectful care [66] [68] [90]. However, midwifery leaders cautioned against leveraging professional hierarchy in a punitive manner against providers, for instance, by blaming providers-in-training as they learn about respectful care. They noted that this does not address root causes of disrespect, such as facility limitations [87].

Clinician-patient hierarchy.

Clinicians expressed an expectation of control over the birthing process. Some providers believed that their clinical expertise could override the mother's agency

and embodied knowledge.

> "*I am the professional and I am the only right person to decide on procedures. What do the woman, or her family know about the care that I ask them for a consent*?"—*Midwife, Ethiopia* [69]

Birth position was cited frequently as a variable that should be under the control of the provider rather than the birthing person [51] [59] [69] [79] [88] [91].

> "*Maybe she is used to squatting, sometimes they do squat, she tells you, I am used to delivering while squatting and maybe you want her to lie on the beds available so she can't squat. And if you tell her she resists, so it forces you to be harsh for her to lie in the position you can manage to support the baby...*"—*Nurse, Kenya* [91]

Even though providers expected a certain degree of control, they sometimes seemed to perceive a lack of agency on their own part: some reported that they "lost control" [68] or were "forced" to abuse their patients [77] [78].

The power dynamics present in delivery rooms are complex. Different levels of hierarchies intersect in the context of a facility-based delivery. For example, clinicians reported awareness of patient social status. Some felt that higher-status patients looked down on them as care providers and used disrespect to exert their clinician-patient power [69]. Others reported being on their best behavior when attending to well-educated patients [77]. In many cases, patients of more vulnerable status may be subject to more disrespect by clinicians. However, in some cases, a patient's vulnerable status may elicit greater compassion from providers. According to one nurse:

> "…*This disabled mother or this the poor mother, the rich one, all of them… there's that what we call equality and there's that what we call first come first served. You can't abandon the, or you can't ignore the poor mother or the disabled and you run for the woman who has a car.*"—*Nurse, Kenya* [91]

3.6. (Mis)understanding and Interpreting the Mother's Experience

Clinicians perceived and/or assumed the delivery of a healthy baby to be the birthing person's top priority. Accordingly, they justified mistreatment if they believed it ensured a birthing person's "cooperation" and baby's safety. In some cultural contexts, providers and birthing people alike may perceive disrespectful care as a necessary or normal means to a safe delivery [61] [68] [84].

Interestingly, some clinicians who were also mothers reported their own experiences of disrespectful care during childbirth [65].

> "*During my labour, the midwife insulted me, my junior. Even I myself, when I went into labour, I was beaten. They hit my thighs multiple times.*"—*Midwife, Kenya* [92]

Laboring birthing people were expected to comply in a specific way, based on a particular society's norms and culture. In some hospitals, they may be expected to bring their own delivery supplies, arrive well-groomed, and remain compliant throughout delivery. If a birthing person does not comply, staff may perceive her as intentionally troublesome [65].

Perception of the effect of labor pain on birthing persons, and the correct response from care providers, varied. Some believed that a birthing person in pain necessitated a harsher approach [78]

> "*... You know some mothers are uncooperative because of the pain* […] *if you are so gentle and so you can find some of them even injuring the baby so you have to be* '*firm*'*...*"—*Nurse-Midwife, Kenya* [78]

Other times, they acknowledged that labor pain makes polite compliance difficult for the birthing person and her "misbehavior" is unintentional [51] [84]. Treating a birthing person in pain, therefore, called for extra patience:

> "*Most times, a woman in labour tends to get angry, insulting and can be aggressive. You tend to talk to them on a softer tone and don't get offended with whatever you feel they are saying, respect their wishes.*"—*Midwife, Nigeria* [84]

In the event of proper and effective provider-patient communication, however, it was possible to establish rapport, which led to a better experience for the birthing person [67] [69] [93].

> "*Humanization of childbirth takes place when you know the pregnant woman's expectations, when you allow them to express themselves, to scream if they think it is going to relieve. She can choose her position and not be stuck on the bed. It is to know how she wants the delivery to be, if she wants to give birth sitting or in another way, she has to choose, it is not up to us, as professionals, to decide on that.*"—*Nurse, Brazil* [93]

3.7. Integrated Summary

Like the variation in perspectives on different attributes of facility-based birth, the quantitative studies included in this review yielded a wide range of prevalence data. For example, one study in Kenya suggested that 53% of respondents witnessed and 45% perpetrated verbal abuse, compared to 37% and 35% for witnessing and perpetrating physical abuse [37]. A study located in Zambia suggested prevalence for D&A to be approximately 40.1% and 68.7% for perpetration and witnessing of D&A, respectively [52]. Another study in Nigeria identified the witnessing of D&A at a much higher rate of 73.1% [54], and nurses and midwives in Tanzania reported that 96.1% of participants had performed at least one form of D&A [57]. Seeing as this data ranges anywhere from 30 to 96%, there remains a critical lack of measurement standardization. While many studies attempted to operationalize the variable of obstetric violence/disrespectful maternity care, some looked at it

strictly through the lens of risk factors and positive appraisal, whereas others examined it through the lens of provider mental health [41] [42].

Privacy was the element of respectful care most commented upon. In Ethiopia, the most witnessed form of D&A was lack of privacy protection, and in Jordan, leaving birthing people exposed was also most commonly witnessed [94] [95]. Likewise, in Tanzania, not draping for vaginal exams and conducting deliveries and other medical examinations in the presence of excess staff or students was also commonly witnessed and reported [57]. In Netherlands, it was common to disregard a birthing person's privacy for the benefit of training students and allowing them to "practice" when the birthing persons were foreign and did not speak Dutch [86].

Both quantitative and qualitative studies emphasized the impact of staffing and healthcare infrastructure on care provision. The majority of qualitative studies noted that poor resources were a major barrier to respectful care [24] [40] [52] [54] [58]-[76]. Quantitative studies also found negative relationships between respectful maternity care and organizational factors such as staffing and workload [38] [56] [57].

Differences in training also accounted for differences in provider knowledge of obstetric violence and disrespectful maternity care. In Kigali City, Rwanda, midwives at three different district hospitals shared that their curriculum was oriented around RMC, with orientation and internal regulation serving as training methods [83]. This education also ensured that midwives were aware of the rights of birthing people and what they were owed in healthcare settings [83]. Within the various types of providers, there were also different understandings of what constituted maternal rights and ethical practices, and whether certain behaviors were in violation or not. For example, in Ethiopia, some midwifery trainees and students reported that the focus of professional ethics in midwifery curriculum was mostly concerned with patient privacy and confidentiality [70]. In China, a longer training period, via either an internship or practicum, was associated with both a better understanding of RMC and fewer occurrences of disrespect and abuse [47]. However, in India, better-trained personnel were less likely to report observation of RMC at their facility [43].

