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Research Article

DISRESPECT AND ABUSE IN MATERNITY CARE: IMPLICATIONS FOR MATERNAL HEALTH OUTCOMES

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Abstract

Pregnancy and childbirth are pivotal events in a woman's reproductive life, characterized by heightened vulnerability. Ensuring compassionate and respectful maternity care (RMC) is essential for safeguarding women from harm and promoting safe motherhood. RMC encompasses care that upholds dignity, privacy, confidentiality, and informed choice while providing continuous support during labor and childbirth. Despite global advocacy and World Health Organization (WHO) recommendations, disrespect and abuse (D&A), often termed obstetric violence, remain prevalent in many healthcare settings. Women experience mistreatment, dehumanized care, and abuse during facility-based childbirth, with documented prevalence in Nigeria ranging from 12–98%. Addressing these challenges requires the systematic implementation of RMC, emphasizing the human rights of women and improving maternal health outcomes. This study highlights the urgency of promoting respectful, dignified, and patient-centered care in maternity services to reduce maternal mortality and enhance women's childbirth experiences.

Keywords: Respectful Maternity Care, Disrespect and Abuse, Obstetric Violence, Maternal Health, Childbirth

INTRODUCTION

Pregnancy and childbirth are critical events in the reproductive life of women and denote a period of high susceptibility. Thus, compassionate and respectful care should be given for all pregnant women during labor and child birth to promote safe motherhood. Respectful maternity care refers to harmonized care given to all women to the highest possible standard and safeguards them from harm and mistreatment during labor and childbirth (Ejioye & Gbenga-Epebinu 2021). Women's experience of institutional childbirth has garnered unprecedented global attention in recent years. Quality midwifery care through Respectful Maternity Care (RMC) is key to reducing maternal mortality (Lukasse et al., 2015)

The term 'obstetric violence' has been used to describe the mistreatment, disrespect and abuse or dehumanized care of women during childbirth by health care providers. RMC is recommended by the World Health Organization and refers to care that maintains dignity, privacy, confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth (WHO, 2018). In September 2014, the WHO released a statement on preventing and eliminating disrespect and abuse during facility-based childbirth. This statement is a critical step for improving the reproductive care of women. It rightfully acknowledges that while "disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth

Disrespect and abuse (D&A), a concept closely related to obstetric violence, has been documented in many countries across the globe. Prevalence rate of D&A in Nigeria vary significantly from 1298% (Bohren et al,

2015). Freedman and Kruk (2014) identified seven categories of disrespectful and abusive care during childbirth, providing a comprehensive framework for understanding the various manifestations of this issue. These categories include physical abuse, where women may experience direct physical harm or force during labor or delivery; non-consented clinical care, where medical procedures are performed without the woman's informed consent; non-confidential care, which breaches the privacy and confidentiality of the woman's medical information; nondignified care, where women are subjected to disrespectful or humiliating treatment; discrimination, where individuals are unfairly treated based on factors such as ethnicity, socioeconomic status, or HIV status; abandonment, where women are left unattended or neglected during labor; and detention in health facilities, where women are held against their will, often due to inability to pay for services or as a form of coercion.

Subsequent research, such as the 2013 systematic review (Finlayson and Downe 2013), has expanded upon this framework to include additional forms of D&A. This updated framework highlights the prevalence of sexual abuse, verbal abuse, stigma, and discrimination within obstetric care settings. Sexual abuse refers to any unwanted sexual contact or advances experienced by women during childbirth. Verbal abuse encompasses demeaning or threatening language used by healthcare providers towards women. Stigma and discrimination encompass biases and prejudices that result in unequal treatment or denial of care based on certain characteristics or identities.

Additionally, failure to meet professional standards of care and poor rapport between women and providers are identified as contributing factors to D&A within health systems.

A more recent study by Orpin, et al. (2019), confirms 12 domains of RMC, the first being freedom from harm and mistreatment. The concept of drivers of disrespect and abuse in obstetric care is of utmost importance. In a systematic review of high-quality clinical guidelines for maternity practice, Okafor et al. (2015) noted that even the provision of evidence-based clinical care cannot be considered quality care unless the care is provided respectfully. However, non-clinical intrapartum care practices, such as emotional support through labour companionship, continuity of carer , effective communication , and respectful care are often not prioritized in many settings.

