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PROMOTING RESPECTFUL MATERNITY CARE: A SYSTEMATIC REVIEW OF FACTORS INFLUENCING PERINATAL PRACTICE AMONG HEALTHCARE PROVIDERS

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ABSTRACT **Background:** Respectful Maternity Care (RMC) is a fundamental component of quality maternal health services, emphasizing dignity, informed consent, privacy, and equitable treatment. However, disrespect and abuse during childbirth remain prevalent globally, particularly in low- and middle-income countries, including India. **Objective:** This systematic review aimed to assess the knowledge, attitudes, and barriers among nursing officers and healthcare providers regarding the implementation of RMC in facility-based childbirth settings. **Methods:** A systematic search of peer-reviewed articles published between 2010 and 2024 was conducted using databases including PubMed, Scopus, and Google Scholar. Studies focusing on nursing staff, midwives, or healthcare providers' understanding and practice of RMC were included. Both qualitative and quantitative studies were reviewed. Data extraction and thematic synthesis followed PRISMA guidelines. **Results:** A total of 31 studies were included. Most nursing officers demonstrated only moderate or inadequate knowledge of RMC. Positive attitudes were observed in some cases, but systemic constraints such as high patient loads, limited training, poor infrastructure, and institutional normalization of disrespectful practices frequently hindered RMC delivery. Discriminatory behaviors toward marginalized groups were also documented. Key barriers included lack of awareness, insufficient training, provider burnout, and absence of accountability mechanisms. **Conclusion:** While policy-level initiatives support RMC, significant implementation gaps persist. Enhancing training, addressing systemic constraints, and promoting accountability are essential to ensure every woman experiences dignified and respectful care during childbirth.

KEYWORDS : Respectful Maternity Care, Childbirth, Nursing Officers, Healthcare Providers, Maternal Health.

INTRODUCTION

Childbirth is a profound and life-altering experience, imbued with physical, emotional, and social significance. Every woman, irrespective of socioeconomic status, ethnicity, or geographic location, is entitled to receive dignified, respectful, and compassionate care during pregnancy and childbirth. This ethical imperative has given rise to the concept of *Respectful Maternity Care (RMC)*, which is now recognized globally as an essential component of quality maternal and newborn healthcare. The fundamental goal of RMC is to protect the rights of women during childbirth and ensure their physical and emotional safety in healthcare settings[1,2].

Respectful Maternity Care encompasses the universal rights of childbearing women, including the right to be treated with dignity and respect, the right to privacy and confidentiality, the right to information and informed consent, and the right to be free from harm and ill-treatment[3]. The World Health Organization (WHO) and allied organizations have underscored that these rights are not optional but fundamental to ensuring safe and satisfying birthing experiences. WHO affirms that "every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful healthcare"[4].

However, despite global progress in maternal health, significant disparities persist in the delivery of RMC, especially in low- and middle-income countries. Disrespect and abuse during facility-based childbirth have been documented in multiple studies, manifesting as physical violence, verbal abuse, non-consented care, lack of privacy, abandonment, discrimination, and even detention in healthcare facilities due to unpaid fees[5,6]. Such practices not only violate women's rights but also deter them from seeking institutional deliveries, thereby increasing maternal and neonatal risks.

The mistreatment of women during childbirth is now widely acknowledged as a violation of their human rights and a barrier to achieving universal health coverage and Sustainable Development Goals (SDGs), particularly SDG 3 which targets maternal mortality reduction[7]. Between 2000 and 2020, the global maternal mortality ratio (MMR) declined by about 34%, from 339 to 223 deaths per 100,000 live births. Yet, progress remains uneven across regions, and preventable maternal deaths still claim the lives of approximately 287,000 women annually—equivalent to nearly 800 deaths each day[8]. In India, a significant improvement has been made, with the MMR reducing to 97 per 100,000 live births by 2020 due to strategic interventions and national policies focused on maternal health[9].