Some studies contextualized disrespect and abuse as breaches of professional conduct and responsibilities, but also sometimes justified to save the birthing person or baby [69]. Other studies viewed disrespectful maternity care through the lens of humanization, while still others looked specifically at one type of provider (such as charge midwives) and explored their perceived role in improving RMC [90] [93].

The role of organizational and professional hierarchy and accountability appears differently in quantitative and qualitative studies. For example, in Rwanda, healthcare providers in five different hospitals described internal policies to manage cases of disrespect and abuse; approaches ranged from appointing a team leader, to reassigning specific staff members if problems arise to the use of a "quality book"

to keep track of staff infractions [96]. In quantitative terms, professional and organizational hierarchy/accountability was used as a statistical predictor and driver. For example, positive relationships with facility managers and team leaders were significantly associated with increased RMC scores in Malawi [42].

Ultimately, the question of operationalizing RMC and understanding what supports and hinders it is best explored through quantitative and qualitative methodology. There is a wide variance in the reported prevalence of disrespect and abuse. Beyond measurement issues, this could be due to cultural differences in reporting norms or selection bias of the specific types of providers surveyed in the different studies. Across this large swath of research from every region of the world, there are notable consistencies between variables of importance, such as privacy, training, and hierarchy, that are framed and considered differently within the context of methodology. Thus, to produce effective solutions for disrespectful maternity care, understanding how these variables can be measured and operationalized in multiple ways is crucial.

4. Discussion

This review's focus on provider perspectives allows for deeper examination of dynamics outside of the birthing person-provider dyad; providers report personal, interprofessional, organizational, and system-level factors that impact delivery of respectful maternity care.

The plurality of studies focused on Sub-Saharan Africa [41] [42] [48] [51]-[55] [57] [59]-[61] [63]-[70] [73] [76] [78] [79] [82]-[85] [88] [90] [91] [95]-[98]. This is a priority region in global health due to its high maternal mortality ratio (545 maternal deaths per 100,000 live births in 2020) [6]. There is a relative dearth of research in higher-income countries, with only three from Europe [58] [80] [86] and two from North America [50] [62]. The lack of research in North America is notable, given that it is the only region in which the maternal mortality ratio has increased since 2000 [6]. The important implications of this gap may be directly related to emerging challenges for obstetrical care in North America.

4.1. Strengths and Limitations

One limitation of this review is the possible exclusion of relevant articles due to lack of consistent terminology used to describe the continuum of respectful and disrespectful care. The language limitation of English-only articles is also exclusionary, given the fact that much of the research happening in this field is globally located. It is likely that social desirability bias may also influence the results of the included studies. This review focused on intrapartum care. While this period is one of unique vulnerability that is not found at other timepoints in the maternity care continuum, such focus may overlook the ways that disrespect and abuse may manifest and perhaps originate in antenatal care. Additionally, the obstetrical training, work demands, and work-related stressors of birthing providers may vary by region and the socioeconomic and medical infrastructures of different countries. These

differences may require interventions to improve respectful maternity care to be tailored to the specific country.

A strength of this review is that it aims to cover the full spectrum of care quality, both positive and negative. Thematic synthesis will allow for a fresh interpretation of both the qualitative and quantitative evidence. Ultimately, this review equips policymakers and healthcare providers with the insights needed to design and implement targeted interventions that improve the quality of maternity care and ensure respectful treatment for all patients.

4.2. Complexities of Defining Disrespectful Maternity Care

Due to the many different frameworks and definitions used to understand disrespectful maternity care, there are more qualitative than quantitative studies in this field. This lack of standardization and operationalization often stems from cultural variations, differing healthcare practices, and the subjective nature of what constitutes disrespect. Additionally, disparities in resources, training, and awareness among healthcare institutions contribute to the inconsistent recognition and documentation of disrespectful behaviors, as each clinical site in this review is differently staffed and structured.

The absence of standardized measures for disrespectful maternity care necessitates an integrated methods approach to synthesizing providers' perspectives. By employing an integrated methods approach, combining qualitative and quantitative data, researchers can capture the nuanced experiences and attitudes of providers, leading to more effective interventions and policy development aimed at improving maternity care standards universally. Without such an approach, the pervasiveness of disrespectful maternity care will continue alongside its obscureness; a problem becomes easier to ignore when it is ill-defined.

Inconsistencies in metrics and the operationalization of respectful and disrespectful maternity care mirror the broader challenges in defining and measuring other metrics in maternal health. Both areas suffer from a lack of standardized definitions and criteria, influenced by varying cultural, social, and institutional contexts. Just as respectful and disrespectful care can be subjective and context-dependent, maternal mortality definitions can differ based on what is included in maternal death statistics—such as indirect causes or timeframes post-delivery.

The development of valid quantitative measurement tools is an emerging area of research in this field. This review found that many studies had a descriptive element that focused on categorizing types of respectful and disrespectful care [43] [44] [47]-[52] [57] [85] [94] [95]. This echoes earlier research and frameworks, such as the landscape analysis by Bowser and Hill (2010) [25]. Others go beyond description to examine barriers and facilitators to respectful care. This recalls the work of researchers such as Bradley *et al.* (2019) [100], Behruzi *et al.* (2013) [101], and Sadler *et al.* (2016) [102], who expanded beyond earlier descriptive frameworks to incorporate organizational and society-level factors that address structural dimensions of respectful maternity care.

4.3. Recommendations

This review may aid in identifying points of intervention. Currently, fragmented systems and inflexible policies dominate this landscape. Using this systematic analysis of diverse contexts and healthcare systems could help pinpoint the healthcare processes that subject birthing people to increased vulnerabilities, disrespect, and harm [89]. Recommendations are summarized in Table 3.

Table 3. Recommendations to improve respectful maternity care.

Category	Intervention	Description
Human Resources and Organizational Culture	Interventions focused on cultivating leadership and supportive supervision	Strategies aimed at improving leadership skills and providing supportive supervision to manage and mitigate the effects of resource limitations within an organization.
	Improving peer support among clinician groups	Encouraging peer support among health care providers to enhance teamwork, communication, and the sharing of best practices.
	Anticipated planning for staffing shortages	Proactive strategies to anticipate and plan for potential staffing shortages, ensuring that resource limitations do not critically impact patient care.
	Transformed leadership policies	Reforming leadership policies within health care organizations to create a more effective and responsive leadership structure.
Training and Workforce Development	Workforce development	Investment and support of maternal health care providers, especially midwives, to increase staffing.
	Training health care providers within a specific site's context	Contextualized training programs designed to educate health care providers based on the specific needs and circumstances of the site where they work.
	Educating providers to improve knowledge and attitudes towards Respectful Maternity Care (RMC)	Educational initiatives aimed at improving providers' understanding and attitudes towards RMC, with the goal of enhancing the quality of care provided.
	Combination of childbirth education for parents and RMC training for providers	Comprehensive interventions that involve both educating parents on childbirth and training providers on RMC to improve outcomes, which could be considered more effective than staff training alone.
Policy and Legislation	Address provider accountability through legislation	Legislative measures designed to ensure health care provider accountability, while considering the complex dynamics of the provider-patient relationship as it manifests while managing the maternal-fetal dyad.
	Balance mother and child rights	Reexamine laws that prioritize fetal interest over maternal autonomy.
Research	Measure respectful and disrespectful care	Develop validated tools to measure the prevalence and type of respectful and disrespectful care, adapting for context.
Norms and Hierarchies	Understand ingrained norms and hierarchies in facility-based birth	Exploring and challenging the existing norms and hierarchies within health care facilities that may influence provider behavior and impact the implementation of accountability measures.