It is important to recognize that D&A during childbirth is not solely attributable to individual provider behavior but is often deeply entrenched within health system conditions and constraints (Ejioye & Gbenga-Epebinu 2021). Factors such as understaffing, inadequate training, lack of accountability mechanisms, and systemic biases contribute to the perpetuation of D&A within maternal health services. Addressing this issue requires a multi-faceted approach that addresses both individual behaviors and systemic barriers to respectful and dignified maternal care (Orpin et al 2019). By promoting a culture of respect, autonomy, and accountability within healthcare settings, it is possible to mitigate the prevalence of D&A and ensure that all women receive the quality care they deserve during childbirth.

Ensuring respectful and dignified maternal healthcare is essential for promoting positive maternal and neonatal outcomes, as well as upholding the fundamental human rights of women. However, despite global efforts to improve maternal health services, instances of disrespect and abuse (D&A) within obstetric care persist, posing

significant challenges to the delivery of quality healthcare. Understanding the underlying drivers of D&A is crucial for developing effective interventions aimed at mitigating its prevalence and fostering a culture of respectful maternity care. The objectives of this study revolve around investigating the drivers of disrespect and abuse in obstetrics, with a specific focus on antenatal, intra-partum, and postnatal care settings. By delving into the evidence surrounding the drivers of D&A among mothers throughout the continuum of maternal healthcare, this study seeks to identify key factors contributing to the perpetuation of disrespectful and abusive practices within obstetric settings.

To achieve these objectives, the study poses several specific review questions:

1. What is the evidence regarding the drivers of disrespect and abuse experienced by mothers during antenatal care?
2. What factors contribute to disrespect and abuse during intra-partum care, as reported in the literature?
3. How do postnatal care settings contribute to instances of disrespect and abuse towards mothers, according to available evidence?

By systematically examining existing research and literature, this study aims to provide insights into the multifaceted nature of disrespect and abuse within maternal healthcare contexts. By identifying the main drivers of D&A across the antenatal, intra-partum, and postnatal care continuum, this research seeks to inform policy-makers, healthcare providers, and stakeholders on strategies to address and mitigate these challenges effectively. In addressing these objectives, this study contributes to the broader discourse on maternal health and human rights, highlighting the importance of promoting respectful maternity care as a cornerstone of comprehensive maternal healthcare services. Ultimately, the findings of this study have the potential to inform evidencebased interventions and policy initiatives aimed at enhancing the quality, safety, and dignity of maternal healthcare delivery worldwide.

METHODOLOGY

In conducting this study, an integrative review methodology was employed to thoroughly examine existing literature concerning the drivers of violence against women during childbirth, focusing particularly on the typology outlined by Bohren et al. (2015). The review process involved a systematic search of peer-reviewed articles and research studies accessible through prominent databases such as PubMed, Google Scholar, and JSTOR. The search strategy was meticulously designed, incorporating specific keywords and phrases including "obstetric violence,""mistreatment,""disrespect and abuse," and "dehumanized care" to ensure the retrieval of relevant studies. These terms were inputted into the search engines of the aforementioned databases to identify potentially pertinent literature.

To ensure the relevance and suitability of the studies, a set of inclusion and exclusion criteria were established. Included studies were required to be based on empirical research focusing on women's experiences during childbirth. Additionally, only studies published between the years 2015 and 2023 were considered to ensure alignment with contemporary issues. Furthermore, studies had to be available in English for ease of analysis and interpretation. The selection process involved screening the titles and abstracts of the retrieved studies to assess

their alignment with the research objectives and inclusion criteria. Studies that passed this initial screening were subjected to a fulltext review to determine their eligibility for inclusion in the integrative review.

Data extraction was carried out systematically, with relevant information extracted from the selected studies. This included details regarding study design, participant characteristics, methodology employed, key findings, and conclusions drawn. The extracted data were meticulously organized and synthesized to identify common themes and patterns related to the drivers of violence against women during childbirth. To ensure the validity and reliability of the review findings, the quality of included studies was rigorously assessed. Factors such as study design, sample size, data collection methods, and analysis techniques were scrutinized to gauge the methodological robustness of each study. Studies of high methodological quality were accorded greater weight in the synthesis process.

The synthesized findings from the selected studies were then analyzed to identify key drivers of violence against women during childbirth. Bohren et al.'s (2015) typology served as a framework for organizing and categorizing these identified drivers. Common themes and patterns across the literature were explored to gain deeper insights into the underlying factors contributing to obstetric violence. Acknowledging the limitations inherent in the review process, efforts were made to minimize bias and ensure the comprehensiveness and validity of the findings. Potential biases introduced by the selection criteria and the exclusion of non-English language studies were duly noted. Ethical considerations were paramount throughout the review process to ensure the protection of the rights and privacy of study participants.

