International Journal of Women's Health

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REVIEW

Respectful Maternity Care in South Asia: What Does the Evidence Say? Experiences of Care and Neglect, Associated Vulnerabilities and Social Complexities

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Background: Respectful maternity care encompasses the right to continuity of care and dignified support for women during the reproductive period, enabling informed choice. However, the evidence is limited in the context of South Asia region where maternal, perinatal and newborn mortality is still a critical challenge to health systems. Evidence is required to better understand the context of respectful maternity care to inform directions for appropriate policy and practice.

Objective: The objective of this scoping review was to explore facilitators and barriers of respectful maternity care practice in South Asia.

Design: CINAHL, EMBASE, PubMed, Medline, SCOPUS and Cochrane databases were used to identify related studies. Data were systematically synthesized and analysed thematically.

Findings: There was considerable heterogeneity in the 61 included studies from seven South Asian countries, with most of the research conducted in Nepal and India. While the experience of abuse and neglect was common, 10 critical themes emerged related to neglected choices and compromised quality of care (particularly where there were health inequities) in the context of institutional care experiences; and the imperative for improved investment in training and significant policy and legislative change to enforce equitable and respectful maternity care practice.

Conclusions and Implications for Practice: Evidence about respectful maternity care in South Asia indicates that women accessing professional and facility-based services experienced high levels of disrespect, abuse and maltreatment. Women from vulnerable, socially disadvantaged and economically poor backgrounds were more likely to experience higher level abuse and receive poor quality of care. There is an urgent need for a well-resourced, sustained commitment to mandate and support the provision of respectful and equitable maternity care practice in South Asia.

Keywords: maternal health, respect, pregnancy, maternity care, health service, South Asia

Introduction

Around 810 women die globally each day from preventable causes related to pregnancy and childbirth, 94% of which occur in low resource settings (World Health Organisation, 2019). Reducing maternal, perinatal and neonatal mortality in developing countries has been a concerted focus of both Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) with efforts to address underlying mortality risks by promoting institutional births, increasing skilled professional support and ensuring that every woman has access to basic maternal health care.[1]

However, the challenge remains high for sub-Saharan Africa and South Asia in particular to tackle the complex factors contributing to higher mortality.[2] In resource-limited settings, a range of social, cultural, economic and structural barriers consistently impact on women's access to care during pregnancy and childbirth,[3,4] thus reductions in related deaths remain a critical challenge for health systems. Furthermore, significant disparities exist within the regions and

Received: 3 December 2021
Accepted: 3 March 2022
Published: 7 July 2022

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countries in which the burden of maternal, perinatal and neonatal mortality is highest, concentrated among women who experience disproportionate health inequities and poorer health outcomes associated with structural deficiencies and discrimination.[1,5]

The South Asia region includes eight countries – Afghanistan, Bangladesh, Bhutan, India, Nepal, Maldives, Pakistan, and Sri Lanka – where maternal, perinatal and newborn mortality has been an ongoing challenge for the health system. With concerted efforts of all sectors, South Asia has demonstrated a significant reduction in maternal mortality ratio (MMR) from 384 per 100,000 live births in 2000 to 157 in 2017 (World Health Organisation, 2019), underpinned by improved access to skilled providers and quality maternity care.[6,7] These figures contrast to MMRs of 10–18 per 100,000 live births in high-income countries and there is work to be done to continue (and sustain) decreased MMRs.

A critical aspect of continued progress in better maternal outcomes is having access to respectful maternity care (RMC). Based on human rights principles, RMC ensures that every woman receives dignified, equitable care without coercion or discrimination, including the right to her choice of care and preferences during the childbirth to support positive experiences. These rights are violated when a woman experiences disrespect, abuse, refusal or mistreatment by care providers or professionals during pregnancy and childbirth.[8,9] A growing recognition of the extent of mistreatment, abuse, disrespect and neglect of women during childbirth has in turn led to demands for an urgent response to address these concerns.[10,11] Experiences of abuse and disrespect among women giving birth in health institutions create barriers for women seeking health care during pregnancy and birth-related complications, as well as being a serious human rights concern.[12,13]

Provision of respectful maternal care requires collaborative efforts across disciplines, systems and stakeholders, including women, families, care providers, health services and health care systems.[14] The increased utilisation of pregnancy-related services by women in South Asia offers an opportunity to demonstrate the impacts of quality care in the further reduction of maternal, perinatal and neonatal mortality. In turn, this supports services to operationalise the concept of respectful maternity care fully in practice, improving positive experiences for women seeking professional services and promoting choice and agency for women. A better understanding of the context of existing practice, barriers and enablers is required to inform RMC practice in South Asia. A scoping review was determined as the appropriate method to map and explore current practice and perspectives in South Asian countries, examining evidence of RMC experiences to women who attend services during pregnancy, childbirth and postnatal period.

Methods

The review used the framework and Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping reviews (PRISMA-ScR) guidelines.[15,16]

The following questions guided the review process.

1. What is respectful maternity care and how it is defined?
2. What are current practices around respectful maternity care in South Asia?
3. What facilitators and barriers exist in maintaining respectful maternity care in South Asia?
4. Which populations are at a higher risk of not receiving respectful maternity care in South Asia?
5. What actions and policies are required to support improvements in respectful maternity care in South Asia?

Eligibility and Search Strategy

Eligibility criteria comprised peer-reviewed research published in English from 2010 to 2020 that focused on experiences of women, their families, service providers, stakeholders and community (see Table 1).

An initial limited search of MEDLINE and CINAHL was conducted, followed by a brief analysis of the text words contained in the title and abstract of retrieved papers. A second search using identified keywords and index terms was undertaken across all included databases. Thirdly, the reference list of identified reports and articles from full-text sources included in the screening review was then searched for additional sources. Search terms for CINAHL, EMBASE, PubMed, Medline, SCOPUS and Cochrane databases related to pregnancy and childbirth; professional and other birth support role; attributes of care; and country location and included maternity OR maternal OR pregnant* OR childbirth

Table 1 Inclusion and Exclusion Criteria of Studies

Inclusion	Exclusion
Peer reviewed	Non-peer reviewed Scoping and systematic reviews Reports and guidelines
English	Languages other than English
2010–2020	Outside these years
Experiences during antenatal, peripartum and postnatal periods	Experiences of abortion care
Perspectives of women, their families, service providers, stakeholders and communities	

OR birth* OR antenatal OR perinatal OR postnatal AND midwife* OR midwives OR obstetric* OR "healthcare provider" OR "health care provider" OR "healthcare professional" OR "health care professional" OR "health volunteer" OR "birth attendant" AND "health services" OR "models of care" OR "health system" OR "health practice" OR community OR healthcare OR "health care" OR "health practice" AND respect* OR dignity OR woman-centred OR "woman centred" OR "client centred" OR "person centred" OR "culturally safe" OR quality OR compassion* OR holistic OR disrespect* OR abuse OR discrimination OR stigma AND "South Asia" OR "South Asian" OR Afghanistan* OR Bangladesh* OR Bhutan* OR India* OR Maldives OR Nepal* OR Pakistan* OR "Sri Lanka" OR Sri Lanka*.

The searches were conducted in November and December 2020, resulting in 1157 articles.

Study Selection

Two reviewers (SK and GV) independently reviewed the titles of identified articles (1157) and those clearly not relevant to the topic were excluded. Abstracts of all articles were reviewed for inclusion using the screening checklist developed with criteria for this review. The full texts of potentially eligible papers (155) were retrieved and reviewed by two reviewers (SK and GV) based on the criteria with a primary focus on respectful maternity care during pregnancy, childbirth and up to six weeks' postpartum in the South Asia region. During the screening, disagreement between reviewers were resolved by discussion with a third reviewer (MS). See Figure 1.

Quality Assessment

Two reviewers (SK and GV) conducted assessment independently and discussed together until the consensus was reached in the case of discrepancies. This appraisal process helped to refine and interpret the findings of the review.

Data Extraction

Population and study characteristics, data collection and analysis, themes, author's interpretations including the data around current practice, barriers, enablers of respectful care, characteristics of abuse and study recommendations were extracted to a standardised table developed for this review (see Table 2).

