



Figure 2. Geographical distribution of the contributing primary research countries in the analysis synthesis.

typology of RMC during childbirth developed from a synthesis of the qualitative evidence. The summary of findings and the CERQual assessments are presented in Table S3. Most studies explored the experiences of women; however, many studies also included family members, midwives, obstetricians, paediatricians, nurses, facility managers, physiotherapists, midwifery students, and hospital advisory committee members as respondents.

Qualitative synthesis

Twelve themes emerged from the qualitative synthesis that were relevant to providing a typology of RMC during

childbirth in health facilities. Many themes were homogeneous across country income levels and type of participants; we have indicated where any substantive heterogeneity existed. Key findings across themes are presented below.

Being free from harm and mistreatment

Both women and healthcare providers across countries referred to not using a loud voice when speaking to women, and having a warm and measured manner, as representing respectful care.^{22,23,25–27}

Support from midwives enabled women to feel safe.^{25,26,28–41} Women believed that their sense of security was facilitated by professional treatment,⁴² and by the availability of equipment and technologies.³² Health professionals believed that providing a safe and secure environment for women was part of humanised care.⁴¹

Maintaining privacy and confidentiality

Both women and healthcare providers across the world reported maintaining privacy and confidentiality as humanised care. Women expressed a need for privacy during physical examinations and procedures,^{26,43,45,54} by shielding them from visitors or other women,^{43,55} and male staff,^{24,44,48,51,52,56} and by limiting the number of staff,^{24,51,55} and attendants,^{36,48} who are present. Healthcare providers reported that they care about women's privacy.^{49,50,53}

Women in Malawi, Tanzania, and Nepal believed that maintaining confidentiality and 'secrets' about their health was a component of good-quality care.^{25,26,57}

Box 1. Twelve domains of respectful maternity care derived from the qualitative findings*

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

*These 12 domains are the 'third-order themes' from Table 2.

Preserving women's dignity

Women from diverse settings emphasised the importance of a positive atmosphere in the labour ward by feeling welcomed into the labour environment.^{22,26,28,35,39,45,48,55,59,60}

Women preferred healthcare providers that had kind attitudes, spent time with women, and were calm, tactful, warm, smiling, and caring.^{28–31,39,41,44,58,63–65} Women described their expectation to be treated as a person and not as 'processed things'.^{36,60,61} To be seen as an individual – with differences and peculiarities – was expressed by women and healthcare providers as being met with respect.^{31,41,51,53,56}

Respecting the cultures, values, and beliefs of women was highlighted by women and healthcare workers.^{34,41,49,51} Women, mostly Muslims, in different countries expressed their strong preference for having a female birth attendant during labour or birth.^{44,48,51,52}

Prospective provision of information and seeking informed consent

Women reported the need to receive information about the practice of labour, including breathing techniques, pushing, and relaxation techniques, as well as how to be prepared physically and psychologically to give birth.^{26,29,33,36,37,40,56,58,61} Healthcare providers reported that explaining the interventions that women were about to undergo was part of RMC.^{41,67}

Women believed that midwives should ask permission from women prior to undertaking potentially embarrassing procedures like vaginal examinations.^{24,44,54,56} Similarly, several multi-country studies highlighted the importance of informed consent as a component of RMC.^{49,53}

Ensuring continuous access to family and community support

Most women and some healthcare providers emphasised the importance of family attendance and presence of labour companions of choice,^{32,33,38,44,48,50,51,56,66,70,72,74} and valued it as every woman's right.^{36,39,40,64,65} Healthcare providers valued family interaction with the women and active involvement in their care.^{36,39,40,64–67,71} In Japan, the healthcare providers and women categorised some rules and regulations as barriers to humanising birth, such as the policies restricting labour companions.⁴⁹ The physical structure of the space was important for accommodating companions on the labour ward.^{59,75}

Enhancing the quality of the physical environment and resources

Both women and healthcare providers believed that providing comfortable, clean, and calming birth environments with restricted visiting hours were conducive to promoting RMC.^{22,27,36,49,51,53,55,62,64,65,67,68,73,77} Healthcare

providers in India and Brazil believed that to humanise birth they had to have better physical environments, including a waiting area, cleanliness, adequate bedding, and the regular supply of water and electricity, and medicines.^{55,56,78}

Women from several countries expressed the need for adequate access to medical and non-medical technologies, which they perceived as mechanisms to help them feel safe and reassured.^{26,51,76,79}

Providing equitable maternity care

The availability of services for all, regardless of age, ethnicity, sexuality, religion, or other subgroups, was highlighted,^{36,51,53,80} and treating all women equally was considered respectful.⁸¹ For example, several Somali-born immigrant women in Finland were pleased with the doctors' and nurses' attitudes and behaviours towards them.⁷⁶ In contrast, Somali immigrant women in Canada desired non-judgmental care, but reported experiences of cultural discrimination.⁴³

Engaging with effective communication

Both women and healthcare providers across the world emphasised the importance of effective communication as a key component of RMC. Women appreciated receiving verbal praise and encouragement during labour, and valued the emotional support that they received from midwives.^{24,26,34,35,41,45,51,57,58,61,66,76,82,83,86} Healthcare providers agreed that talking and listening to the women was a critical component of humanised care,^{65,67} and valued providing empathy to women.^{39,41,53,56,71,74}