The complexity of this issue necessitates a multifaceted response. There is no one way to define or capture all the ways in which disrespectful maternity care

prevails, especially when factoring in the global differences in healthcare system resources and provider roles. Thus, training health care providers within a specific site's context is a common intervention strategy. A review of educational interventions to improve RMC found low-level evidence that educating providers can improve their knowledge of and attitudes toward RMC [103]. Team simulation training and collaborative workshops can also improve the quality of patient-provider communication [75] [104] [105]. However, while staff training may improve respectful maternity care to some degree, it is hardly a singular cure-all. Several studies in this review revealed a gap between provider's knowledge of respectful maternity care and its practice [84]. This gap is a critical barrier and future interventions should move beyond simple education to focus on implementation science and identification of systemic obstacles to practice. Multi-pronged interventions (e.g., a combination of childbirth education for parents and RMC training for providers) appear more promising than staff training alone [106].

Resource-driven factors such as staffing, workforce development, hospital design, and medical supplies also act as barriers to RMC. Interventions focused on leadership, supportive supervision, peer support, and anticipated planning for staffing shortages may reduce the impact of resource limitations within an organization [107]. At the same time, the impact of medical and professional hierarchies cannot be overlooked: studies suggest that entrenched power structures can exacerbate resource and organizational issues. Workforce development, therefore, should not only consider staffing needs but also the redesign of existing power hierarchies via transformed leadership policies and approaches. Interventions should target not only individual training but also institutional power structures. This could be accomplished through formalized mentorship programs and safe, anonymous reporting systems for junior staff.

Policy and legislation are other avenues to address disrespectful care. South American legislation is notable in its criminalization of obstetric violence. Addressing health care provider accountability through legislation cannot be undertaken without an understanding—and perhaps questioning—of the ingrained norms and hierarchies that govern the context of facility-based birth. Societal norms that value women primarily for their reproductive function are reflected in laws that prioritize fetal protection over birthing people's autonomy [108]. Any measures, especially punitive legislative measures, that aim to hold providers accountable for fetal safety, along with maternal safety and autonomy, must consider the complexity of the provider's obligations to the unique two-patient dyad. Any measures that take a rights-based approach to emphasize the importance of consent in maternal care must consider the inherent power imbalance between providers and patients. Some feminist scholars have questioned the possibility of true consent in the setting of such an entrenched hierarchy [99].

5. Conclusion

While the manifestations of disrespectful care differ across the world, the need for

a greater understanding of respectful maternity care transcends borders. Researchers have advocated for a universal set of clinical guidelines to offer interventions at the ideal time, while prioritizing and respecting birthing people's rights [72]. Furthermore, the global reach of D&A offers opportunity for care models to be referenced around the world.

Availability of Data and Material

The data underlying this article will be shared upon reasonable request to the corresponding author.

Funding

This work was supported by the Massachusetts General Hospital endowed Global Health Fund—Strength & Serenity, fund number 1200 020707.

Authors' Contributions

The design and literature search were carried out by KDF. Screening, analysis and synthesis were done by KDF and SN. Substantive revisions were performed by MG and AG.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] (2019) Levels of Maternal Care: Obstetric Care Consensus No, 9. *Obstetrics & Gynecology*, **134**, e41-e55.

[2] Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A., Daniels, J., *et al.* (2014) Global Causes of Maternal Death: A WHO Systematic Analysis. *The Lancet Global Health*, **2**, e323-e333. https://doi.org/10.1016/s2214-109x(14)70227-x

[3] Ronsmans, C. and Graham, W.J. (2006) Maternal Mortality: Who, When, Where, and Why. *The Lancet*, **368**, 1189-1200. https://doi.org/10.1016/s0140-6736(06)69380-x

[4] Petersen, E.E., Davis, N.L., Goodman, D., Cox, S., Mayes, N., Johnston, E., *et al.* (2019) Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017. *Morbidity and Mortality Weekly Report*, **68**, 423-429. https://doi.org/10.15585/mmwr.mm6818e1

[5] Vogel, J.P., Pileggi-Castro, C., Chandra-Mouli, V., Pileggi, V.N., Souza, J.P., Chou, D., *et al.* (2015) Millennium Development Goal 5 and Adolescents: Looking Back, Moving Forward. *Archives of Disease in Childhood*, **100**, S43-S47. https://doi.org/10.1136/archdischild-2013-305514

[6] World Health Organization (2023) Trends in Maternal Mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. World Health Organization.

[7] Townsend, R., Chmielewska, B., Barratt, I., Kalafat, E., van der Meulen, J., Gurol-Urganci, I., *et al.* (2021) Global Changes in Maternity Care Provision during the COVID-19 Pandemic: A Systematic Review and Meta-Analysis. *E Clinical Medicine*, **37**, Article ID: 100947. https://doi.org/10.1016/j.eclinm.2021.100947

[8] Leite, T.H., Carvalho, T.D.G., Marques, E.S., Pereira, A.P.E., da Silva, A.A.M., Nakamura-Pereira, M., *et al.* (2022) The Association between Mistreatment of Women during Childbirth and Postnatal Maternal and Child Health Care: Findings from "Birth in Brazil". *Women and Birth*, **35**, e28-e40. https://doi.org/10.1016/j.wombi.2021.02.006

[9] Olza Fernández, I. (2013) PTSD and Obstetric Violence. *Midwifery Today with International Midwife*, **105**, 48-49.