Data Synthesis

A combined inductive and deductive thematic analysis approach was employed, where initial open coding on each relevant text unit elicited key themes emerging from the data. We developed the preliminary coding framework with main domains drawn from the literature and checked against the studies selected for inclusion. All included studies were reviewed until no new themes emerged and the co-researchers agreed on the definition, scope and interpretation of each theme. During the synthesis process, we revised some codes and merged some sub-themes. Based on the initial coding,

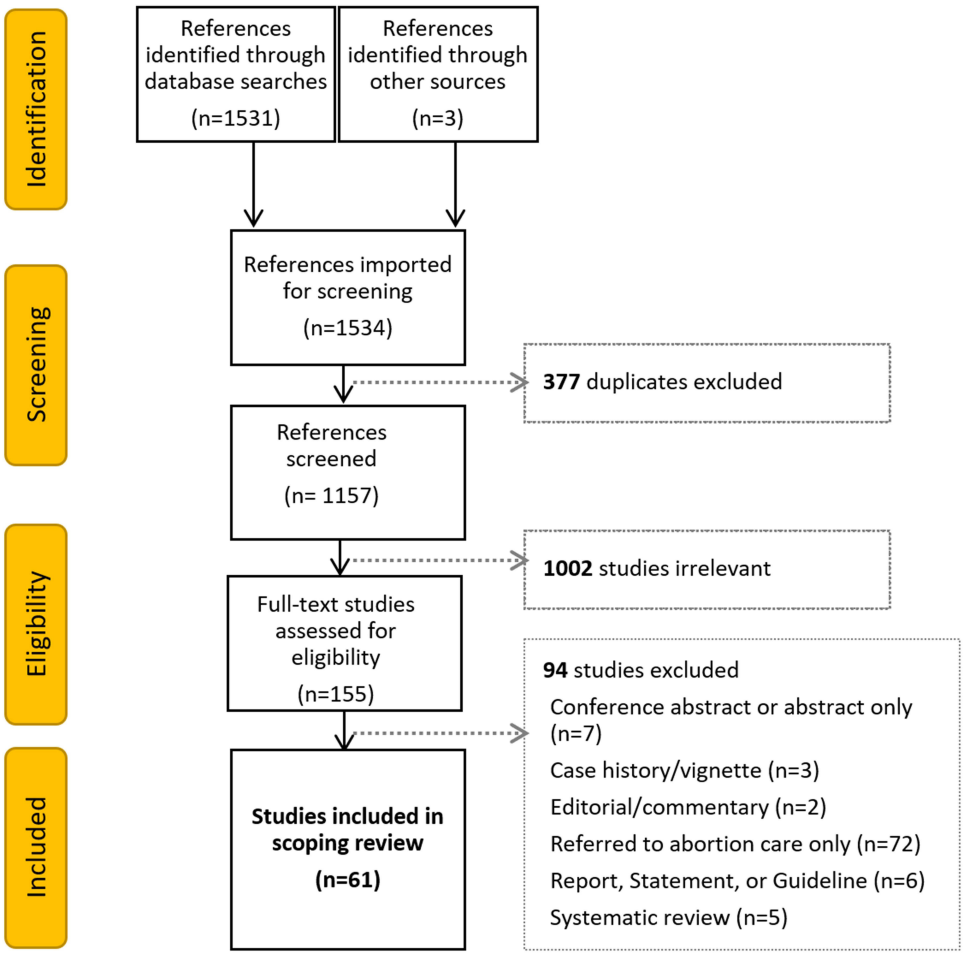

Figure 1 PRISMA reporting framework for study selection.
Notes: Adapted from: Tricco AC, Lillie E, Zarin W et al PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern, Med*. 2018;169(7):467–473. doi:10.7326/M18-0850.[16] Copyright © 2018, The American College of Physicians. Creative Commons Attribution License (https://creativecommons.org/about/cclicenses/).

repeated review of codes and emerging themes, 10 broad themes were developed to provide focused interpretations of the results.

Results

The analysis synthesised findings from 61 studies conducted across seven countries: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka (Figure 2). No eligible papers from the Maldives were sourced. Most studies explored the experiences of women, with some including perspectives of family members, midwives, obstetricians, midwifery students, hospital officials, community stakeholders and community-based care providers. The research included a mix of quantitative (21), qualitative (29) and mixed methods (11) study designs.

Table 2 describes the characteristics of included studies. Table 3 summarises the preliminary codes and categories from included studies that addressed the scoping review research questions and guided the development of themes. Ten themes emerged that described issues in the provision of respectful maternity care for women in South Asia. These in turn were grouped, reflecting the focus on two broad overlapping domains that described deficits of care and influencing factors (Compromised quality of care, Context and inequities influencing experiences); and calls for change (Responses and needs, and System level changes – policy, education, funding). Themes and domains were related according to how they were referenced by women, family and community, and workforce (see Figure 3).

The 10 themes are described after Table 2.

Table 2 Characteristics of Included Papers

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Adamson, Krupp et al 2012[17]	India	Semi-urban	Population-based survey	Marginalized women with young children	Interviewer-administered questionnaire	Descriptive statistics: multivariable logistic regression analysis to estimate association of variables with receiving antenatal care.	Increasing institutional delivery and access to antenatal care; however significant disparities among different castes.	The financial barriers to access care, deep rooted social and cultural norms lead to preference of traditional birth attendant, and unequal distribution of services particularly according to caste.	Health interventions should target both perceived and actual stigma and discrimination, in addition to providing needed services. Barriers impacting access to maternal health care must be addressed by developing targeted and culturally appropriate community-level interventions.
Akter, Davies et al 2020[18]	Bangladesh	Rural	Qualitative descriptive study	Indigenous women from three ethnic groups within 36 months of delivery	Semi-structured interviews	Thematic analysis	Improved access to services and having indigenous health care providers encourage women to access care.	Lack of knowledge about the services and facilities, lack of knowledge on the importance of attending ANC and PNC services, distance and lack of available transport and fears related to medical intervention. Services or facilities were not culturally welcoming for women to access care.	Women preferred a flexible payment option that local Traditional Birth Attendant provides to them. Women's preference of having connections/relatives in the health care settings enabled trust to services. Culturally appropriate and user-friendly information about services required. Health promotion programs must be designed in collaboration with indigenous communities.
Alcock, Das et al 2015[19]	India	Urban	Mixed method study	Married women from Mumbai informal settlements. Community organisers. Mothers-in-law	Census data Focus group discussions In-depth interviews	Regression model of associations between maternal characteristics and uptake of care and choice of provider. Grounded theory approach	Women sought various types of information from relatives, friends and neighbours to identify suitable health care providers.	Economic and social status of women impacted health care decisions. Choosing providers often dependent on women's ability to negotiate social and economic conditions. The medical risk model created uncertainty, fear and anxiety to women.	Focus on addressing health care disparities by providing access to care to poor women. Clear understanding of context of women and how health care decisions are made. Implement effective health system strategies – high-quality maternity services across sectors to improve women's choices and experiences

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https://doi.org/10.2147/IJWH.S341907 DovePress

Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Arnold, van Teijlingen et al 2018[20]	Afghanistan	Urban	Critical ethnographic study	Health workforce (observation, interviews with doctors, midwives and care assistants). Background interviews with community leaders, officials, educators Groups of women	Participant observation Semi-structured interviews Focus groups	Thematic analysis	The strong connections to family needs, obligations and demands were evident in staff of all cadres and seniority. Multiple perspectives provide rich insight to understand.	The different ways of understanding about the need of care among the health care providers is problematic. Direct link between the values, social obligations of Afghan providers, the political economy and the quality of care revealed in this study – which somehow provided a conflicting worldview.	Further research needed to understand the different value perspectives. Local solutions and courageous leaderships are required to improve the quality of care in maternity hospitals. Quality equity and respectful maternity care for women in childbirth need to be tempered with a major paradigm shift by donors and global health communities to see outside biomedical lens.
Arnold, van Teijlingen et al 2019[21]	Afghanistan	Urban	Qualitative study	Health workforce (observation, interviews with doctors, midwives and care assistants). Focus groups of pregnant and postnatal women in community Pregnant and postnatal women	Observation Semi-structured interviews	Thematic analysis	Women opening talking about their dissatisfaction of care opens opportunity for future discussion.	Research demonstrated the complexities of institutional cultures and dangers of making judgements without gaining first-hand insights from health care providers themselves. Observations revealed overwhelming demands staff faced working a night shift in under-resourced hospital.	Multi-components interventions are recommended to address the complexities of providing respectful quality care to women. Providing quality care requires strong enforcement of standards and consequences for deliberate neglect or extortion, as well as support and acknowledgement for staff members who are working well. Approaches are required to identify and address all facets of poor-quality care and mistreatment.