Through this thorough and comprehensive methodology, the review aimed to provide an understanding of the drivers of violence against women during childbirth. By shedding light on these underlying factors, the study contributes to the development of evidence-based interventions and policy initiatives aimed at promoting respectful maternity care and safeguarding the rights and well-being of women during childbirth

RESULTS

Authors	Main goal	Methodology	Participants	Result/finding

Shrivastava, S.,& Sivakami, M. (2020) Evidence of 'obstetric violence' in India: an integrative review (2020)	Synthesize evidence of 'obstetric violence' in India	An integrated review of studies on women's experience during childbirth in india. Studies were analysed	women	Obstetric violence' in India was found to be associated with sociodemographic factors, with women of lower social standing experiencing greater levels of mistreatment.
Gita, S., Bhavya, R.,& Aditi, I. (2018)	The main goal is to identify gaps and raise	A rapid review of various literatures on identified drivers of	Women of reproductive age	Intersecting social and economic inequality, and the institutional
Beyond measurement: the drivers of disrespect and abuse in obstetric care, Reproductive Health Matters,	questions about deeper causes of D&A	disrespect and abuse		structures and processes that frame the practice of obstetric care are two major drivers identified

Afulani, P.A., Kelly, A.M., Buback, L., Asunka, J., Kirumbi, L., &Lyndon, A.(2020) A Rapid Review of Available Evidence to Inform Indicators for Routine Monitoring and Evaluation of Respectful Maternity Care	Aim is to provide practical evidencebased recommendations on indicators that may be used for routine measurement of RMC in programs	A rapid review approach, which included (1) reviewing existing documents and publications to extract RMC indicators and identify which have or can be used in facilitybased QI, CSCs, and PBF schemes; surveying RMC and maternal health experts to rank indicators, and analyzing survey data to select the most recommended indicators	Maternal health experts	49 indicators were identified spanning several domains of RMC and mistreatment including dignified/non dignified care, verbal and physical abuse, privacy/confidentiality, autonomy/loss of autonomy, supportive care/lack thereof, communication, stigma, discrimination, trust, facility Environment/culture, responsiveness, and non evidencebased care.
Wassihun, B.,& Zeleke, S. (2018)	The study aimed at assessing the status of compassionate and respectful maternity care and associated factors in health	Institution based cross-sectional study design was conducted.	Women intending to use maternity services	This study showed a high prevalence of disrespect and abuse during facility child birth in Bahir Dar town, Ethiopia as

Compassionate and respectful maternity care during facility based child birth and women's intent to use maternity service in Bahir Dar, Ethiopia	facility-based childbirth in Bahir Dar town			Compared to previous literature. Being from rural area, having complications during delivery and mothers who gave birth through caesarian section were more likely to be exposed to disrespect and abuse than other women.

Heather E. Rosen, Pamela F. Lynam , Catherine Carr , Veronica Reis, Jim Ricca , Eva S. Bazant Direct observation of respectful maternity care in five countries: a crosssectional study of health facilities in East and Southern Africa	The goal of this paper is to provide a descriptive overview of the quality of respectful maternity care in diverse facility settings in East and Southern Africa The study is one of the first to report prevalence of respectful maternity care and disrespectful and abusive behavior at facilities in multiple low resource countries.	Structured, standardized clinical observation checklists were used to directly observe quality of care at facilities in five countries: Ethiopia, Kenya, Madagascar, Rwanda, and the United Republic of Tanzania.. For each country, percentage of women receiving these practices and delivery room privacy conditions were calculated. Clinical observers' open-ended comments were	Quality of care in health care facilities in 5 countries	This analysis identified Insufficient communication and information sharing by providers as well as delays in care and abandonment of laboring women as deficiencies in respectful care. Failure to adopt a patient-centered approach and a lack of health system resources are contributing structural factors.
		also analyzed to identify examples of disrespect and abuse.		