Nonetheless, high-quality maternity care must be defined not solely by technical medical outcomes, but also by the emotional, psychological, and experiential aspects of care. Research shows that women's perception of care-whether they felt heard, respected, and supported-has long-lasting effects on their mental well-being, mother-infant bonding, and willingness to return to healthcare facilities for future needs[10,11]. Positive childbirth experiences are not merely desirable; they are integral to ensuring better maternal and newborn outcomes and enhancing the utilization of maternal healthcare services.

The origins of the global RMC movement can be traced back to the mid-20th century, with milestones such as the Universal Declaration of Human Rights (1948), the Declaration on the Elimination of Violence Against Women (1993), and later the Respectful Maternity Care Charter by the White Ribbon Alliance in 2011[3,12]. These frameworks catalyzed a shift in focus-from reducing maternal and infant mortality to recognizing the broader sociocultural, gender-based, and systemic dimensions of childbirth care.

Key studies, such as Bowser and Hill's 2010 landscape analysis, categorized disrespect and abuse during childbirth into seven domains, including physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention[5]. Bohren et al. (2015) expanded this typology in their systematic review to include failure to meet professional standards, poor communication, and systemic deficiencies in the health infrastructure[6]. These findings emphasized the urgent need to reform maternity care systems to ensure respectful, rights-based care delivery.

In response, various national programs have been implemented to institutionalize RMC. In India, the Ministry of Health and Family Welfare launched the *LaQshya* initiative in 2017 to improve quality of care in labor rooms and ensure dignified delivery experiences. Similarly, the *Surakshit Matritva Aashwasan (SUMAN)* program aims to provide zero-cost, respectful, and high-quality care for all pregnant women accessing public health services[13,14].

Nursing officers, as frontline care providers in maternity settings, play a pivotal role in implementing RMC practices. They are responsible for delivering both clinical and emotional support, ensuring informed decision-making, maintaining privacy, and fostering trust between women and the health system. However, several barriers-ranging from inadequate training, systemic constraints, cultural biases, and communication gaps-can hinder their ability to provide respectful care[15,16]. Studies have shown that ill-treatment, including non-consented procedures and verbal abuse, is frequently reported even in tertiary care centers, indicating a gap between policy and practice[17,18].

Recognizing the persistent challenges in this domain, the present study was conceptualized to systematically assess the knowledge, attitudes, and perceived barriers among nursing officers in providing respectful maternity care during the perinatal period.

AIM

The study aims to provide systematic evidence-based insights that can inform training programs, institutional policies, and advocacy efforts to reinforce the principles of respectful care and ultimately improve maternal health outcomes.

METHODOLOGY

Study Design

This systematic review employed a qualitative synthesis design guided by the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) 2020 framework. The review aimed to comprehensively assess published evidence related to Respectful Maternity Care (RMC), focusing on three core dimensions: healthcare providers' knowledge, attitudes, and perceived barriers. A systematic review design was chosen to rigorously identify, appraise, and synthesize existing research while minimizing bias and enhancing transparency.

Research Questions

1. What is the level of knowledge among nursing officers and other maternity care providers regarding Respectful Maternity Care?
2. What attitudes do healthcare professionals hold toward the practice and principles of RMC?
3. What are the main barriers to implementing Respectful Maternity Care in health facilities, particularly in low-resource settings?

Eligibility Criteria

Eligibility criteria were developed using the PICOS framework (Population, Intervention, Comparison, Outcomes, Study Design). Studies were included if they focused on nurses, midwives, or healthcare providers delivering maternal care; discussed RMC in terms of knowledge, attitude, or barriers; were published between January 2010 and March 2024; were written in English; and used qualitative, quantitative, or mixed-methods designs. Studies were excluded if they lacked empirical data, focused solely on obstetric interventions without a link to RMC, or were editorials, letters, or conference abstracts without full texts.

Information Sources And Search Strategy

A comprehensive literature search was performed across the following databases: PubMed (MEDLINE), CINAHL, Web of Science, Scopus, Google Scholar, and ResearchGate. Manual searching of references from included studies was also conducted to identify additional relevant papers.