Atif, Lovell et al 2016[22]	Pakistan	Rural	Qualitative study	Depressed mothers. Primary health care staff Family and community (peer volunteers, husbands, mothers-in-law)	In-depth interviews Focus groups	Framework analysis	Peer volunteer (PV) level of motivation played key role. PV's attributes – local, approachable, empathetic, trustworthy and having similar experience to mothers contributed to acceptability.	Family and community support, good training and supervision staff	Training and supervisory supports to health workers needed. Peer Volunteers sustained motivation to perform well in their role is needed. Appropriate organisational support and appropriate incentivisation.
Atif, Nazir et al 2020[23]	Pakistan	Semi-urban	Mixed method study	Women with experiences of perinatal anxiety Obstetric health care professionals	In-depth interviews	Thematic analysis	Women agreed on the potential for a talking therapy to help with their anxiety.	The lack of awareness about mental illnesses and the stigma attached to them, often preventing disclosure, fear of being judged by others, lack of empowerment and financial dependence on husband and in laws contributed anxiety.	Staff training recommended to help women minimise perinatal anxiety.
Awasthi, Awasthi et al 2018[24]	Nepal	Rural	Descriptive cross-sectional study	Childbearing women of reproductive age	Face-to-face – questionnaire	Descriptive analysis	Women's attendance of ANC clinic and husband's involvement in decision-making	Lower SES of women, low level of awareness of ANC care and lack of decision-making capacity of women about the care/ANC visits.	Address factors influencing poor utilisation and access to free safe motherhood services provided by the government, intensive awareness programs and behaviour change intervention, community engagement activities to help promote maternal health.
Azhar, Oyebode et al 2018[25]	Pakistan	Rural	Cross sectional household-based study	Women with recent experiences of giving birth	Structured questionnaire	Multiple logistic regression	Less experience of disrespect and abuse in home setting.	Health facility-based discriminations and abuse. Non-consented care and lack of informed choice.	Targeted interventions are needed to address issues and improve maternal health. Policy needs to be revised based on the charter of respectful maternity care.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Baral, Skinner et al 2016[26]	Nepal	Rural	Qualitative study	Married women from rural area who had given birth. Key informants (husbands, and parents-in-law)	Semi-structured interviews	Thematic	Access to SBA to give birth, education and employment linked to the positive experiences	Lack of SBA in rural areas, difficult terrain, widespread poverty and illiteracy, lack of women's autonomy, limited resources, traditional attitudes and gender factors	More female service providers, autonomy to women to make decisions, increased access to services, focus on social change and training for midwives to follow code of conduct.
Bhattacharyya, Srivastava et al 2013[27]	India	Urban	Qualitative study	Women with live births at home and in primary health centres.	In-depth interviews Focus group discussion	Thematic analysis	Women identified non-clinical aspects of care as important aspect of good care. Emphasis is given to improve infrastructure, human resource, medical supplies, and equipment.	The process of care includes promptness, responsiveness and women centred care/ behaviours – respect, dignity and support have not been given attention.	Health care quality improvement program needs to address non-clinical aspects of care. Importance of raising awareness among the providers about the respectful attitudes and behaviour towards women. Appropriate interventions to improve quality maternity care needed.
Bhattacharyya, Issac et al 2015[28]	India	Rural, semi-urban and urban	Qualitative study	Women who attended secondary health facilities to give birth. Health care providers	Semi-structured in-depth interviews	Thematic analysis	Common experiences of challenges by providers and service recipients opens opportunity for improvement.	Service providers outlined barriers around – pre-referral management, vacant positions, inadequate incentives and infrastructural support and blood supplies.	Respect, dignity, privacy during delivery, sharing of information and cost of care issues experienced by women should be prioritised and incorporated in quality improvement plan to make services responsive to the needs and expectations of women.
Bhattacharya and Sundari Ravindran 2018[29]	India	Rural and semi-urban	Cross-sectional community-based study	Women who attended health facilities to give birth	Cross-sectional, quantitative. Structured interviews	Descriptive and bivariate analysis measuring prevalence and nature of obstetric violence	Community-based study provides insights to disrespect and abuse among slum-dwelling women of India.	Doctors were more abusive than nurses. Women who experience complications experience more abuse than those who does not. Abusive provider's behaviour increases risk of other complications.	Rights based approach required to increase access to quality services for women. There should be accountability measures for directly addressing the inequities in power between the providers and women.

Bhattacharyya, Srivastava et al 2018[30]	India	Urban	Qualitative study	Women in the last trimester of pregnancy Health care providers	Focus group discussion with pregnant women In-depth interviews with care providers	Thematic analysis approach	Women would like to go to hospital or health facility if the care if provided in respectful way allowing women to choose what they want and how they want the care provided to them. Both providers and women agreed that the respectful care is needed – so does the good communication.	Concerns around gaps in women-centred care. Facility environment has been concerning for women as it was not clean. Concept of respectful care interpreted differently by women and the providers – women were safety focused and wanted spontaneous birth – where providers were risk focused and wanted to minimise complications and take clinical actions. Cost has been consistent barriers to women – added financial burden and lack of trust to public services among women.	Prioritize the improvement of the quality of maternity services – more doctors, better referral systems, more hygiene, respectful behaviour, better communication and more supportive care. Educating women about the need of good care, and adequate information sharing and communication by providers
Bogren, Erlandsson et al 2018[31]	Bangladesh	Urban	Qualitative study	Midwifery students in public nursing institutes/ college	Focus group discussions	Qualitative deductive content analysis	Opportunities to address these barriers enables better access to quality of care to all women.	Numerous barriers experienced/mentioned by student midwives impacted providing quality care to women. Provision of quality maternity care falls outside the parameters of cultural norms shaped by beliefs associated with religion, society and gender norms making midwives more vulnerable.	Consider strategies to support women leadership, proper midwifery workforce planning, education and training, and effective management of professional and midwifery jurisdiction. Mobilise midwifery workforce across the continuum of care to provide quality reproductive health services to women. Attention should be given to constructed gender norms while designing education training and care.
Cederfeldt, Carlsson et al 2016[32]	Nepal	Urban	Prospective cross -sectional study	Pregnant women in labor ward	Questionnaire	Quantitative	Skin to skin contact between mother and baby benefitting both mother and baby	Continuous support was not a part of intra-partum care in hospital, high level of technical interventions and lack of one-on-one professional care by registered midwives.	Women should get freedom of movement and the birthing positions to choose. Measures to promote normal birth needed with the provision of registered midwives to assist birthing and introduction to midwife-led care.

(*Continued*)

Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Chattopadhyay, Mishra et al 2018[33]	India	Rural	Qualitative study	Married women with pregnancy and childbirth experiences Families Doctors and community health workers, nurses	Surveys Interviews Observations	Thematic analysis	Women's experiences against obstetric violence are critical.	High level of disadvantages contributes to disempowerment of women by medical professionals. Reported intentional violence in service settings.	Systemic issues supporting obstetric violence must addressed. Unnecessary technological interventions to support births must be reduced while encouraging institutional births and women's dignity and rights should take into the account.
Devkota, Murray et al 2017[34]	Nepal	Semi-urban	Mixed method study	Maternal care users – disabled women Healthcare providers in public health facilities Eighteen in-depth interviews with women with disabilities who used maternal healthcare services in a healthcare facility	Attitude towards disabled person (ATDP) tool Interview guide	Descriptive Grounded theory	Mixed experiences about HCW with some positive notes but health professionals struggled to understand the need of disabled women.	Negative experience about the care provided by health workers as women found it discouraging, rude, disrespectful, disengaged and abusive.	Effective specific training and resources to support health professionals to change their attitude and to enable them to provide effective care.
Devkota, Murray et al 2018[35]	Nepal	Semi-urban	Mixed method study	Women with and without disabilities accessing maternal healthcare services during pregnancy.	Cross-sectional surveys and in-depth interviews	Descriptive bivariate statistical analysis Thematic analysis	Incentives program of the government to cover transport cost of accessing services has been beneficial to women and positive experiences of receiving care from female providers	Service location, distance to travel, associated costs and availability of staff/services has been reported as constant barriers to access maternal health services by women. Disabled women were more likely to experience barriers of accessing services.	Need to review of the effectiveness and equitable coverage of financial incentives program. Need to develop a comprehensive demand side financing strategy to reach the poor and marginalised group of women – including women with disabilities

Devkota, Kett et al 2019[36]	Nepal	Rural	Mixed method study	Dalit and non-Dalit women with and without disabilities Female community health volunteers	Interviews Survey Focus group	Thematic	Support from families, neighbours and FCHV.	Discriminations, disrespectful behaviour, exclusion by family and society.	Social policy, education, support system and more information.
Dey, Shakya et al 2017[37]	India	Rural, semi-urban and urban	Observational study – quasi-experimental design	Women attending public health facility to give births. Health care providers	Observation; self-reported follow-up surveys; Interviews	Cohen's Kappa scores Chi-square analysis T tests	Skilled providers found to be more respectful to women.	Lack of transparency and lack of consent in providing care, physical and verbal abuse are higher and women who reported abuse experienced complications.	Training to the providers, availability of skilled and trained providers, a review of curriculum of medical and nursing education with inclusion of additional modules about mistreatment and focused interventions directed towards women and their families to demand respectful and quality maternity care.
Diamond-Smith, Sudhinaraset et al 2016[38]	India	Urban slums	Cross sectional quantitative study	Women who had experienced childbirth in last 5 years in a health facility and were living in slums	Researcher administered household surveys	Regression analysis	Support of and friends and family members – MIL, Mother, Husband, Sister, Brother, Father was supportive.	Not having someone who help them talk to the providers, health care providers exerting power over women and controlling birth and lower caste women are more likely to experience mistreatment by providers.	Attention needs to examine the support and experience of mistreatment among women. Engagement of family members and health workers to provide to design and provide appropriate interventions/support s to women.
Diamond-Smith, Treleaven et al 2017[39]	India	Urban	Cross sectional quantitative study	Women who had experienced childbirth recently in a health facility and were living in slums	Cross-sectional survey	Statistical analysis of association of women's empowerment with mistreatment at time of delivery	Young women are likely to feel empowered after giving birth. Women with higher SES reported experiences of mistreatment.	Gender issues play critical role in violence, abuse and mistreatment of women during childbirth, women's expectations of services and power dynamics play significant role in shaping service experiences and broader social contexts need consideration for quality care.	Demand for respectful maternity care must be increased. All four domains of GEM scale should be considered to design interventions for reducing mistreatment during childbirth. Women's socio-demographic background should take into consideration to design empowerment programs.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Dorairajan, Gopalakrishnan et al 2020[40]	India	Urban	Cross-sectional descriptive quantitative study	Women with birthing experiences in a tertiary hospital	Cross-sectional survey with questionnaire	Univariate analysis in Stata	Low parity and higher education have significant association with felt need of complete pain relief and more information and free childbirth services for women.	Not having options for prayer room, complete pain relief and presence of relatives during birth acted as barriers to women.	Birth companion for all, birth preparedness classes for all, alternate pain relief measures for women to choose and recruitment of more nurses and midwives to reduce the abandonment of care.
Dorji, Das et al 2019[41]	Bhutan	Urban	Mixed method study	Pregnant women. Antenatal care providers	Cross-sectional survey In-depth interviews	Statistical and thematic analysis	Women were able to make decisions about accessing care with the support of family members. Peer and community support were crucial.	Geographic inaccessibility of care, gender sensitivity reported by healthcare workers and cost and time required to access care.	MCH programs should develop a comprehensive information package for aspiring parents. Deploy female health assistant and nurses in the primary level MCH activities. Health education needs to target family members who are decision makers using television and social media. Opportunity to review and strengthen the maternal and child health care policies and strategies.
Dynes, Rahman et al 2011[42]	Bangladesh	Rural	Non-experimental descriptive design	Community health research workers Pregnant women Support persons Programme co-ordinators	Review of records, performance testing, group discussions and key informant interviews	Descriptive statistical and thematic analysis	Women were satisfied with the care received at home.	Shared concerns about the lack of involvement of men in home care. High workload for health workers reported.	Expansion of emergency obstetric care services and train additional staff members to provide continuous care.