Practicing and encouraging effective non-verbal communication was appreciated by women and midwives.^{29,31,48,58}

Immigrant women living in developed countries highlighted the importance of the availability of interpreters because of language difficulties, and appreciated having interpreters to translate and explain.^{53,76,84}

Respecting women's choices that strengthen their capabilities to give birth

Respecting women's choices and empowering them was discussed across multiple settings by women,^{29,45,55,66,72} and by health professionals.^{31,49,64,65,67} Providing an opportunity for women to make decisions regarding their childbirth process was influenced by cultural contexts. Healthcare providers in Japan and women in South Africa reported that women were likely to obey the decisions made by others,^{49,61} whereas in the USA, Canada, Sweden, Norway, China, Australia, Taiwan, Tanzania, and Iran women expressed strong desires to be involved in decision making.^{26,28,29,33,41,45,46,49,73,81,87} Midwives believed that being a good advocate was based on ensuring that women are involved in decision making,^{51,53,70} and considering the

women's right to choose and participate in the decision-making process.^{36,41,65}

Encouraging free mobilisation and allowing a preferred position for birth was stated as part of humanised care by women,^{45,52,62,66} and by healthcare providers.⁶⁴

Availability of competent and motivated human resources

Both the proficiency and the adequacy of staff were reported as being important in providing RMC.^{28,69} Midwives' professional knowledge and competence were considered essential by women for developing a trusting relationship.^{31,35,43,80}

The use of guidelines and protocols was discussed as potentially diminishing women's dignity in the UK by midwives, as they felt under pressure to demonstrate their compliance with guidelines.⁵³ The need to gain knowledge on RMC was discussed in several studies, predominantly by healthcare providers.^{49,57,64,69,75} Supportive supervision from managers was needed to provide RMC.⁶⁵

Provision of efficient and effective care

Many women believed that a natural birth with minimal interventions was healthiest for themselves and for their baby,⁶⁶ and they often wanted fewer interventions than they had received.^{36,43,53,87} Healthcare providers in Benin believed that they should support and respect decisions made by women, and considered birth as a physiological process that does not necessarily require intervention.⁶⁷

Women expected healthcare providers to prevent unnecessary painful interventions (e.g. minimising the use of a urinary catheter, vaginal examinations, and episiotomy). Healthcare providers believed that providing pain relief was a component of respectful care.^{25,26,36,37,41,45,58,62,68,72–74,86,88}

Women in the UK, Sweden, Italy, and Tanzania also highlighted that maternity care should be available with minimal delay.^{26,30,37,51}

Continuity of care

Being cared for by a familiar midwife was valued by women across the world.^{28,36,38,46,47,49,62,66,88} The continuous presence of staff during and after childbirth was reassuring for most women and was requested by them.^{25,33,34,36,69,70,73,85} Some nurses in Canada described humanised birth as 'being with the woman and being available on demand'.⁴¹

Being with their babies in the facility was a stated desire for women across the globe.^{40,73,78,79}

Discussion

Main findings

The findings of 67 qualitative studies on the views of women, healthcare providers, and other stakeholders on

what constitutes RMC were largely consistent globally. The emerging themes were used to develop a typology of RMC during childbirth in health facilities to inform further work in this important area.

Our review showed that women living in high-income countries (HICs) tended to emphasise their rights to decision making and to active participation in their childbirth. Comparatively, women in lower-income countries were less likely to expect personal choice and decision making over their childbirth experience. This may be attributable to differences in cultural norms around childbirth, or it could be that women in lower-income countries were not empowered to make their own decisions. Globally, healthcare providers consistently identified the necessity of raising awareness about RMC; however, it was often described as a hard-to-reach target, in the face of legal and cultural pressures, particularly within cultures of blame for poor outcomes, defensive medical practices, and an over-emphasis on documentation rather than quality of care.⁵³ Healthcare providers also expressed the view that academic curricula mostly focus on biomedical care, to the exclusion of humanistic aspects of care.

Strengths and limitations

To our knowledge, this is the first attempt to use an evidence-based approach to develop a typology for RMC. This study used rigorous methods for synthesising and assessing the confidence of review findings.¹⁴ The typology can inform further work on developing evidence-based definitions of how women experience RMC in facilities during childbirth, and how this can be measured.

These findings cannot necessarily be generalised to home birth by trained birth attendants. Moreover, new quantitative studies may add additional information related to factors affecting RMC. Two studies were excluded because of language limitation; we consider it unlikely that this has affected the overall findings.

Interpretation (findings in light of other evidence)

Respectful maternity care (RMC) is a topic of growing attention around the world. Several recent studies have aimed to develop tools, and/or promote RMC, through applying various forms of interventions.^{89–91} A strong theoretical base is needed to inform the further development and validation of measurement tools.

This QES contributed to the framing and development of recommendations in the forthcoming WHO guideline 'WHO recommendations on intrapartum care for a positive childbirth experience'. The domains of WHO's quality of maternal and newborn care are supported by this review.^{17,92} This review further highlighted the importance of more specific themes under the domains in the WHO framework, however, including: being free from harm and