[10] Taghizadeh, Z., Ebadi, A. and Jaafarpour, M. (2021) Childbirth Violence-Based Negative Health Consequences: A Qualitative Study in Iranian Women. *BMC Pregnancy and Childbirth*, **21**, Article No. 572. https://doi.org/10.1186/s12884-021-03986-0

[11] Martinez-Vázquez, S., Hernández-Martínez, A., Rodríguez-Almagro, J., Delgado-Rodríguez, M. and Martínez-Galiano, J.M. (2022) Relationship between Perceived Obstetric Violence and the Risk of Postpartum Depression: An Observational Study. *Midwifery*, **108**, Article ID: 103297. https://doi.org/10.1016/j.midw.2022.103297

[12] Kujawski, S., Mbaruku, G., Freedman, L.P., Ramsey, K., Moyo, W. and Kruk, M.E. (2015) Association between Disrespect and Abuse during Childbirth and Women's Confidence in Health Facilities in Tanzania. *Maternal and Child Health Journal*, **19**, 2243-2250. https://doi.org/10.1007/s10995-015-1743-9

[13] Perrotte, V., Chaudhary, A. and Goodman, A. (2020) "At Least Your Baby Is Healthy" Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review. *Open Journal of Obstetrics and Gynecology*, **10**, 1544-1562. https://doi.org/10.4236/ojog.2020.10110139

[14] World Health Organization (2014) The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth. WHO Statement.

[15] Savage, V. and Castro, A. (2017) Measuring Mistreatment of Women during Childbirth: A Review of Terminology and Methodological Approaches. *Reproductive Health*, **14**, Article No. 138. https://doi.org/10.1186/s12978-017-0403-5

[16] Williams, C., Jerez, C., Klein, K., Correa, M., Belizán, J. and Cormick, G. (2018) Obstetric Violence: A Latin American Legal Response to Mistreatment during Childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology*, **125**, 1208-1211. https://doi.org/10.1111/1471-0528.15270

[17] Borges, M.T. (2018) A Violent Birth: Reframing Coerced Procedures during Childbirth as Obstetric Violence. *Duke Law Journal*, **67**, 827-862.

[18] Zacher Dixon, L. (2015) Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices. *Medical Anthropology Quarterly*, **29**, 437-454. https://doi.org/10.1111/maq.12174

[19] Pérez D'Gregorio, R. (2010) Obstetric Violence: A New Legal Term Introduced in Venezuela. *International Journal of Gynecology & Obstetrics*, **111**, 201-202. https://doi.org/10.1016/j.ijgo.2010.09.002

[20] Diniz, S.G., Salgado, H.D.O., Aguiar Andrezzo, H.F.D., Cardin de Carvalho, P.G., Albuquerque Carvalho, P.C., Azevedo Aguiar, C., *et al.* (2015) Abuse and Disrespect in Childbirth Care as a Public Health Issue in Brazil: Origins, Definitions, Impacts on Maternal Health, and Proposals for Its Prevention. *Journal of Human Growth and Development*, **25**, 377-384. https://doi.org/10.7322/jhgd.106080

[21] Ferrão, A.C., Sim-Sim, M., Almeida, V.S. and Zangão, M.O. (2022) Analysis of the Concept of Obstetric Violence: Scoping Review Protocol. *Journal of Personalized Medicine*, **12**, Article 1090. https://doi.org/10.3390/jpm12071090

[22] Sen, G., Reddy, B. and Iyer, A. (2018) Beyond Measurement: The Drivers of Disrespect and Abuse in Obstetric Care. *Reproductive Health Matters*, **26**, 6-18.

https://doi.org/10.1080/09688080.2018.1508173

[23] Vogel, J., Bohren, M., Tunçalp, Ö., Oladapo, O. and Gülmezoglu, A. (2016) Promoting Respect and Preventing Mistreatment during Childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology*, **123**, 671-674. https://doi.org/10.1111/1471-0528.13750

[24] Bohren, M.A., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K., Souza, J.P., *et al.* (2015) The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine*, **12**, e1001847. https://doi.org/10.1371/journal.pmed.1001847

[25] Bowser, D. and Hill, K. (2010) Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis. USAID-Tract Project.

[26] Marmot, M., World Health Organization and UCL Institute of Health Equity (2014) Review of Social Determinants and the Health Divide in the WHO European Region: Final Report. World Health Organization, Regional Office for Europe.

[27] Kawish, A.B., Umer, M.F., Arshed, M., Khan, S.A., Hafeez, A. and Waqar, S. (2023) Respectful Maternal Care Experience in Low- and Middle-Income Countries: A Systematic Review. *Medicina*, **59**, Article 1842. https://doi.org/10.3390/medicina59101842

[28] Jolivet, R.R., Gausman, J., Kapoor, N., Langer, A., Sharma, J. and Semrau, K.E.A. (2021) Operationalizing Respectful Maternity Care at the Healthcare Provider Level: A Systematic Scoping Review. *Reproductive Health*, **18**, Article No. 194. https://doi.org/10.1186/s12978-021-01241-5

[29] Mannava, P., Durrant, K., Fisher, J., Chersich, M. and Luchters, S. (2015) Attitudes and Behaviours of Maternal Health Care Providers in Interactions with Clients: A Systematic Review. *Globalization and Health*, **11**, Article No. 36. https://doi.org/10.1186/s12992-015-0117-9

[30] Arnold, R., van Teijlingen, E., Ryan, K. and Holloway, I. (2019) Villains or Victims? An Ethnography of Afghan Maternity Staff and the Challenge of High Quality Respectful Care. *BMC Pregnancy and Childbirth*, **19**, Article No. 307. https://doi.org/10.1186/s12884-019-2420-6

[31] Filby, A., McConville, F. and Portela, A. (2016) What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. *PLOS ONE*, **11**, e0153391. https://doi.org/10.1371/journal.pone.0153391

[32] Lizarondo, L., Carrier, J., Godfrey, C., Rieger, K., Salmond, S., Apostolo, J., *et al.* (2020) Mixed Methods Systematic Reviews. In: *JBI Manual for Evidence Synthesis*, JBI, Chapter 8, 1-5.

[33] Tricco, A.C., Lillie, E., Zarin, W., O'Brien, K.K., Colquhoun, H., Levac, D., *et al.* (2018) PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*, **169**, 467-473. https://doi.org/10.7326/m18-0850

[34] Hong, Q.N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., *et al.* (2018) The Mixed Methods Appraisal Tool (MMAT) Version 2018 for Information Professionals and Researchers. *Education for Information*, **34**, 285-291. https://doi.org/10.3233/efi-180221

[35] Arksey, H. and O'Malley, L. (2005) Scoping Studies: Towards a Methodological Framework. *International Journal of Social Research Methodology*, **8**, 19-32. https://doi.org/10.1080/1364557032000119616

[36] Thomas, J. and Harden, A. (2008) Methods for the Thematic Synthesis of Qualitative

Research in Systematic Reviews. *BMC Medical Research Methodology*, **8**, Article No. 45. https://doi.org/10.1186/1471-2288-8-45

[37] Afulani, P.A., Kelly, A.M., Buback, L., Asunka, J., Kirumbi, L. and Lyndon, A. (2020) Providers' Perceptions of Disrespect and Abuse during Childbirth: A Mixed-Methods Study in Kenya. *Health Policy and Planning*, **35**, 577-586. https://doi.org/10.1093/heapol/czaa009