Erlandsson, Sayami et al 2014[43]	Nepal	Urban	Qualitative exploratory study	Skilled Birth Attendants (SBA)	Focus group discussion	Phenomenological approach	Women's sense of respectful maternity care is facilitated by relatives or family members engagement.	SBA argued that 'safety comes before comfort' and reported that women can only have respectful care if facilitated by relatives.	Professional midwives need to be recruited, trained, resourced, and supported to provide respectful care, educational programmes to consider women's desire, rights, choices and engagement is needed so the SBAs do not underestimate the rights of women to receive respectful care, relatives and family members should be engaged to provide care and women and girls should be empowered about their reproductive rights.
Hameed and Avan 2018[44]	Pakistan	Semi-urban and urban	Comparative study	Women who had given birth at home or in a healthcare facility over the past year.	Survey Face-to-face interviews	Descriptive analysis	Women's empowerment, levels of women's involvement in household decision-making and prior education of birth preparedness positively contributed to experience of mistreatment.	Quality of care is still questionable, traditional birth attendant treat women more respectfully than the physicians and women faced discrimination based on ethnicity.	Violation of women's right to information, consented care and confidential care must be addressed. All settings must made aware of current measures to ensure provision of quality antenatal and maternity care. Care should be provided in a respectful and culturally appropriate manner.
Herath, Balasuriya et al 2017[45]	Sri Lanka	Rural	Descriptive cross-sectional study	Pregnant women	Interviewer administered questionnaire	Statistical analysis	Husband helping women to do household work contributed to minimise the physical and psychological problems.	Younger women under the age of 25 were more likely to experience psychological distress and depression. Physical problems associated with getting back to physical work or exercise needs to be looked more closely.	Husband's support must be highlighted and utilised to address the issue of psychological problems. Psychological distress should be monitored periodically as a part of antenatal consultations.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Infanti, Lund et al 2015[46]	Sri Lanka	Urban	Qualitative study	Public health midwives Pregnant women	Group interviews and a participatory workshop Individual interview with pregnant women	Thematic analysis	Midwives' relationships with women relationships were valued and provided safe space to talk about discuss the experience of domestic violence.	Social, economic and systemic barriers identified to address the issue of domestic violence among pregnant women.	Following strategies could help to address the issues. Measures to ensure privacy and confidentiality, connecting to meet emotional needs of women, intervention on time when violent relationship disclosure happens and using reconciliation as socially desirable solution. Collaborations to other sectors, policy makers and sectors needed to address the issue of domestic violence in pregnancy.
Infanti, Zbikowski et al 2020[47]	Sri Lanka	Urban	Qualitative study	Physicians and nurses from hospitals	Theatre technique workshops Focus groups	Content analysis	Participatory theatre techniques hold potential as an intervention method for preventing and addressing abuse in health care in Sri Lanka.	Various institutional barriers reported – policy and accountability system to prevent abuse in health care are not detailed, nuanced, integrated or enforced. Lack of commitment and support from hospital leadership to ensure respectful and dignified patient care. Patient lacks effective process to report the experiences of abuse in clinical settings.	Addressing abuse in health care requires a multifaceted approach ranging from small structural changes to more complex behavioural change interventions.
Kaphle, Hancock et al 2013[3]	Nepal	Remote	Qualitative study	Women who were pregnant or recently given birth Family Service providers Community stakeholders	In-depth interviews	Thematic analysis	Women considered family and community as supportive resources to experience safe childbirth within the village. They valued tradition and cultural safety more than the physical safety during pregnancy and childbirth.	Lack of transport, limited access to services, financial burden, heavy domestic workload, and confined traditional rules to give birth in cowshed are critical barriers to safe pregnancy and birth outcomes for women in the remote mountain.	Enabling access to resources and support to experience culturally appropriate and respectful care during pregnancy, childbirth and postnatal period is imperative to save lives of mothers and babies in remote setting. This requires priority attention from the government to implement context specific strategies.

Kaphle and Newman 2020[4]	Nepal	Remote	Qualitative study	Women who were pregnant or recently given birth.	In-depth interviews	Thematic analysis	Local community was the main support for women and families. Cultural determinants were valued by women to ensure childbirth safety.	No access to transport or road, geographic terrain, lack of access to professionals and consistent food insecurity impacted women's health and birth outcomes.	Addressing broader determinants impacting access to quality of care is critical in remote areas.
Khan, Blum et al 2012[48]	Bangladesh	Rural	Qualitative study	Women who gave birth in hospital with severe obstetric complications	In-depth interviews	Thematic analysis	Women's resistance to the C/S decisions made by the health professionals to manage complications.	Cost of care has been consistent barriers to women due to family circumstance. ANC consultation provides little information regarding complication and how to manage them. Women have misconceptions and concerns about C/S and distrust to health workers making decisions.	Underlying importance of educating women and families regarding pregnancy related complications. Improved quality of antenatal consultations and policy makers need to develop protocols regarding appropriate C/S and ensure those women in clinical need of life saving surgery have access to care. Additional research needed to examine perceptions of C/S from socio-economic point of view to understand the impacts.
Khatri, Dangi et al 2017[49]	Nepal	Remote	Qualitative study	Service users (women with birthing experiences and/or their husbands). Health service providers (health workers with paramedical or midwifery training. Community stakeholders (social workers, leaders, teachers, civil servants)	Interviews Focus group discussion	Used logic model	Family members increasing interests for women to give birth in birthing centre and maternity incentive program	Lack of onsite accommodation for service providers, lack of skilled providers, lack of coordinated care, limited equipment, difficult access to care and limited resources	Community-based planning and management of resources, awareness raising activities, investment on health resources and support from the policy level.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Maharjan, Rishal et al 2019[50]	Nepal	Rural	Qualitative study	Young married pregnant women. Key informants (community and health leaders, NGOs)	Semi-structured interviews Focus group discussion	Systematic text condensation	Services that are free, accessible, and provided by skilled health care providers.	Poor knowledge about RHC and services, judgement, discrimination stigma, shyness discomfort, poor quality of care, gender of HCW, minority of caste /ethnicity and structural issues – resources, transport, distance.	Govt led strategies re adolescent health care with higher priority to poor and rural settings, train and motivate health personnel for quality services, expand access to RHC and education to improve adolescent girls' knowledge about SRH and their status in the families and society.
Maheen, Hoban et al 2020[51]	Pakistan	Rural	Mixed method study	Pregnant and postnatal women	Face-to-face interviews Survey questionnaire	Inductive thematic analysis Descriptive statistics	Utilisation of continuum of care (CoC) for pregnancy childbirth can reduce the burden of maternal deaths.	Lack of respectful maternity-care a major barrier to utilisation of PHC facilities, especially for childbirth.	Emphasise preventative health care every visit, useful if the community midwives can offer ANC education at village level, in-service training programmes with a focus on delivering respectful maternity-care, voucher scheme for geographically isolated + poor women to access maternity-care and services to ensure CoC from community to facility.
McNojia, Saleem et al 2020[52]	Pakistan	Rural	Exploratory qualitative study design	Rural-dwelling women who had experienced a stillbirth. Traditional birth attendants	In-depth interviews (IDIs) and focus group discussions (FGDs)	Qualitative content analysis	Appropriately trained workforce; adequate resources	Difficulty in accessing care due to nonavailability of female doctors, high cost of care, access to facility, and need of escort poor treatment facilities and non-availability of staff.	Address poor behaviour and attitude of providers. Respectful maternity care should become the norm and proposed framework to guide and enhance efforts for prevention of stillbirths.