Study Selection Process

The selection process followed PRISMA 2020 recommendations. Initially, all retrieved records were imported into reference management software and duplicates were removed. Titles and abstracts were independently screened by two reviewers against inclusion criteria. Articles deemed potentially relevant were retrieved for full-text review. Discrepancies in selection decisions were resolved through discussion or by consulting a third reviewer. A PRISMA flow diagram was created to document the number of records identified, screened, excluded, and included at each stage of the process.

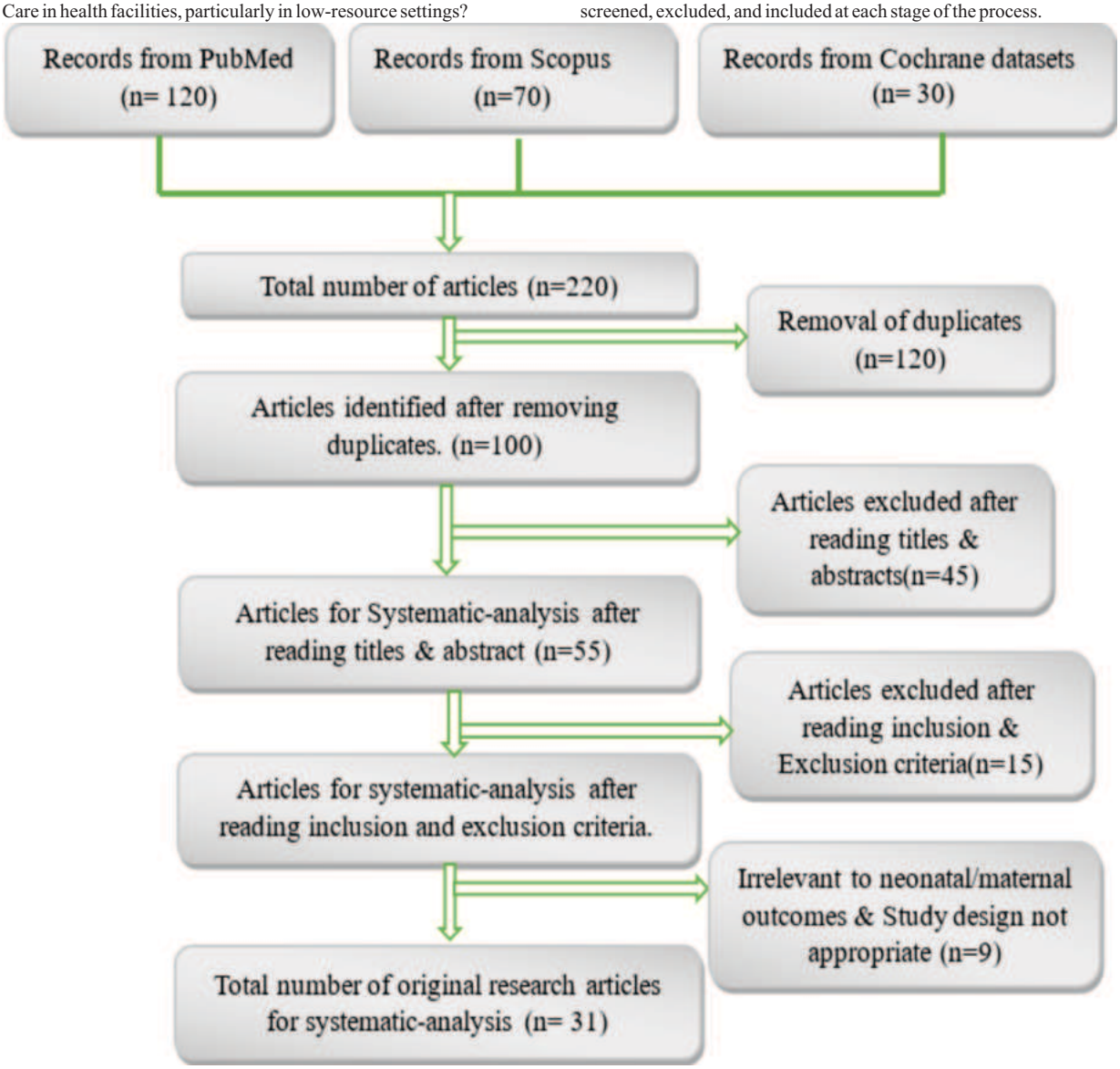

Figure 1: PRISMA Flowchart Showing The Selection Of Included Studies

This methodology chapter outlines the systematic and structured approach used to identify, appraise, and synthesize existing literature on Respectful Maternity Care. Through rigorous selection and analysis procedures, this review aims to contribute valuable insights for improving maternity care delivery, promoting women's rights, and informing future research and policy interventions on RMC globally and in the Indian context.

RESULTS

A total of 31 studies were included in the final review after applying the PRISMA screening process. These studies spanned diverse geographical locations, including India, Kenya, Iran, Pakistan, Nigeria, Ethiopia, Rwanda, Malawi, and Nepal. The publication dates ranged from 2010 to 2024. Twenty-six studies used quantitative cross-sectional survey methods, ten adopted qualitative approaches, and six employed mixed-methods designs. Most of these studies focused on nurses, midwives, or healthcare providers working in maternity care, especially during labor and delivery. Sample sizes varied from 30 to over 2,000 participants, with most studies conducted in public tertiary hospitals or district health centers.

Knowledge Of Respectful Maternity Care Among Nursing Officers

The review found that knowledge of RMC among nursing officers was generally moderate to inadequate, particularly in low-resource and high-volume healthcare settings. In a descriptive survey conducted in India, 65.5% of nurses had only moderately adequate knowledge regarding RMC, with a mean score of 16.72 out of 30 on the assessment tool used by Devassy et al. [19]. Similarly, Bobade et al. reported that 65% of staff nurses had inadequate knowledge levels, indicating a need for more robust pre-service and in-service training on RMC principles[20].