McLeish, J., & Redshaw, M.(2019) Maternity experiences of mothers with multiple disadvantages in England: A qualitative study	To explore the maternity care experiences of mothers with multiple disadvantages	: A qualitative descriptive study based on semistructured interviews with 40 mothers with multiple disadvantages, using thematic analysis	Mothers with multiple disadvantage	Mothers with multiple disadvantages value being treated as an individual, making informed choices, and feeling safe, but they may lack the confidence to ask questions or challenge disrespectful treatment.
Lukpata, F. E., Nwakwue, N., Lukpata, H. O., Tangban, E., Anagor, C. R. & Mgbekem, M. A. (2020) Maternity Clients Satisfaction with ClientHealth Provider Interaction in Stateowned Secondary Health Facilities in Cross River State	The aim is to determine Maternity Clients Satisfaction with Client-Health Provider interaction in State-owned Secondary Health Facilities in Cross River State.	The study adopted a cross-sectional survey design while a multistage sampling technique was used to select a sample population of 754 women of reproductive age found accessing maternal healthcare services in the studied facilities. A structured questionnaire was used to collect data	Maternity clients	Based on the findings, it was concluded that disrespect for clients dimension of client-health provider interaction is a cause of Dissatisfaction among maternity clients accessing care in State-Owned secondary health facilities.

		And data obtained was analyse using descriptive techniques.		
Ige, W.B., & Cele, W.B.(2021) Provision of respectful maternal care by midwives during childbirth in health facilities in Lagos State, Nigeria: A qualitative exploratory inquiry	The study aims to explore provision of respectful maternity care by midwives during childbirth in selected health facilities in Lagos State, Nigeria.	This study adopted an exploratory descriptive research design. As a result, the collection of data was through semistructured individual interviews. The purposive selection of 20 midwives was from two health facilities	Midwives working in the facilities	The study revealed the poor provision of the majority of categories of RMC by midwives;. Poor provision of RMC was attributed to normalisation of disrespectful care, inadequate supplies and commodities, midwives' personal beliefs, ineffective redress for violation of women's right during FBD, poor implementation of RMC and poor accountability. Provision of standard RMC will promote access to quality maternity services. These findings have significant implications in the promotion of facility-based maternity care and

				contribute to the reduction of MMR.

Ansari, H.& Yeravdekar, R (2020) Respectful maternity care during childbirth in India: A systematic review and metaanalysis	Aim is to identify various forms of illtreatment, determinants, and pooled prevalence of disrespectful maternity care in India.	A systematic review was performed in various databases. After quality assessment, seven studies were included. Pooled prevalence was estimated using the inverse variance method and the random-effects model using Review Manager Software.	Maternity women	The systematic review and metaanalysis identified that the prevalence of disrespectful maternity care is high in the country. The highest reported forms of ill-treatment were non consent, verbal abuse, threats, physical abuse, and discrimination. Socio-cultural and environmental factors were identified as determinants of illtreatment. The analysis also identified the need to achieve comparability across settings by developing tools, consistent methodologies, and standardized definitions. In conclusion, there is a nation-wide need to focus on the quality of care

				Delivered at the health facilities.
Mamadou Dioulde Balde, Khalidha Nasiri ,Hedieh Mehrtash , Anne-Marie Soumah, Meghan A Bohren , Boubacar Alpha Diallo, Theresa Azonima Irinyenikan, Thae Maung Maung , Soe Soe Thwin, Adeniyi K Aderoba, Joshua P Vogel , Nwe Oo Mon, Kwame Adu-Bonsaffoh, Özge Tunçalp (2020) Labour companionship and women's experiences of mistreatment during childbirth: results from a multi-country community-based survey	This study used data from the WHO multicountry study 'How women are treated during facility-based childbirth' in Ghana, Guinea, Nigeria and Myanmar, aiming to describe the characteristics of labour companionship in maternity care settings and explore the relationship between labour companionship and the different types of mistreatment during childbirth	A secondary analysis of the WHO multi-country study on how women are treated during childbirth was conducted, where a cross-sectional community survey was conducted with women up to 8weeks after childbirth in Ghana, Guinea, Nigeria and Myanmar. Descriptive analysis and multivariable logistic regression were used to examine whether labour companionship was associated with various types of mistreatment	Maternity clients	Labour companionship is associated with lower levels of some forms of mistreatment that women experience during childbirth, depending on the setting.