[38] Alzyoud, F.A., McCurry, M.K., Hunter Revell, S.M. and Kellogg, M. (2023) Nurse Disrespect and Abuse toward Laboring and Child-Birthing Women. *Nursing Research*, **72**, 347-354. https://doi.org/10.1097/nnr.0000000000000674

[39] Asefa, A., Bekele, D., Morgan, A. and Kermode, M. (2018) Service Providers' Experiences of Disrespectful and Abusive Behavior towards Women during Facility Based Childbirth in Addis Ababa, Ethiopia. *Reproductive Health*, **15**, Article No. 4. https://doi.org/10.1186/s12978-017-0449-4

[40] Asefa, A., Semaan, A., Delvaux, T., Huysmans, E., Galle, A., Sacks, E., *et al.* (2022) The Impact of COVID-19 on the Provision of Respectful Maternity Care: Findings from a Global Survey of Health Workers. *Women and Birth*, **35**, 378-386. https://doi.org/10.1016/j.wombi.2021.09.003

[41] Bakker, R., Sheferaw, E.D., Yigzaw, T., Stekelenburg, J. and de Kroon, M.L.A. (2020) Risk Factors for Positive Appraisal of Mistreatment during Childbirth among Ethiopian Midwifery Students. *International Journal of Environmental Research and Public Health*, **17**, Article 2682. https://doi.org/10.3390/ijerph17082682

[42] Burnett-Zieman, B., Warren, C.E., Chiundira, F., Mandala, E., Kachale, F., Mchoma, C.H., *et al.* (2023) Modeling Pathways to Describe How Maternal Health Care Providers' Mental Health Influences the Provision of Respectful Maternity Care in Malawi. *Global Health: Science and Practice*, **11**, e2300008. https://doi.org/10.9745/ghsp-d-23-00008

[43] Datta, M., Das, I. and Samanta, S. (2023) Perspectives of Doctors and Nurses about the Implementation of Respectful Maternity Care in a Teaching Hospital in India. *Hamdan Medical Journal*, **16**, 20-25. https://doi.org/10.4103/hmj.hmj_72_22

[44] Deki, S. and Choden, J. (2018) Assess Knowledge, Attitude and Practices of Respectful Maternity Care among Nurse Midwives in Referral Hospitals of Bhutan. *Bhutan Health Journal*, **4**, 1-7. https://doi.org/10.47811/bhj.50

[45] Dhakal, P., Mohammad, K.I., Creedy, D.K., Gamble, J., Newnham, E. and McInnes, R. (2022) Midwifery and Nursing Students' Perceptions of Respectful Maternity Care and Witnessing of Disrespect and Abuse: A Comparative Study from Nepal and Jordan. *Midwifery*, **112**, Article ID: 103426. https://doi.org/10.1016/j.midw.2022.103426

[46] Haghdoost, S., Abdi, F. and Amirian, A. (2021) Iranian Midwives' Awareness and Performance of Respectful Maternity Care during Labor and Childbirth. *European Journal of Midwifery*, **5**, 1-9. https://doi.org/10.18332/ejm/143873

[47] Huang, J., Fu, L., Fu, Y., Creedy, D.K., Gamble, J., Da, Z., *et al.* (2024) Exposure to Disrespectful Maternity Care and Perceptions of Respectful Maternity Care among Nursing and Midwifery Pre-Registration Students in China: A National Cross-Sectional Study. *Nurse Education in Practice*, **78**, Article ID: 104026. https://doi.org/10.1016/j.nepr.2024.104026

[48] Kasaye, H., Scarf, V., Sheehy, A. and Baird, K. (2024) Health Care Providers' Perspectives on the Mistreatment towards Women during Maternity Care: Do Perceptions of the Working Environment and Empathy Level Matter? *Women and Birth*, **37**, Article ID: 101601. https://doi.org/10.1016/j.wombi.2024.101601

[49] Moridi, M., Pazandeh, F. and Potrata, B. (2022) Midwives' Knowledge and Practice

of Respectful Maternity Care: A Survey from Iran. *BMC Pregnancy and Childbirth*, **22**, Article No. 752. https://doi.org/10.1186/s12884-022-05065-4

[50] Morton, C.H., Henley, M.M., Seacrist, M. and Roth, L.M. (2018) Bearing Witness: United States and Canadian Maternity Support Workers' Observations of Disrespectful Care in Childbirth. *Birth*, **45**, 263-274. https://doi.org/10.1111/birt.12373

[51] Moyer, C.A., McNally, B., Aborigo, R.A., Williams, J.E.O. and Afulani, P. (2021) Providing Respectful Maternity Care in Northern Ghana: A Mixed-Methods Study with Maternity Care Providers. *Midwifery*, **94**, Article ID: 102904. https://doi.org/10.1016/j.midw.2020.102904

[52] Nankamba, N.S.W., Ngoma, C.M. and Makoleka, M.M. (2021) Midwives' Perceptions of Disrespect and Abuse of Women during Labour and Childbirth in Lusaka, Zambia. *African Journal of Midwifery and Women's Health*, **15**, 1-12. https://doi.org/10.12968/ajmw.2020.0042

[53] Okedo-Alex, I.N., Akamike, I.C., Nwafor, J.I., Abateneh, D.D. and Uneke, C.J. (2020) Multi-Stakeholder Perspectives on the Maternal, Provider, Institutional, Community, and Policy Drivers of Disrespectful Maternity Care in South-East Nigeria. *International Journal of Women's Health*, **12**, 1145-1159. https://doi.org/10.2147/ijwh.s277827

[54] Okedo-Alex, I.N., Akamike, I.C. and Okafor, L.C. (2021) Does It Happen and Why? Lived and Shared Experiences of Mistreatment and Respectful Care during Childbirth among Maternal Health Providers in a Tertiary Hospital in Nigeria. *Women and Birth*, **34**, 477-486. https://doi.org/10.1016/j.wombi.2020.09.015

[55] Okedo-Alex, I.N., Akamike, I.C., Nwafor, J.I., Igwilo, U. and Abateneh, D.D. (2022) Is the Training, Knowledge, and Perception of Maternal Health Providers Adequate for the Provision of Respectful Maternity Care? Policy Implications for Practice in a Nigerian Tertiary Hospital. *Nigerian Medical Journal*, **62**, 139-148.