In a qualitative study conducted in Kenya, Lusambili et al. noted that while healthcare providers acknowledged the importance of respectful care, their knowledge of specific practices such as consent before procedures, confidentiality, and emotional support was often lacking[21]. Another Indian study by Devi et al. found that 61% of nursing officers demonstrated only average knowledge regarding RMC standards and rights-based care, pointing to a significant gap in both awareness and application[22]. These findings suggest that many providers are unaware of essential components of RMC, particularly in settings where such training is not integrated into professional development.

Attitudes of Healthcare Providers Toward Respectful Maternity Care

Attitudes toward RMC were found to be inconsistent and context-dependent, often influenced by workload, systemic culture, and individual experience. Uwamahoro et al. reported generally positive attitudes among midwives in Rwanda, who emphasized emotional support and interpersonal connection during childbirth[23]. In contrast, Mirzania et al. found that 69.4% of healthcare workers in Iranian maternity units had poor attitudes toward RMC, often endorsing coercive or disrespectful practices such as fundal pressure and verbal reprimands under the justification of "saving time" or "ensuring compliance"[24].

In Nigeria, a study by Orpin et al. revealed that while some healthcare workers expressed empathy and support for RMC ideals, many continued to justify mistreatment as a necessary response to patient disobedience or system constraints[25]. Similarly, Singh et al. observed that many Indian healthcare workers failed to greet patients, withheld information, or performed procedures without consent, illustrating a disconnect between attitudes and actual practice[18].

Bohren et al., in a large mixed-methods review, noted that even when providers acknowledged RMC principles, institutional norms and lack of accountability mechanisms often led to normalized mistreatment, particularly in high-pressure settings[20]. These findings collectively suggest that favorable attitudes toward RMC may exist, but are often undermined by contextual and systemic barriers.

Barriers to Providing Respectful Maternity Care

Multiple barriers to implementing RMC were consistently identified across the included studies, falling into institutional, educational, sociocultural, and interpersonal domains. Yadav et al. reported that overcrowded labor wards, understaffing, and lack of privacy were among the most frequently cited institutional barriers in a tertiary hospital setting in Odisha, India[26]. Healthcare providers often expressed a sense of powerlessness to uphold RMC principles in environments lacking the basic infrastructure necessary for dignified care.