Mehata, Paudel et al 2017[53]	Nepal	Rural	Secondary analysis of exit survey data	Women who had either given birth or who had experienced obstetric complications	Exit interviews. Survey	Secondary analysis of survey and interview data	Providers' attitude, provider competence, outcome, physical environment, continuity of care, access, information, cost and bureaucracy.	Our study also reported significantly lower satisfaction among those who were scolded at facilities by the health providers. This finding suggests communication skill and behaviour improvement should be integrated with other health related trainings.	Key supply side factors, such as longer waiting times and overcrowding at facility, were associated with poor client satisfaction, whereas getting an opportunity to ask questions was positively associated with client satisfaction.
Milne, van Teijlingen et al 2015[54]	Nepal	Urban and semi-urban	Mixed methods study	Staff at community hospitals working with low-risk women from poorer communities.	Qualitative interviews and non-participant observation	Thematic analysis	Local staff who know women and the context of community was beneficial.	Barriers resembled 3 phases of delay model.	Train midwives adequately to care for low-risk women and refer women with risk factors to a reliable tertiary service.
Montagu, Landrian et al 2019[55]	India	Rural and semi-urban	Cross-sectional - survey	Women who gave birth in government facilities	Self-administered survey	Descriptive, analysis with logistic regression	Lower-level facilities are more accessible, women have greater trust for the providers and women report being better treated than in hospitals.	Higher-level facilities provide inferior patient-centred treatment than lower-level facilities throughout the continuum of care.	Good clinical services must be paired with good person-centred care, and balancing the attention to each aspect of care will be important for future quality improvement efforts in India.
Morrison, Basnet et al 2014[56]	Nepal	Rural	Qualitative study	Married women with different impairments who had delivered a baby in the past 10 years. Maternal health workers.	Semi-structured interviews	Thematic analysis	Health workers from local area who speak same language and free delivery care with additional incentives.	Judgement – scolding ≫ impact on accessing care, feeling unsupported (by community as well as HW), lack of info/education by HCW appropriate women's needs w disability, HCW felt unprepared, inappropriate equipment, sense of exclusion and overall, barriers similar disabled and non-disabled.	Improvement in costs, resources, access, consult with disabled women themselves and monitor progress of interventions.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Panday, Bissell et al 2019[57]	Nepal	Rural and semi-urban	Qualitative study	Ethnic minority women. Female Community Health Volunteers Paid local health workers.	Semi-structured interviews Focus group discussion	Thematic analysis	Improved education and awareness	Major themes underlying barriers to accessing available maternal and child healthcare services by ethnic minority groups include a) lack of knowledge; b) lack of trust in volunteers; c) traditional beliefs and healthcare practices; d) low decision-making power of women; and e) perceived indignities experienced when using health centres.	Community health programmes should focus on increasing awareness of CHVs among ethnic minority groups, involve family members and traditional health practitioner and better training.
Panth and Kafle 2018[58]	Nepal	Urban	Descriptive cross-sectional study	Postnatal mothers	Semi-structured interviews	Descriptive and inferential analysis	Inverse relationship between education, and level of maternal satisfaction. Multiparous women more likely to be satisfied with delivery service than primiparous.	Limited ability to engage in health facility.	Study could be done in community setting where postnatal mothers could freely express themselves and care givers need to better understand expectations of mothers.
Pathak and Ghimire 2020[59]	Nepal	Urban	Descriptive cross-sectional study	Pregnant, birthing and postnatal mothers	Structured interviews	Descriptive and inferential analysis	Friendly, abuse-free, timely, and discrimination-free care promoted perceptions of respectful maternity care	Abusive, lack of friendly, lack of timeliness and lack of discrimination-free services.	Woman centered care provided in a respectful and non-abusive manner needs to be given adequate emphasis to improve quality care.
Paudel, Javanparast et al 2018[60]	Nepal	Health services	Qualitative study	Women and their families with perinatal loss experience. Health service providers. Female health volunteers, local stakeholders, traditional healers	In-depth interviews	Thematic analysis	Women felt unsafe in health settings	Disrespectful care	Perinatal focus but reference to maternal care respect.

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Perera, Lund et al 2018[61]	Sri Lanka	Urban	Qualitative study	Pregnant women with previous childbirth experience. Public health midwives	Focus groups Interviews Follow-up in-depth interviews	Thematic analysis	Women expressed gratitude towards health care system as a whole and to individual health care provider for their support	Women were not aware of the process or opportunity of reporting obstetric violence, and they were mostly stay silent when it happened. Obstetric care providers were the perpetrators of violence against women. Experience of violence was linked to the financial, social, cultural and linguistic status of women.	Toned to examine the intersections of violence and social characteristics of women to understand the obstetric violence against pregnant women particularly in low socio-economic settings. Making obstetric violence visible is the first step. Health system reform and improvements to ensure professional accountability for the safety and wellbeing of patients and ethics of providing respectful care should be re-enforced.
Senanayake, Wijesinghe et al 2017[62]	Sri Lanka	Urban	Descriptive cross-sectional study	Consultant obstetricians in state hospitals.	Online survey	Descriptive statistical analysis	Cochrane review analyzing 22 trials involving 15,288 women from 16 countries, all women should have continuous support throughout labor.	Among those who completed the questionnaire, the majority did not allow birth companionship in their units.	Support education and awareness among obstetricians of the benefits of allowing a female labour companion, empower women to request a labour companion and education.
Shahabuddin, Delvaux et al 2019[63]	Nepal	Semi-urban	Prospective qualitative study	Married adolescent girls pre-and post-birth. Community health workers Family members Government stakeholders and health care providers.	In-depth interviews	Thematic content analysis	Safe Motherhood Program, knowledge sharing platforms such as "women's groups" and active role of Female Community Health Volunteers (FCHVs) positively influenced utilization of skilled maternal health services among these girls.	Several factors of each level of SEM negatively impacted the maternal health care-seeking behaviour of adolescent girls, health system, community, family and individual.	Improve access and availability of adolescent-friendly maternal health services to encourage adolescent girls to use skilled maternal health services. improve adolescent girls' knowledge of maternal health, keep them in school, involve family members and overcome negative traditional beliefs within the community.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Sharma, Penn-Kekana et al 2019[64]	India	Urban and semi-urban	Mixed-method study	Women giving birth in public and private sector maternity facilities	Systematic clinical observations. Open-ended comments	Bivariate descriptive analysis. Thematic analysis	See WHO Guidelines	Lack of training; resources; policy implications	Systematic and context-specific effort to measure mistreatment in public and private sector facilities, training initiative to orient all maternity care personnel to the principles of respectful maternity care, innovative mechanisms to improve accountability towards respectful maternity care, participatory community and health system interventions to support respectful maternity care and long-term, sustained investment in health systems to improve work-environments for front-line health workers.
Subramaniyan, Sarkar et al 2013[65]	India	Rural	Descriptive qualitative study	HIV positive postnatal mothers	Interviews	Content analysis	Disclosure of HIV status	Experience of stigma, discrimination and unnecessary referrals is common	Improve access to quality PPTCT services for HIV-infected pregnant women
Sudhinaraset et al 2016[66]	India	Rural	Mixed method study	Women with at least one child under the age of 5 with a birth occurred in health facility	Survey Focus group discussion	Descriptive analysis	Women also blame themselves for their lack of knowledge	Lack of cultural health capital disadvantages women to use resources.	Future strategies should engage women, their families and providers to promote women's cultural health capital to improve respectful care in facilities
Sudhinaraset, Beyeler et al 2016[67]	India	Rural	Qualitative study	Recent mothers	In-depth interviews	Content analysis		Financial barriers, household dynamics and joint decision-making at families and perceived quality of care.	Greater focus on health education and consider role of husbands and mother-in-law in decision-making about the care.

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Swahnberg, Zbikowski et al 2019[68]	Sri Lanka	Urban	Intervention study	Health care providers	Pre and post questionnaire	Content analysis	Potential of the training method to increase staff awareness of obstetric violence and promote taking action to reduce or prevent it.	Evidence of interventions to reduce and prevent obstetric violence is limited. The intervention appears. Promising for improving the abilities of health care providers to recognise obstetric violence, the first step in counteracting it.	The study demonstrates the value of developing further studies to assess the longitudinal impacts of theatre-based training interventions to reduce obstetric violence and, ultimately, improve patient care. FP has the potential to encourage new ways of thinking to prevent and reduce AHC.
Taleb F, Perkins J, Ali NA, et al[69]	Bangladesh	Rural	Qualitative study	Pregnant and postnatal women	Focus group discussion In-depth interviews	Thematic analysis	Community- based programs aiming to influence knowledge and practices can successfully initiate changes in social norms and practices related to MNH.	Institutional and socio-economic barriers.	Results suggest that community-level interventions aiming to affect change in social norms and practices surrounding MNH can influence knowledge and practices even after a short period of time. Further evaluations will be required to quantify the degree to which these changes are having an impact on health services utilization.
Thapa, Bangura et al 2019[70]	Nepal	Rural	Randomised clustered control trials of group antenatal care	Women in the antenatal period	Focus group discussion Demographic survey	Descriptive Content analysis	Knowledge of key pregnancy danger signs were significantly improved in the home visit plus group antenatal care cohort compared with the home visit care-only group.	Significant socio-economic differences noted – highlights the existing barriers to access services.	The potential for impacting women's antenatal care experience and should be studied over a longer period as an intervention embedded within a community health worker program.
Thommesen T, Kismul H, Kaplan I et al 2020[71]	Afghanistan	Rural	Case study approach	Women who gave birth Mothers-in-law Community midwives	In-depth interviews	Thematic and content analysis	Midwives' life-saving experience, skills and care were valued, influencing the choice to give birth in a clinic.	Issue of privacy and shame as well as the experience of disrespectful care affected the acceptability of midwifery services for some.	An increased focus on respectful care and attitudes and on communication in both pre-service and in-service training for midwives is necessary in order to improve the quality of services.