DISCUSSION OF FINDINGS

From the review, evidence reveals that Obstetric violence' was found to be associated with sociodemographic factors, with women of lower social standing experiencing greater levels of mistreatment. Gita, et al. (2018)

opined that drivers of disrespect and abuse in practice are socioeconomic inequalities. The role of socioeconomic inequalities in underpinning women's experiences of obstetric care has been recognised. Feminist literature has documented abusive interactions between women and providers, situating them within broader gendered inequalities. Through this lens, how women perceive, internalise or justify the poor care they receive reflects entrenched gender discrimination and oppression within homes, communities and wider societies. The review underscores the correlation between obstetric violence and socio-demographic factors, particularly highlighting the heightened mistreatment experienced by women of lower social standing. Gita et al. (2018) emphasize that socioeconomic inequalities serve as prominent drivers of disrespect and abuse within obstetric care practices. This observation aligns with the recognition within feminist literature of the significant role socioeconomic disparities play in shaping women's experiences of obstetric care. Documented instances of abusive interactions between women and healthcare providers are situated within broader gendered inequalities, illustrating how women's perceptions, internalizations, or justifications of poor care received are often influenced by entrenched gender discrimination and oppression within various societal contexts, including homes and communities.

Women's requests for attention, comfort or pain relief during labour are not merely ignored or met with anger by overstretched healthcare providers; they are often ridiculed because notions of women's entitlements among providers can be virtually non-existent. Adinew et al., (2023) found gender bias and discrimination to be particularly acute in sexual and reproductive health service provision. Yet, gender does not operate alone: it cross-cuts other socio-economic inequalities. Intersecting inequalities may not only influence how providers perceive and interact with particular categories of women in labour, but also impinge upon their clinical decision-making and obstetric practices. The dynamics surrounding women's requests for attention, comfort, or pain relief during labor are complex and often fraught with challenges. Healthcare providers, who may already be overburdened, not only ignore or respond angrily to these requests but sometimes even ridicule them, reflecting a profound lack of recognition of women's entitlements. Adinew et al. (2021) highlight the pervasive presence of gender bias and discrimination within sexual and reproductive health services, suggesting that such biases intersect with other socio-economic inequalities.

Ishola et al. (2017) illustrate patterns of excessive obstetric intervention along socioeconomic lines. They found that poorer, racial and ethnic minority women who accessed public services were more likely to be given unnecessary episiotomies, while their predominantly richer, Caucasian counterparts who accessed the private sector were more likely to receive caesarean sections. Poor women who overwhelmingly make up the patient profile of public teaching hospitals in many countries, may also be disproportionately subjected to unnecessary procedures such as multiple pelvic examination. Additionally, the patient profile of public teaching hospitals, predominantly comprising poor women, may face disproportionate exposure to unnecessary procedures like multiple pelvic examinations. These findings underscore the urgent need for healthcare systems to address the inter-sectionality of inequalities and biases in maternal healthcare provision to ensure equitable and respectful care for all women during childbirth.

From the study, other drivers include women of multiple dis-adavantage who lack confidence,

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Being from rural area, having complications during delivery and mothers who gave birth through Caesarian Section were more likely to be exposed to disrespect and abuse than other women. Failure to adopt a patient-centered approach and a lack of health system resources are contributing structural factors, ignorance about relevant laws related to human rights, normalization of disrespectful care, inadequate supplies and commodities, midwives' personal beliefs, ineffective redress for violation of women's right during facility based delivery. Socially and economically marginalized groups are known to concurrently suffer poorer access to maternal care and be more likely to face discrimination when they seek it (Kujawski et al., 2015). While conducting verbal autopsies of maternal deaths in a deprived district in southern India, considerable complexity to provider bias was found. For instance, a nurse's perception of how unpleasant a labouring woman smelled was attributed to unbridled sexual behaviour particularly associated with the woman's caste. In Sethi et al's ethnographic research in Malawi (2017), she suggests that urban middleclass physicians' use of the term ranchitos to describe their rural-poor obstetric patients "is often impregnated with meaning related to skin color and degree of indigenous heritage", combined with hostile beliefs about their sexuality and fertility.

The implications of the findings suggest a multifaceted landscape where various factors intersect to perpetuate disrespect and abuse against women during childbirth (Ejioye & Gbenga-Epebinu 2021). Women experiencing multiple disadvantages, residing in rural areas, facing delivery complications, or undergoing Caesarean sections are particularly vulnerable to such mistreatment. Structural factors such as the absence of a patient-centered approach and inadequate health system resources contribute to this phenomenon, along with ignorance about relevant human rights laws and the normalization of disrespectful care. Moreover, midwives' personal beliefs and ineffective mechanisms for addressing violations of women's rights further exacerbate the problem. This underscores the urgent need for healthcare systems to adopt patient-centered approaches, address systemic shortcomings, and provide adequate resources to ensure equitable and respectful maternal care for all women, especially those from socially and economically marginalized groups. Additionally, the findings highlight the insidious influence of provider biases, as evidenced by instances of discrimination based on factors such as caste, skin color, and socio-economic status, emphasizing the imperative for healthcare providers to undergo cultural competence training and address unconscious biases in their practice.