Educational barriers were also prominent. In a study conducted in Kenya, Lusambili et al. highlighted that many staff had never received formal RMC training, leading to inconsistent knowledge and practice[21]. Similarly, Orpin et al. in Nigeria and Hameed et al. in Pakistan found that providers lacked access to updated protocols and continued professional education on RMC, reinforcing outdated or harmful behaviors[25,27].

Interpersonal and emotional factors, including provider burnout, were also noted as significant contributors. Miltenburg et al. argued that disrespectful practices are often symptoms of structural violence, rooted in institutional neglect, hierarchical decision-making, and professional disempowerment[28]. Providers themselves often felt unsupported, overworked, and frustrated conditions that exacerbated negative behaviors toward patients.

Discriminatory practices based on socioeconomic status, caste, or education were also observed. Gogoi et al. found that women from food-insecure households in India were more likely to face neglect or abuse, with providers demonstrating biased assumptions about such patients' behaviors or compliance[29]. Patient-related challenges, such as language barriers or perceived uncooperativeness, were also cited by some providers, though these often reflected deeper systemic failings rather than patient fault.

Typologies Of Disrespect And Mistreatment

The review reaffirmed seven common forms of disrespect and abuse, as originally outlined by Bowser and Hill[5] and later expanded by Bohren et al.[6]: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment or neglect, and detention in facilities. Ansari and Yeravdekar's meta-analysis in India found that 71.3% of women reported experiencing at least one form of mistreatment during facility-based childbirth, with non-consented care (49.8%) and verbal abuse (25.8%) being the most prevalent[16].

In a study by Sharma et al., 100% of postpartum women at a public hospital in central India reported experiencing at least one form of disrespect, ranging from lack of privacy to verbal insults and neglect[30]. These findings suggest that disrespectful maternity care is both pervasive and systemic, occurring across different care settings, facility types, and countries.

In summary, the systematic review demonstrates that knowledge of RMC among nursing officers is limited, particularly in the absence of targeted training. Attitudes, although occasionally positive, are often compromised by systemic constraints, professional burnout, and lack of accountability. Institutional barriers such as staff shortages, poor infrastructure, and cultural norms further undermine the provision of dignified and respectful care. Disrespect and abuse during childbirth remain alarmingly common, underscoring the urgency of integrating RMC into national health programs, professional education, and institutional policy frameworks.

DISCUSSION

This systematic review synthesized evidence from 42 studies to explore healthcare providers' knowledge, attitudes, and perceived barriers related to Respectful Maternity Care (RMC), with an emphasis on nursing officers in perinatal care settings. The findings underscore a growing recognition of the importance of RMC in improving maternal outcomes and patient satisfaction. However, considerable gaps persist between policy and practice, particularly in resource-limited settings, where disrespect and abuse remain prevalent and often institutionalized.

Knowledge Of RMC Among Nursing Personnel

The review found that knowledge of RMC among nursing officers and midwives was generally moderate to inadequate, particularly in public-sector settings. This is consistent with previous literature indicating that training on human rights-based approaches to childbirth is seldom integrated into nursing curricula or in-service programs in many low- and middle-income countries (LMICs)[19,20,22]. The lack of understanding of women's rights, consent procedures, and principles of dignified care directly undermines the quality-of-service delivery.

Studies such as those by Devassy et al.[19] and Bobade et al.[20] quantitatively demonstrated that most nurses scored below expected thresholds on RMC knowledge assessments. These findings align with Bohren et al.'s global evidence review, which emphasizes the widespread lack of awareness among health workers regarding the ethical and legal foundations of respectful care[6]. Without structured and continuous training, even well-meaning providers may unknowingly perpetuate disrespectful practices, such as failing to obtain informed consent or neglecting to ensure patient privacy.