[56] Pokharel, A., Kiriya, J., Shibanuma, A., Silwal, R.C. and Jimba, M. (2023) Association of Workload and Practice of Respectful Maternity Care among the Healthcare Providers, before and during the Early Phase of COVID-19 Pandemic in South Western Nepal: A Cross-Sectional Study. *BMC Health Services Research*, **23**, Article No. 538. https://doi.org/10.1186/s12913-023-09561-x

[57] Shimoda, K., Leshabari, S. and Horiuchi, S. (2020) Self-Reported Disrespect and Abuse by Nurses and Midwives during Childbirth in Tanzania: A Cross-Sectional Study. *BMC Pregnancy and Childbirth*, **20**, Article No. 584. https://doi.org/10.1186/s12884-020-03256-5

[58] Jones, I.H.M., Thompson, A., Dunlop, C.L. and Wilson, A. (2022) Midwives' and Maternity Support Workers' Perceptions of the Impact of the First Year of the COVID-19 Pandemic on Respectful Maternity Care in a Diverse Region of the UK: A Qualitative Study. *BMJ Open*, **12**, e064731. https://doi.org/10.1136/bmjopen-2022-064731

[59] Adu-Bonsaffoh, K., Tamma, E., Maya, E., Vogel, J.P., Tunçalp, Ö. and Bohren, M.A. (2022) Health Workers' and Hospital Administrators' Perspectives on Mistreatment of Women during Facility-Based Childbirth: A Multicenter Qualitative Study in Ghana. *Reproductive Health*, **19**, Article No. 82. https://doi.org/10.1186/s12978-022-01372-3

[60] Ige, W.B. and Cele, W.B. (2022) Barriers to the Provision of Respectful Maternity Care during Childbirth by Midwives in South-West, Nigeria: Findings from Semi-Structured Interviews with Midwives. *International Journal of Africa Nursing Sciences*, **17**, Article ID: 100449. https://doi.org/10.1016/j.ijans.2022.100449

[61] Mwasha, L.K., Kisaka, L.M. and Pallangyo, E.S. (2023) Disrespect and Abuse in Maternity Care in a Low-Resource Setting in Tanzania: Provider's Perspectives of Practice.

PLOS ONE, **18**, e0281349. https://doi.org/10.1371/journal.pone.0281349

[62] Salter, C., Wint, K., Burke, J., Chang, J.C., Documet, P., Kaselitz, E., *et al.* (2023) Overlap between Birth Trauma and Mistreatment: A Qualitative Analysis Exploring American Clinician Perspectives on Patient Birth Experiences. *Reproductive Health*, **20**, Article No. 63. https://doi.org/10.1186/s12978-023-01604-0

[63] Daniel, G., Afolaranmi, T., Mfuh, A., Wina, F. and III Dioso, R. (2023) Experiences of Midwives in Providing Respectful Maternity Care during Childbirth in Jos, Nigeria. *Malaysian Journal of Nursing*, **14**, 35-45. https://doi.org/10.31674/mjn.2023.v14i04.004

[64] Werdofa, H.M., Thoresen, L., Lulseged, B. and Lindahl, A.K. (2023) 'I Believe Respect Means Providing Necessary Treatment on Time'—A Qualitative Study of Health Care Providers' Perspectives on Disrespect and Abuse during Childbirth in Southwest Ethiopia. *BMC Pregnancy and Childbirth*, **23**, Article No. 257. https://doi.org/10.1186/s12884-023-05567-9

[65] Dzomeku, V.M., Mensah, B.A.B., Nakua, E.K., Agbadi, P., Lori, J.R. and Donkor, P. (2020) Exploring Midwives' Understanding of Respectful Maternal Care in Kumasi, Ghana: Qualitative Inquiry. *PLOS ONE*, **15**, e0220538. https://doi.org/10.1371/journal.pone.0220538

[66] Dzomeku, V.M., Mensah, A.B.B., Nakua, E.K., Agbadi, P., Okyere, J., Donkor, P., *et al.* (2022) Promoting Respectful Maternity Care: Challenges and Prospects from the Perspectives of Midwives at a Tertiary Health Facility in Ghana. *BMC Pregnancy and Childbirth*, **22**, Article No. 451. https://doi.org/10.1186/s12884-022-04786-w

[67] Jiru, H.D. and Sendo, E.G. (2021) Promoting Compassionate and Respectful Maternity Care during Facility-Based Delivery in Ethiopia: Perspectives of Clients and Midwives. *BMJ Open*, **11**, e051220. https://doi.org/10.1136/bmjopen-2021-051220

[68] Galle, A., Manaharlal, H., Griffin, S., Osman, N., Roelens, K. and Degomme, O. (2020) A Qualitative Study on Midwives' Identity and Perspectives on the Occurrence of Disrespect and Abuse in Maputo City. *BMC Pregnancy and Childbirth*, **20**, Article No. 629. https://doi.org/10.1186/s12884-020-03320-0

[69] Mehretie Adinew, Y., Kelly, J., Marshall, A. and Smith, M. (2021) Care Providers' Perspectives on Disrespect and Abuse of Women during Facility-Based Childbirth in Ethiopia: A Qualitative Study. *International Journal of Women's Health*, **13**, 1181-1195. https://doi.org/10.2147/ijwh.s333863

[70] Burrowes, S., Holcombe, S.J., Jara, D., Carter, D. and Smith, K. (2017) Midwives' and Patients' Perspectives on Disrespect and Abuse during Labor and Delivery Care in Ethiopia: A Qualitative Study. *BMC Pregnancy and Childbirth*, **17**, Article No. 263. https://doi.org/10.1186/s12884-017-1442-1

[71] Perera, D., Lund, R., Swahnberg, K., Schei, B. and Infanti, J.J. (2018) 'When Helpers Hurt': Women's and Midwives' Stories of Obstetric Violence in State Health Institutions, Colombo District, Sri Lanka. *BMC Pregnancy and Childbirth*, **18**, Article No. 211. https://doi.org/10.1186/s12884-018-1869-z

[72] Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., *et al.* (2016) Beyond Too Little, Too Late and Too Much, Too Soon: A Pathway towards Evidence-Based, Respectful Maternity Care Worldwide. *The Lancet*, **388**, 2176-2192. https://doi.org/10.1016/s0140-6736(16)31472-6

[73] Rominski, S.D., Lori, J., Nakua, E., Dzomeku, V. and Moyer, C.A. (2016) When the Baby Remains There for a Long Time, It Is Going to Die So You Have to Hit Her Small for the Baby to Come Out: Justification of Disrespectful and Abusive Care during Childbirth among Midwifery Students in Ghana. *Health Policy and Planning*, **32**, 215-224.

https://doi.org/10.1093/heapol/czw114

[74] Dwekat, I.M.M., Tengku Ismail, T.A., Ibrahim, M.I. and Ghrayeb, F. (2021) Exploring Factors Contributing to Mistreatment of Women during Childbirth in West Bank, Palestine. *Women and Birth*, **34**, 344-351. https://doi.org/10.1016/j.wombi.2020.07.004

[75] Wilson-Mitchell, K., Robinson, J. and Sharpe, M. (2018) Teaching Respectful Maternity Care Using an Intellectual Partnership Model in Tanzania. *Midwifery*, **60**, 27-29. https://doi.org/10.1016/j.midw.2018.01.019