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Table 2 (Continued).

Paper	Country	Research Setting	Research Design	Participants	Data Collection	Data Analysis	Facilitators	Barriers	Recommendations
Varghese B, Roy R, Saha S, Roalkvam S. 2014[72]	India	Rural and semi-urban	Mixed methods study – evaluation within a quasi-experimental design	Mothers with newborn	In-depth interviews Surveys	Thematic and statistical analysis	Mother and families receiving the intervention of community-based mother's aide and birth companion reported increased care and support in health facilities.	Poor quality of postnatal care persists.	Program made an impact to provide quality care experiences – so scaling up recommended.
Wahlström, Björklund et al 2019[73]	Nepal	Semi-urban	Descriptive phenomenology	Skilled Birth Attendants (SBA)	Semi-structured interviews	Thematic analysis	SBA were problem solver and made decision on their own and in collaboration with colleagues.	Lack of proper equipment and access to other medical professionals impacts patient safety. They also had to relate to the families' decision which could be culturally informed and complex – thus creates ethical dilemma.	Capacity building interventions with modern obstetrics, gynaecology and supportive policies and health institutions.
Waqas, Zubair et al 2020[74]	Pakistan	Urban	Cross-sectional study	Pregnant women	Structured interviews	Logistic regression analysis to identify predictors of antenatal stress	Autonomy in household and healthcare decision-making is beneficial.	Gender preference behaviour, discriminations against giving birth to girl child and household dynamics and socio-cultural stressors are common.	Women should have autonomy and opportunity make decisions.
Wickramasinghe, Gunathunga et al 2019[75]	Sri Lanka	Semi-urban	Cross -sectional study	Postnatal mothers	Structured interviews	Descriptive statistics and multivariate analysis to assess the significant correlates of positive perceptions.	Majority had favourable perceptions of the quality of care they receive.	Ward facilities and environment scored lower ratings compared to technical and interpersonal care.	Patient-centred care recommended.

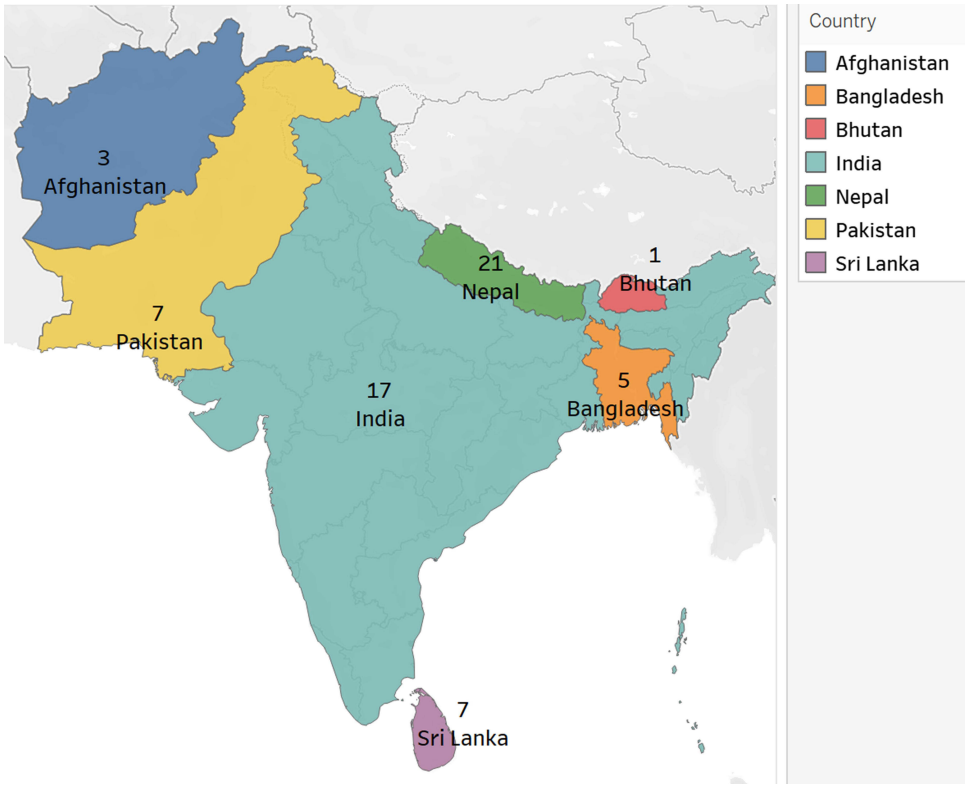

Figure 2 A map of included studies in the review by country.

Women's Choices and Preferences are Neglected

Women and family members described being neglected by health care professionals when their choices and preferences to manage pregnancy, childbirth and postnatal care.[18,20,26,29,40] Women found that professionals took control of their birth and employed routine procedures without including them in decision-making processes[65,76] and that this resulted in a lack of trust in the services provided to women.[74,75]

Within in the context of family relationships, power dynamics, and the way decisions are made about the services and care within South Asian society, the roles of husband and (in particular) mothers-in-law in making childbirth decisions and expectations regarding practice was critical, with mixed acceptance by women.[3,39,52,71,74] This signifies the hidden oppression of women within the social construct of power of patriarchal society and how women are often excluded in making decisions about childbirth.[4]

Compromised Quality of Care

Women who utilised the facility-based professional care shared their negative experiences and questioned the quality of care provided to them.[29,39] Limited access to services was described, ranging from medicines, proper equipment, competent, skilled health care and food supplies. These factors all diminished the quality of services in an environment where women felt they had little agency in the choice of services or health care providers.[19,29,33] Women felt their pregnancy and birth was medicalised within the controlled clinical environment of the hospital and reflected on their experience of a lack of basic respect and kindness to women.[20,21]

Escalated Abuse, Neglect and Disrespect Among Women Who Experience Health Inequities

Women who already experienced health inequities and compromised health outcomes due to underlying social determinants and discrimination experienced more serious forms of abuse, neglect and disrespect from health professionals.[35,49,51,56,65,70]

Table 3 Aspects of Respectful Maternity Care

Scoping Areas	Emerging Themes
Concept of RMC	Care with choices and control[18,20,29,36,57,70,76]; safety;[11,51,52,54,57,59,64,67,70,75] respect,[18,40,51,52,59,75] dignity,[11,51,52,54,57,59,64,67,70,75] quality,[34,36,45,57,60,63] and equity.[17,18,20,30,31,41,49,50,54,57,67,76]
Current care practice	Experience of neglected care,[18,20,26,29,40] compromised quality of care,[19–21,29,33,39] professional control of pregnancy and childbirth,[18,20,26,36,53,55,65,70,74,76,77] lack of agency of women in decision-making processes,[18,20,26,29,40,65,76] lack of trust in services and providers.[74,75]
Facilitators of RMC	Support from families, friends, neighbours, relatives, Female Community Health Volunteers (FCHV)s and Traditional Birth Attendants (TBA)s,[3,36,41,50,52,57,63,67,73,74,79] home village access to SBAs,[26,38,43,50,52,57,63,67,73,79] supportive family members,[18,40,51,52,59,74] caring, respectful and welcoming institutional environments[18,20,21,34,40,51,52,57,59,64]; supported transport access to care,[27,28,30,78] affordable services for all women[18,27,35,51,59]; female care providers to support birthing,[34,36,45,57,60,63] access to education and empowerment programs for women,[39,60,70] ongoing staff training and development,[20,34,56,64,68] shared understanding and trust between women and health care providers,[49,55,57,68] improved opportunities for women to be involved in discussion and decision-making process about their care,[24,57,63,67] enhanced peer – community support models of care[18,41,52,56,70]
Barriers to RMC	Discriminations, disrespectful behaviour, rejection, abuse and exclusion of women in care,[19,25,30,36,37,44,49,54,56,57,59,60,65] lack of resources, services and access to SBA in rural areas,[26,42,49,51,52,60,70,73] medical and technological control of birth,[30,32,38,62] poor interpersonal and communication skills of providers,[34,49] consequences of low socio-economic status and lack of decision-making capacity of women,[19,33,51,53,56,58,61,67] different understandings and attitudes of care providers regarding women's care needs,[20,30,43] burden of costs and transport access to health care services,[4,17,18,28,30,35,38,41,48,50,51,60] economic disadvantage, social norms, construct of gender and power in the society,[3,17,19,21–23,31,39,44,45,50,51,53,63] culturally inappropriate, physically unsafe and unwelcoming hospital environments,[28,30,40,57,75] poor quality of services in public settings,[21,27,28,30,44,50,52,55,61,80] lack of professional knowledge and resources to enable respectful services,[18,23,46,47,50,51,60–62,64,68] lack of policy, leadership commitment and accountability of health system.[46,47,50,58,60–64]
High risk populations and vulnerabilities	Escalated risk of abuse, neglect and disrespect among women who experience vulnerabilities and health inequities[26,33–35,35,36,49,49,51,56,56,65,70,70]; socio-cultural and conditions of women linked with the higher level of abuse by professionals.[18,20,25,31,44–46,50]
Policy actions and implications for RMC	Strengthened leadership, commitment and accountability[17,24,26,35,49,79]; Evidence-based and appropriate policies and guidelines, transformative strategies,[20,77] respectful professional practice in supportive well-resourced environments and resources,[20,21,24,36,41,43,49,81] prioritise improved of quality of care,[17,19–21,27,28,30,39,77,78,81] address systemic barriers,[17–19,33,39,77] increase access to SBA and female care providers,[18,19,21,24,26,35,41,43,49] enable women's access to education, services and economic opportunities,[17–19,21,26,35,39,79,81] additional and continuing training and access to educational resources,[21,34,35,43,81] involvement of women, families and communities in decision-making process.[17,18,21,33,38,40,41,43]