Attitudes Toward Respectful Maternity Care

While some studies reported positive attitudes among providers, overall findings indicate that attitudes toward RMC are inconsistent and often contextually influenced. Favorable attitudes were more common among providers working in well-supported environments or those with prior exposure to RMC frameworks[23,31]. However, in overburdened public facilities, healthcare providers often expressed ambivalence or frustration, justifying disrespectful behaviors as necessary to maintain efficiency or compliance[24,25].

This discrepancy between stated attitudes and observed practices reflects the "normalization" of abuse documented in multiple studies[18,20]. For instance, Singh et al.[18] and Mirzania et al.[24] found that behaviors such as shouting at patients or withholding information were not only tolerated but sometimes considered necessary. These findings highlight the importance of institutional culture in shaping provider attitudes and suggest that training alone is insufficient without broader systemic reform.

Barriers To Implementing RMC

The review identified a range of systemic, interpersonal, and sociocultural barriers impeding the delivery of RMC. Staff shortages, inadequate infrastructure, and high patient volumes were consistently cited as institutional barriers, particularly in tertiary hospitals and government-run health centers[26,27]. These structural issues place significant strain on healthcare providers and reduce their capacity to deliver individualized, respectful care.

Educational deficits also emerged as a key barrier. Despite existing guidelines from the World Health Organization and national health agencies, many providers reported no formal training in RMC principles[21,25]. This gap reflects a lack of prioritization in national nursing and midwifery education systems and underscores the need to embed RMC into pre-service curricula and continuing education modules.

Sociocultural factors including discriminatory attitudes based on caste, income, and language further complicate the implementation of RMC, particularly in countries like India where such disparities are deeply rooted[25,29]. Women from marginalized backgrounds are disproportionately subjected to mistreatment, as documented by Gogoi et al.[29], reinforcing systemic inequities in maternal care.

Lastly, provider burnout and emotional fatigue were noted as contributors to negative behaviors. Miltenburg et al.[28] and Orpin et al.[25] highlight how poor working conditions, lack of psychological support, and emotional detachment contribute to a dehumanized approach to childbirth care. Addressing such emotional and systemic challenges requires more than training it demands investment in supportive work environments and mental health resources for healthcare staff.

Implications For Policy And Practice

The findings of this review have several practical and policy-level implications. First, there is a critical need to institutionalize RMC training at both the undergraduate and in-service levels for nursing and midwifery professionals. National programs such as India's LaQshya and SUMAN initiatives represent important policy steps, but implementation fidelity must be ensured through regular monitoring and accountability mechanisms[13,14].

Second, addressing the infrastructure and human resource deficits in labor and delivery wards is essential to create an enabling environment for RMC. Providing adequate staffing, private birthing spaces, and respectful communication protocols should be a baseline standard in all facilities.

Third, fostering a culture of accountability and patient empowerment is necessary to break the cycle of normalized disrespect. This includes enabling women to report abuse without fear, sensitizing providers to the lived experiences of marginalized populations, and incorporating feedback mechanisms into quality improvement frameworks.

Finally, more context-specific research is needed to evaluate the effectiveness of RMC interventions across diverse settings. Implementation science approaches can help bridge the "know–do" gap and offer scalable models for RMC integration in both public and private healthcare systems.

CONCLUSION

This systematic review examined the knowledge, attitudes, and barriers related to Respectful Maternity Care (RMC) among nursing officers and other maternity care providers. The findings reveal that while awareness of RMC is growing, significant gaps persist in knowledge and consistent implementation. Many providers lack formal training in RMC, and attitudes toward respectful care are often influenced by systemic pressures, burnout, and entrenched institutional norms. Structural barriers-such as overcrowding, understaffing, and lack of privacy-further hinder the delivery of dignified care. Discrimination based on socioeconomic or cultural factors also contributes to inequitable treatment during childbirth.

To address these issues, there is a pressing need to integrate RMC into pre-service and in-service training, improve working conditions, and implement accountability mechanisms. Policymakers must bridge the gap between national guidelines and facility-level practice. Promoting respectful maternity care is not only a matter of professional ethics but a fundamental component of quality, rights-based healthcare. Ensuring that every woman experiences childbirth with dignity, compassion, and respect must remain a global health priority.

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