Across Latin America and in India, systematic documentation of religious, ethnic and racial minority women's interactions with providers speak of the "triple burden" they face when seeking institutional childbirth. Poverty, fertility and gender can form a powerful axis for discrimination in maternal health service provision, which may be further layered with racial, ethnic, religious, caste or other biases. Prejudice against certain categories of women (multi-gravid or obese women). Normalising and tolerating D&A was found as drivers, disempowered or marginalised groups can get so accustomed in some contexts to being treated with disrespect, being forced to negotiate the health system on less favourable terms, or receiving worse care that they may fail to recognise or may normalise and tolerate disrespectful care (Swahnberg et al., 2017).

Providers, in turn, may selectively engage in behaviours and practices that are not in the best interests of the patient, where the selection is biased or discriminatory. These two processes can work together to create an

environment in which disrespectful obstetric care thrives. Role of 'fallback positions' Third, notwithstanding the fact that healthcare institutions tend to privilege the needs and convenience of providers over women (this is discussed in the next section), Women who have stronger "fallback positions" deriving from their caste-class or other positions, social capital and/or familiarity with institutional services, are better able to navigate healthcare institutions and negotiate respectful care. Linguistic and cultural barriers to communication Breakdowns in communication can become a fourth mechanism through which social inequalities impinge upon D&A. Communication is severely tested when healthcare providers do not speak the same language as the women who seek their care (Swahnberg et al., 2017)

Some evidence suggests that ethnic minorities are at greater risk of experiencing D&A during facility-based childbirth. Other factors that might influence a woman's risk include socioeconomic status, parity, age and the partner's race. Being multiparous has been found to be a protective factor, which may suggest that past experience helps patients avoid disrespectful treatment, or that disrespectful treatment is normalized by past experiences among certain groups, such as women of color, young women, and those with economic, social or health challenges

CONCLUSION

The discussion of findings underscores the pervasive impact of socio-demographic factors on women's experiences of disrespect and abuse during childbirth. The review reveals a stark correlation between obstetric violence and socio-economic inequalities, with women of lower social standing bearing the brunt of mistreatment within obstetric care practices. This observation aligns with feminist literature, which situates instances of abusive interactions between women and healthcare providers within broader gendered inequalities. Moreover, the review highlights the inter-sectionality of these inequalities, with women experiencing multiple disadvantages, residing in rural areas, facing delivery complications, or undergoing Caesarean sections being particularly vulnerable to mistreatment. Structural factors, including the absence of a patientcentered approach and inadequate health system resources, contribute to the perpetuation of disrespect and abuse, further compounded by provider biases and cultural barriers to communication. Importantly, the findings underscore the urgent need for healthcare systems to address these intersecting inequalities and biases to ensure equitable and respectful maternal care for all women during childbirth. Additionally, the role of women's "fallback positions" in navigating healthcare institutions and negotiating respectful care, as well as the influence of past experiences on women's risk of disrespectful treatment, further emphasize the complex dynamics at play in the provision of obstetric care. Overall, the implications of the findings call for comprehensive reforms aimed at addressing systemic shortcomings and promoting a culture of respect, dignity, and equity within maternal healthcare systems.

Recommendations

It is every woman's right to give birth in a woman centered context with compassionate and respectful care.

1. Provision of woman-centered care in compassionate and a respectful manner needs to be given adequate emphasis to attract more women to health facilities, and to make services more women friendly.

2. Further research is needed to understand other barriers and develop effective interventions to promote respectful care in this context.
3. Government/policy makers should provide an enabling environment for maternity healthcare staff by training on how to deliver effective RMC services including how to handle women and provide psycho-social support during labour, adequate manpower, financial and non-financial motivation.
4. Health workers should provide supportive environment for pregnant women by providing adequate information and involvement in decision during care, provision of health education to women on what to expect during labour.
5. Families/communities should be oriented on how to respond and report any act of disrespect and abuse faced by women to the appropriate authorities in the existing systems.
6. It is recommended that stakeholders should make recruitment and retention of healthcare providers a priority as work overload affects interpersonal interactions. Training and supervision should also be given priority as it enable maternity professionals to understand how confusing maternity care can be to very disadvantaged mothers.

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