This further marginalised and silenced women and their families who felt unable to speak about their negative experiences with health services.[26,33,34,36,51,56,65,70] Studies questioned the effectiveness of attempts to address inequities in maternity care in socially vulnerable communities.[26,33–36,49] These women are more likely to experience more frequent and significant maternal, perinatal and neonatal morbidity with an associated increased risk of mortality.

Professional Control of Pregnancy and Childbirth Made Women Feel Fearful

Several studies described women's experience of professional control of pregnancy and childbirth, which left women with little or no perceived ability to make any decisions about the services.[20,36,55,65,70,76,77] Women felt they were not involved in decisions about prescribed medicines or procedures and why they were required.[26,53,74] This lack of involvement and communication about procedures resulted in further uncertainties, fear and anxiety for women.[18,36]

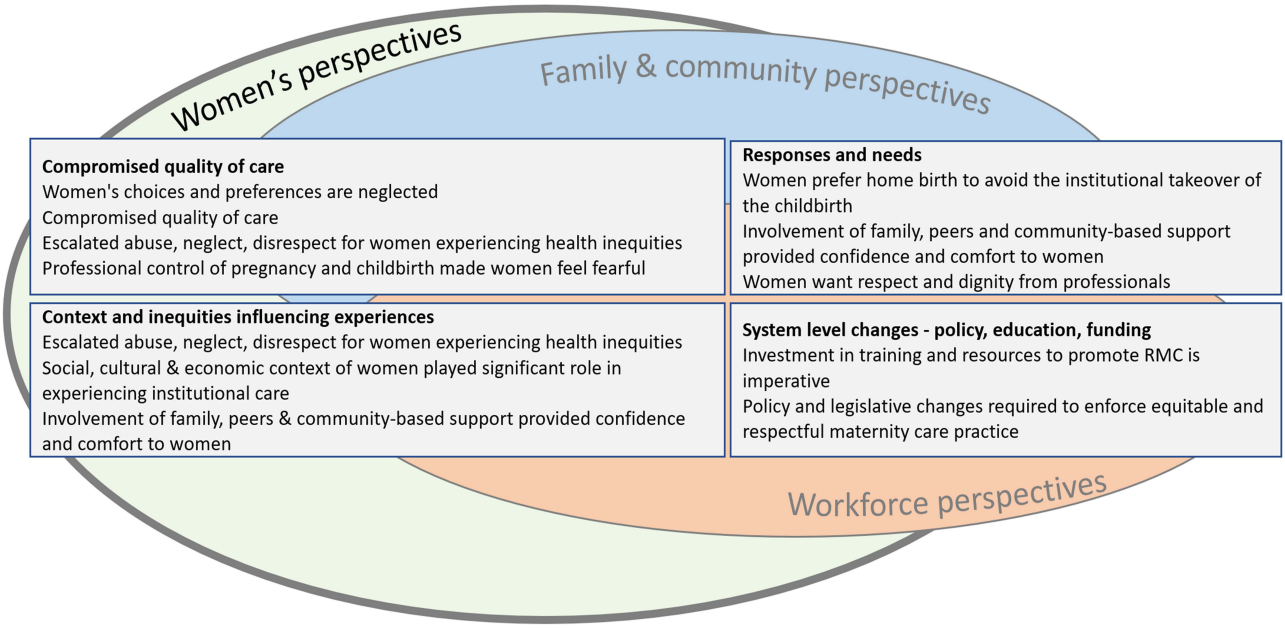

Figure 3 A diagram of reported themes from the scoping review.

Women expressed a preference for access to and choices of medical and technological interventions while giving birth.[33,38,41,59,63,64]

Women Prefer Home Birth to Avoid the Institutional Takeover of the Childbirth

In this context of professional control and institutional takeover of birth, studies described women's preference to stay away from the hospital environment in order to exercise some freedom of choice.[18,20,29,36,57,70,76] They were more likely to stay home to give birth and seek assistance from family members and community-based care providers to manage problems they experienced during pregnancy, childbirth and postnatal period.[26]

Where previous experiences of abuse, disrespect, unnecessary clinical procedures, lack of empathy by midwives and doctors and mistreatment created fear, this aversion increased.[27,49,56,63,64,67,78] Consequent delays resulted in an increased risk of emergency hospital attendance during pregnancy and childbirth.[36,49,56,62,67,70,76]

Social, Cultural and Economic Context of Women Played Significant Role in Experiencing Institutional Care

Studies described the social, cultural and economic contexts that impacted on women's experiences of disrespect, abuse and poor quality of care in the hospital environment. This was heightened for younger women, women from lower socio-economic background, women with disability, women living in rural and remote areas and women from minority religious backgrounds.[25,44,46,50,69] In South Asian societies women's needs, choices and preferences were often neglected during pregnancy and childbirth,[31] leading to psychological distress and anxiety, particularly for those women who lacked support from family and health institutions.[45] Women and families also spoke about the burden of hidden and unofficial costs required to manage transport, food and other supplies while accessing services in the hospital.[18] One study described an interesting pattern between providers and women regarding their cultural and social background in terms of understanding, empathy, trust and provision of respectful care.[20]

Involvement of Family, Peers and Community-Based Support Provided Confidence and Comfort to Women

Women described being happy to receive the care, support and respect from family, peers, and community-based care providers,[41] although the family relationships and power dynamics described in the first theme were influencing factors.[3] They tended to seek advice and support from families, relatives, friends and neighbours to make decisions about the types of services and the care providers within their socio-economic circumstances.[18,19,72] The collective decisions made about the services for women were based on the intention of gaining positive experiences and minimising the risks of poor birth outcomes. In most cases, women expressed a preference to use traditional birth attendants to support birthing[17,52] and female community health volunteers to seek information before or after childbirth.[56]

Women Want Respect and Dignity from Professionals

Women from diverse settings described hospital environments that created feelings of uncertainties, discrimination, abandonment and neglect by health care providers.[11,51,52,54,57,59,64,67,70,75] They shared expectations of having health care providers who would listen and understand their concerns, problems and preferences while providing care with a kind attitude.[18,40,51,52,59,75] Women wanted to be treated with respect and dignity without judgement about their social, cultural and economic backgrounds.[11,51,52,54,57,59,64,67,70,75]

Women preferred to have female doctors and midwives from their cultural and linguistic background to support positive experiences.[34,36,45,57,60,63] These findings were congruent with health care providers who agreed about the importance of respect; however, they also highlighted various barriers limiting capacity to do so in their institutional role.[17,18,20,30,31,41,49,50,54,57,67,76]

Investment in Training and Resources to Promote RMC is Imperative

Health care providers emphasised the need to provide more resources to health care institutions and provide continuous training in respectful maternity care to enable appropriate practice environments.[20,34,56,64,68] Studies described an urgent need for improved resourcing – including medicine, equipment and other essential items – to provide quality maternity care to all women.[19,26,28,35,49] Public health care facilities were typically more challenged compared to private based on the available infrastructure, resources, support to staff and knowledge of respectful practice.[28,49] Women and family members further highlighted the issue of cleanliness, better food, medical supplies, promptness of providing care and attitude of the doctors and midwives.[35,53,59,64,74,75]

Policy and Legislative Changes Required to Enforce Equitable and Respectful Maternity Care Practice