[76] Balde, M.D., Bangoura, A., Diallo, B.A., Sall, O., Balde, H., Niakate, A.S., *et al.* (2017) A Qualitative Study of Women's and Health Providers' Attitudes and Acceptability of Mistreatment during Childbirth in Health Facilities in Guinea. *Reproductive Health*, **14**, Article No. 4. https://doi.org/10.1186/s12978-016-0262-5

[77] Buback, L., Kinyua, J., Akinyi, B., Walker, D. and Afulani, P.A. (2021) Provider Perceptions of Lack of Supportive Care during Childbirth: A Mixed Methods Study in Kenya. *Health Care for Women International*, **43**, 1062-1083. https://doi.org/10.1080/07399332.2021.1961776

[78] Oluoch-Aridi, J., Smith-Oka, V., Milan, E. and Dowd, R. (2018) Exploring Mistreatment of Women during Childbirth in a Peri-Urban Setting in Kenya: Experiences and Perceptions of Women and Healthcare Providers. *Reproductive Health*, **15**, Article No. 209. https://doi.org/10.1186/s12978-018-0643-z

[79] Mselle, L.T., Kohi, T.W. and Dol, J. (2018) Barriers and Facilitators to Humanizing Birth Care in Tanzania: Findings from Semi-Structured Interviews with Midwives and Obstetricians. *Reproductive Health*, **15**, Article No. 137. https://doi.org/10.1186/s12978-018-0583-7

[80] Mena-Tudela, D., Roman, P., González-Chordá, V.M., Rodriguez-Arrastia, M., Gutiérrez-Cascajares, L. and Ropero-Padilla, C. (2023) Experiences with Obstetric Violence among Healthcare Professionals and Students in Spain: A Constructivist Grounded Theory Study. *Women and Birth*, **36**, e219-e226. https://doi.org/10.1016/j.wombi.2022.07.169

[81] Grecia, L.M.R., Lopes Neto, D., Dias, V.P. and Moisés, M.S. (2019) Doulas' Perceptions and Actions in the Process of Humanization of Labor and Delivery. *Revista Mineira de Enfermagem*, **23**, e1209.

[82] Orpin, J., Puthussery, S. and Burden, B. (2019) Healthcare Providers' Perspectives of Disrespect and Abuse in Maternity Care Facilities in Nigeria: A Qualitative Study. *International Journal of Public Health*, **64**, 1291-1299. https://doi.org/10.1007/s00038-019-01306-0

[83] Uwamahoro, V., Semasaka, J.P.S., Ndagijimana, A. and Humuza, J. (2023) Perceptions and Attitudes of Midwives on Respectful Maternity Care during Childbirth: A Qualitative Study in Three District Hospitals of Kigali City of Rwanda. *The Pan African Medical Journal*, **46**, Article 110. https://doi.org/10.11604/pamj.2023.46.110.40764

[84] Ngcobo, W.B. and Bell, W.B. (2022) Exploring Midwives' Perceptions of Respectful Maternity Care during Childbirth in Lagos State, Nigeria: A Qualitative Inquiry. *African Journal of Reproductive Health*, **26**, 21-30.

[85] Afulani, P.A., Buback, L., Kelly, A.M., Kirumbi, L., Cohen, C.R. and Lyndon, A. (2020) Providers' Perceptions of Communication and Women's Autonomy during Childbirth: A Mixed Methods Study in Kenya. *Reproductive Health*, **17**, Article No. 85. https://doi.org/10.1186/s12978-020-0909-0

[86] van der Waal, R., van Nistelrooij, I. and Leget, C. (2023) The Undercommons of Child-

birth and Its Abolitionist Ethic of Care: A Study of Obstetric Violence among Mothers, Midwives (in Training), and Doulas. In: *Birth Justice*, Amsterdam University Press, 155-181. https://doi.org/10.5117/9789048562398_ch07

[87] Mayra, K., Matthews, Z. and Padmadas, S.S. (2022) Why Do Some Health Care Providers Disrespect and Abuse Women during Childbirth in India? *Women and Birth*, **35**, e49-e59. https://doi.org/10.1016/j.wombi.2021.02.003

[88] Bohren, M.A., Vogel, J.P., Tunçalp, Ö., Fawole, B., Titiloye, M.A., Olutayo, A.O., *et al.* (2017) Mistreatment of Women during Childbirth in Abuja, Nigeria: A Qualitative Study on Perceptions and Experiences of Women and Healthcare Providers. *Reproductive Health*, **14**, Article No. 9. https://doi.org/10.1186/s12978-016-0265-2

[89] Collins, E.C., Burns, E.S. and Dahlen, H.G. (2024) 'It Was Horrible to Watch, Horrible to Be a Part of': Midwives' Perspectives of Obstetric Violence. *Women and Birth*, **37**, Article ID: 101631. https://doi.org/10.1016/j.wombi.2024.101631

[90] Dzomeku, V.M., Mensah, A.B.B., Nakua, E.K., Agbadi, P., Okyere, J., Aboagye, R.G., *et al.* (2023) Charge Midwives' Awareness of and Their Role in Promoting Respectful Maternity Care at a Tertiary Health Facility in Ghana: A Qualitative Study. *PLOS ONE*, **18**, e0284326. https://doi.org/10.1371/journal.pone.0284326

[91] Lusambili, A., Wisofschi, S., Shumba, C., Obure, J., Mulama, K., Nyaga, L., *et al.* (2020) Health Care Workers' Perspectives of the Influences of Disrespectful Maternity Care in Rural Kenya. *International Journal of Environmental Research and Public Health*, **17**, Article 8218. https://doi.org/10.3390/ijerph17218218

[92] Dzomeku, V.M., Boamah Mensah, A.B., Nakua, E.K., Agbadi, P., Lori, J.R. and Donkor, P. (2020) "I Wouldn't Have Hit You, but You Would Have Killed Your Baby:" Exploring Midwives' Perspectives on Disrespect and Abusive Care in Ghana. *BMC Pregnancy and Childbirth*, **20**, Article No. 15. https://doi.org/10.1186/s12884-019-2691-y

[93] Possati, A.B., Prates, L.A., Cremonese, L., Scarton, J., Alves, C.N. and Ressel, L.B. (2017) Humanization of Childbirth: Meanings and Perceptions of Nurses. *Escola Anna Nery*, **21**, e20160366. https://doi.org/10.1590/2177-9465-ean-2016-0366

[94] Dhakal, M.P., Creedy, D., Gamble, J. and Newnham, E. (2022) Nepalese Nursing Students' Experiences of Witnessing Disrespectful and Abusive Care towards Women during Labour and Childbirth. *Women and Birth*, **35**, 2. https://doi.org/10.1016/j.wombi.2022.07.005

[95] Erlandsson, K., Sayam, T. and Sapkota, S. (2014) Safety before Comfort: A Focused Enquiry of Nepal Skilled Birth Attendants' Concept of Respectful Maternity Care. *Evidence Based Midwifery*, **12**, 52-58.

[96] Muhayimana, A. and Kearns, I. (2024) Healthcare Providers' Perspectives on Sustaining Respectful Maternity Care Appreciated by Mothers in Five Hospitals of Rwanda. *BMC Nursing*, **23**, Article No. 442. https://doi.org/10.1186/s12912-024-02017-5

[97] Balde, M.D., Diallo, B.A., Bangoura, A., Sall, O., Soumah, A.M., Vogel, J.P., *et al.* (2017) Perceptions and Experiences of the Mistreatment of Women during Childbirth in Health Facilities in Guinea: A Qualitative Study with Women and Service Providers. *Reproductive Health*, **14**, Article No. 3. https://doi.org/10.1186/s12978-016-0266-1

[98] Lusambili, A.M., Wisofschi, S., Wade, T.J., Temmerman, M. and Obure, J. (2023) A Qualitative Enquiry of Health Care Workers' Narratives on Knowledge and Sources of Information on Principles of Respectful Maternity Care (RMC). *PLOS Global Public Health*, **3**, e0000157. https://doi.org/10.1371/journal.pgph.0000157

[99] Mohapatra, S. and Wiley, L.F. (2019) Feminist Perspectives in Health Law. *Journal of Law, Medicine & Ethics*, **47**, 103-115. https://doi.org/10.1177/1073110519898047

[100] Bradley, S., McCourt, C., Rayment, J. and Parmar, D. (2019) Midwives' Perspectives on

(Dis)respectful Intrapartum Care during Facility-Based Delivery in Sub-Saharan Africa: A Qualitative Systematic Review and Meta-Synthesis. *Reproductive Health*, **16**, Article No. 116. https://doi.org/10.1186/s12978-019-0773-y

[101] Behruzi, R., Hatem, M., Goulet, L., Fraser, W. and Misago, C. (2013) Understanding Childbirth Practices as an Organizational Cultural Phenomenon: A Conceptual Framework. *BMC Pregnancy and Childbirth*, **13**, Article No. 205. https://doi.org/10.1186/1471-2393-13-205

[102] Sadler, M., Santos, M.J., Ruiz-Berdún, D., Rojas, G.L., Skoko, E., Gillen, P., *et al.* (2016) Moving beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence. *Reproductive Health Matters*, **24**, 47-55. https://doi.org/10.1016/j.rhm.2016.04.002

[103] Dhakal, P., Creedy, D.K., Gamble, J., Newnham, E. and McInnes, R. (2022) Educational Interventions to Promote Respectful Maternity Care: A Mixed-Methods Systematic Review. *Nurse Education in Practice*, **60**, Article ID: 103317. https://doi.org/10.1016/j.nepr.2022.103317

[104] Arora, A., Sharma, B., Sikka, P., Assi, G. and Suri, V. (2021) A Quality Improvement Study on Improving Communication between Health-Care Provider and Laboring Woman: A Step toward Respectful Maternity Care. *Indian Journal of Community Medicine*, **46**, 524-527. https://doi.org/10.4103/ijcm.ijcm_1034_20

[105] Horiuchi, S., Shimpuku, Y., Iida, M., Nagamatsu, Y., Eto, H. and Leshabari, S. (2016) Humanized Childbirth Awareness-Raising Program among Tanzanian Midwives and Nurses: A Mixed-Methods Study. *International Journal of Africa Nursing Sciences*, **5**, 9-16. https://doi.org/10.1016/j.ijans.2016.09.001

[106] Kasaye, H., Sheehy, A., Scarf, V. and Baird, K. (2023) The Roles of Multi-Component Interventions in Reducing Mistreatment of Women and Enhancing Respectful Maternity Care: A Systematic Review. *BMC Pregnancy and Childbirth*, **23**, Article No. 305. https://doi.org/10.1186/s12884-023-05640-3

[107] Reddy, B., Thomas, S., Karachiwala, B., Sadhu, R., Iyer, A., Sen, G., *et al.* (2022) A Scoping Review of the Impact of Organisational Factors on Providers and Related Interventions in LMICs: Implications for Respectful Maternity Care. *PLOS Global Public Health*, **2**, e0001134. https://doi.org/10.1371/journal.pgph.0001134

[108] Diaz-Tello, F. (2016) Invisible Wounds: Obstetric Violence in the United States. *Reproductive Health Matters*, **24**, 56-64. https://doi.org/10.1016/j.rhm.2016.04.004

Abbreviations

D&A	Disrespect and Abuse
RMC	Respectful Maternity Care
PCC	Population-Concept-Context

Appendix A: Mixed Methods Appraisal Tool (MMAT)

Quality Assessment Questions	Question Details
1. Screening Questions	1.1 Are there clear research questions? 1.2 Do collected data allow to address the research questions?
2. Qualitative Studies	2.1 Is the qualitative approach appropriate to answer the research question? 2.2 Are the qualitative data collection methods adequate to address the research questions? 2.3 Are the findings adequately derived from the data? 2.4 Is the interpretation of results sufficiently substantiated by data? 2.5 Is there coherence between qualitative data sources, collection analysis & interpretation?
3. Randomized Controlled Trials	3.1 Is randomization appropriately performed? 3.2 Are the groups comparable at baseline? 3.3 Are there complete outcome data? 3.4 Are the outcome assessors blinded to the intervention provided? 3.5 Did the participants adhere to the assigned intervention?
4. Non-Randomized Studies	4.1 Are the participants representative of the target population? 4.2 Are the measurements appropriate regarding both the outcome & intervention (or exposure)? 4.3 Are there complete outcome data? 4.4 Are the confounders accounted for in the design & analysis? 4.5 During the study period, is the intervention administered (or exposure occurred) as intended?
5. Quantitative Descriptive Studies	5.1 Is the sampling strategy relevant to address the research question? 5.2 Is the sample representative of the target population? 5.3 Are the measurements appropriate? Is the risk of nonresponse bias low? Is the statistical analysis appropriate to answer the research question?
Mixed Methods Studies	Is there an adequate rationale for using a mixed methods design to address the research question? Are the different components of the study effectively integrated to answer the research question? Are the outputs of the integration of qualitative & quantitative components adequately interpreted? Are the divergences & inconsistencies between quantitative & qualitative results adequately addressed? Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

From: [34].

Appendix B

Database	Search Term
PubMed	(doctor* OR physician* or obstetrician* OR clinician* OR nurse* OR provider* OR health worker* OR "skilled birth" OR midwife* OR midwives) AND ("obstetric violence" OR "abuse in childbirth" OR "respectful maternity" OR disrespect* OR humaniz* OR humanis* or dehumanis* OR mistreat*) AND (childbirth* OR birth* OR deliver* OR labour OR labor OR "maternity care" OR "intrapartum care" OR "obstetric care")