Most studies reinforced the obligation of providing quality maternity care to all women with equity and respect regardless of age, ethnicity, religion, culture, socio-economic background and physical ability.[20,36,50,60,73,76] Providing women an opportunity to make choices about their childbirth was significant but not understood or practiced by the health care professionals.[19,59] Women and families believed that government has accountability to provide respectful care, but health care providers constantly highlighted the barriers to provide quality of care to women.[29,33,43,54,55,70]

It was clear that women's preference was dismissed in the institutional setting and women subsequently became victim of unnecessary clinical interventions.[17,29,43,54,67] Women from low socio-economic background received little attention from health care providers while receiving care.[17,21,31,35,50,59] The need for strong policy efforts were recommended as the way to mandate equitable and respectful care in a South Asian context.[20,36,60,62,78]

Facilitators and Enablers for RMC

Facilitators and enablers to enhance positive experiences to women in South Asia were identified as including support from families, friends, neighbours, relatives, Female Community Health Volunteers (FCHV)s and Traditional Birth Attendants (TBA)s,[3,36,41,50,52,57,63,67,73,74,79] having access to SBAs in the village,[26,38,43,50,52,57,63,67,73,79] supporting family members to take women to the birthing centre,[18,40,51,52,59,74] the provision of a caring, respectful and welcoming institutional

environments;[18,20,21,34,40,51,52,57,59,64] economic support to women to attend care,[27,28,30,78] involvement of female care providers to support birthing,[34,36,45,57,60,63] access to education and empowerment programs for women,[39,60,70] affordable services to all women;[18,27,35,51,59] shared understanding and trust between women and health care providers,[49,55,57,68] improved opportunities for women to be involved in discussion and decision-making process about their care,[24,57,63,67] enhancing peer-community support models of care;[18,41,52,56,70] ongoing training for staff on emerging issues.[20,34,56,64,68] The roles of midwives and FCHVs were seen as influential in determining women's experiences and ensuring their access to community-based services.[21,26,31,34,43,70,74,75]

Barriers to RMC

In summary, barriers to the provision of respectful maternity care included discriminations, disrespectful behaviour, rejection, abuse and exclusion of women in care,[19,25,30,36,37,44,49,54,56,57,59,60,65] lack of resources, services and access to SBA in rural areas,[26,42,49,51,52,60,70,73] medical and technological control of birth,[30,32,38,62] poor interpersonal and communication skills of providers,[34,49] consequences of low socio-economic status and lack of decision-making capacity of women,[19,24,33,51,53,56,58,61,67] different understandings and attitudes of care providers regarding women's care needs,[20,30,43] the burden of costs and transport access to health care services,[4,17,18,28,30,35,38,41,48,50,51,60] economic disadvantage, social norms, construct of gender and power in the society,[3,17,19,21–23,31,39,44,45,50,51,53,63] culturally inappropriate, physically unsafe and unwelcoming hospital environments,[28,30,40,57,75] poor quality of services in public settings,[21,27,28,30,44,50,52,55,61,80] lack of knowledge and resources to enable respectful services,[18,23,46,47,50,51,60–62,64,68] and lack of policy, leadership commitment and accountability of health system.[46,47,50,58,60–64]

Implications for Policy and Practice

Several studies discussed implications of their findings for evidence-based policies, transformative strategies and respectful professional practice.[20,77] The imperative of appropriate social policies, guidelines, supportive environment and resources to raise awareness about the concept of respectful maternity care was consistently highlighted.[20,21,24,36,41,43,49,81] Attention to prioritise the improvement of quality of care in health facilities was described.[17,19–21,27,28,30,39,77,78,81] Addressing systemic barriers requires considering the socio-cultural contexts of women while designing and providing care.[17–19,33,39,77]

Similarly, investment should be made to increase access to SBA and female care providers[18,19,21,24,26,35,41,43,49] with parallel efforts to enable women's access to education, services and economic opportunities.[17–19,21,26,35,39,79,81]

Several studies argued for improved leadership, commitment and accountability at the government level in order to improve the infrastructure, human resources, social capital and equitable coverage of services.[17,24,26,35,49,79]

The need for additional and continuing training and access to educational resources for health care providers about respectful maternity care was described as a crucial priority.[21,34,35,43,81] It was also recommended to involve women, families and communities in health service planning, policy development, service delivery and other decision-making process.[17,18,21,33,38,40,41,43]

Discussion

The findings of this scoping review draw voices of women, health care professionals, family members and other stakeholders to explore the current practice, facilitators, barriers and policy implications of providing respectful maternity care in South Asian countries. The review found consistent negative experiences of abuse, neglect and disrespect in institutional settings.

Emerging themes captured the experiences of women during pregnancy and childbirth and described the critical complexities of maintaining quality of care within often resource-limited circumstances. Health care providers felt unable to adhere with the norms of providing respectful maternity care to women due to gaps in their own knowledge and skills, resources, institutional supports, policy direction and clinical guidelines.

Vulnerable women and marginalised families experienced higher levels of abuse and discrimination while coming to hospital to receive care. Given the focus of maternity care now is on women centred model where decisions are made valuing the choices and preference that women make,[82–87] this puts women at further risks of marginalisation and raises a serious human rights issue of receiving equitable, quality and respectful care.

Studies in our review consistently described women avoiding institutional pregnancy care due to the fear of being misjudged, mistreated and abused in health care settings. Studies described examples of women lacking agency in decision-making processes about their care, where their choices or preferences were dismissed by the professionals who took control of the birthing process. This suggests a medical domination of care and oppression of women seeking care when fight to survival is critical. The impact of choice and control on women's childbirth experiences to determine safety has been consistently discussed from the perspective of giving power back to women to decide where and how they would like to give birth.[88–92] However, a lack of trust in health care provision was described where women had a fear of being victimised by their behaviour and actions. While hospitals took actions to ensure the physical safety of women and the newborn, the emotional safety of women needs further attention.[93,94]

Social, economic and cultural differences all played influential roles in the experience and provision of care. When women found providers shared similar cultural and religious backgrounds, their experiences of receiving care were typically positive. Similarly, influences of families, friends, neighbours and community-based lay care providers helped women to feel safe, supported and well looked after. The critical role that socio-economic factors play in determining pregnancy and birth outcomes has been the ongoing challenge for disadvantaged settings where maternal and perinatal mortality is still high.[95–99] The findings of this review strongly emphasise the significance of involving women, families, communities and service providers from the similar backgrounds to design and deliver culturally appropriate model of care.

The notion of care that women want and need to experience respectful maternity care in South Asia aligns well with the concept of collaborative care that many countries adopted to provide responsive services to their diverse and culturally rich community settings.[100–105] This review reaffirms that enforcing respectful maternity care practice in South Asia requires systematic actions across all levels of health care system. Health care providers mostly agreed on the principles and necessity of providing respectful maternity care, however it was often described as impractical in the current health system, social practice, institutional resources and policy environment. Other studies confirm that without taking appropriate policy actions, the challenges that each country is facing to ensure the safe pregnancy and birth outcomes will remain longer and women from diverse social and cultural backgrounds will continue face the barriers of accessing respectful and quality maternity care.[106–111]

In the context of limited supplies of resources including basic medicine, equipment, staff and lower benefits to the midwives providing care, maintaining welcoming hospital environment and providing quality care to women was considered not possible.

Strengths and Limitations

There is a lack of evidence to understand the current practice of respectful maternity care as a region in South Asia and the significance of enabling the respectful approach to ensure quality of care has not yet got enough attention. This review used a rigorous method for gathering evidence, synthesising data and assessing the validity of findings. The barriers and enablers drawn from experiences of women and others involved in providing care can be instrumental to strengthen relevant policies and respectful maternity care practice across the countries.

These findings cannot be generalised in all contexts of pregnancy, childbirth and postnatal experiences even in South Asia, as the culture, social and structural issues that women experience differ from one place to another. Given that most studies focused on health facility-based experiences from urban and semi-urban settings, there is a lack of insight specific to remote dwelling and other women who are disproportionately affected by social and health inequities. There were no studies found that that met the inclusion criteria from the Maldives, and limited information from Bhutan; thus, insights from these countries are limited and call for resourced research.

Our review focused on respectful maternity care within the context of health services: we acknowledge other factors that profoundly impact on decision-making, childbirth experience and maternal outcomes, particularly familial norms associated with husband and mothers-in-law relations, which in turn is mediated by gender equity (including intimate partner and in-law violence) and social determinants such as economic status and education.[112–117]

Conclusion

The provision of respectful maternity care is an imperative factor in supporting improved maternal and perinatal outcomes. Concerns and principles that challenge the provision of RMC in South Asian nations are associated with resource-challenged environments (particularly in rural settings), gender equity, educational status, health workforce awareness, education and resourcing, culture, economy and other social determinants. Many of these factors are consistent with other settings; however, they are experienced and expressed diversely in South Asian contexts related to the specific characteristics of individual countries, cultures, and economies.

Sustained improvements in RMC demand strong policy actions, political will and appropriate well-funded programs to provide a well-educated and adequately resourced health workforce and counter economic disadvantage and gender inequities, privileging women's choices and preferences.

Ethical Approval

Not applicable for review article.

Funding

No funding received.

Disclosure

The authors report no conflicts of interest in relation to this work.

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