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Research Article

Perception of Women Regarding Respectful Maternity Care during Child Birth, Minia, Egypt

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Abstract

Background: Respectful maternity care is a critical component of quality obstetric services, yet many women continue to face mistreatment during facility-based childbirth. Understanding women's perceptions and experiences during labor and delivery is essential for improving the quality of care and maternal outcomes. **Aim of study**: To determine perception of services received and experience of women seeking maternity care during facility-based childbirth. **Methods:** A cross-sectional community-based study was conducted during the period from November 2018 to May 2019 in a rural area in Minia governorate. A total of 622 women who have a youngest child aged 2 years or less, were participated in this study. Well-structured questionnaire consisted of two parts; 1) Demographical data: age, marital status, educational status, occupation, date of hospital admission, and labor site. 2) Dignity related: included question related to three dimensions; hospital environment and privacy, personal communication, and the processes delivery. **Results:** Nearly 48% of the studied women experienced a disrespectful maternity care. The privacy during maternity care was undermined in more than half (56.3%) of studied women. The mean score of total dignity was 36.004±6.2 and the range of total score varies from 21 to 69. There was significant relation between disrespectful maternity care and increasing mother age and lower education. **Conclusion:** The results showed high levels of perceived disrespectful maternity care in postpartum women. Therefore, appropriate interventions, such as encouraging spouses' presence and training obstetric residents and midwives by holding ethics classes, with particular emphasis on empathy with patients.

Key words: Postpartum, Labor, Maternity Care, Respect.

Introduction

Women's experiences throughout pregnancy and childbirth are life-changing. when their friends, family, and various national sectors provide them with social, emotional, financial, nutritional, and public support. Safe motherhood should respect women's basic human rights, including their dignity, choices, and preferences throughout the maternity care journey, in addition to preventing morbidity or death **(WHO, 2012).**

Since many women give birth without receiving considerate or respectful care, an effective and functional health system is necessary to ensure that all women receive dignified medical care (**Pathak and Ghimire, 2020**). Respectful Maternal Care (RMC) **(Shakibazadeh et al., 2018)** is a method of providing high-quality care that prioritizes the fundamental rights of women, infants, and families.

Disrespect and abuse in maternity care include physical and verbal abuse, as well as degrading treatment. This can happen both in a systemic way (because of problems in the environment) and one-on-one (because of healthcare workers). Women who are pregnant or who are about to become pregnant often face seven main

types of disrespect and abuse during maternity care: non-consented clinical care, non-confidential care, non-dignified care (including

verbal abuse), discrimination based on patient characteristics, abandonment or denial of care, and detention in facilities **(Freedman and Kruk, 2014)** It is terrible to be rude to women before, during, and after giving birth **(Freedman et al., 2014).**

Respectful, inclusive, and high-quality healthcare should be provided to women. Even though they may not always be able to deliver it due to workload or resource limitations, healthcare providers acknowledge that respectful care is a crucial component of safe, high-quality care (**WHO, 2016; Vogel et al., 2016) .**

The significance of women's rights during pregnancy and childbirth was highlighted by WHO's attention to disrespect and abuse during childbirth **(WHO, 2018).** According to the World Health Organization, women who give birth in a medical facility should be guaranteed that they will be treated with respect and dignity **(Asefa, 2015, Bohren et al., 2015).**

The World Health Organization released a statement on stopping mistreatment of women during pregnancy and childbirth, including disrespect and abuse in health facilities **(Pathak and Ghimire, 2020),** and there is evidence that women's past birth experiences have a significant influence on their choice of future birth settings **(Malatji and Madiba, 2020).** Programs to provide high-quality health services and respectful maternity care are supported by governments (**Pathak and Ghimire, 2020).**

Twelve domains of RMC **(Shakibazadeh et al., 2018)**

- No harm and mistreatment
- Having privacy and confidentiality
- Protect women’s dignity
- Seeking informed consent
- Family and community support
- Achieve quality of physical environment and resources
- Equitable maternity care
- Effective communication
- Respecting women’s choices to give birth
- Availability of competent and motivated human resources
- Provision of efficient and effective care
- Continuity& persistence of care

A culture of uncertainty around childbearing is exacerbated by women's frequent sharing of their recollections of their birthing experiences with other women. The purpose of the current study is to ascertain the prevalence and correlates of perceived disrespectful maternity care among a group of Egyptian women, as there is a relative dearth of official research on the subject.

Objective of the study:

This study seeks to understand how women perceive respectful maternity care (RMC) during childbirth in healthcare facilities located in Minia, Egypt, with a special focus on the elements that influence feelings of dignity and respect.

Specific Objectives:

1 -To assess how the physical environment of healthcare facilities affects women’s sense of dignity and comfort during labor and delivery.
2 -To examine provider behaviors and interpersonal interactions that shape women’s experiences of respect, support, and emotional safety during childbirth.
3- To identify specific care practices and protocols that enhance women’s perceptions of being treated with dignity and respect during labor and birth.

Patients and Methods:

A cross-sectional community-based study was conducted during the period from November 2018 to May 2019 in a rural area in Minia governorate that was chosen by a multistage random sample as Minia governorate was found to be divided into 9 districts from which Minia district was chosen randomly then Minia district was found to be divided into villages from which a village (Sawada) was chosen randomly .

Study population

Participants were chosen by a systematic random sample from the village (the 1st house was chosen randomly then every 3rd house) .

The sample size was calculated using EP Info version 2000. A total of 622 women who have a youngest child aged 2 years or less, were participated in this study.

Inclusion criteria:
-Women who agreed to participate in the study.
-Women who have a youngest child aged 2 years or less.

Exclusion criteria:
-Women who refused to participate in the study.
-Women who have a youngest child aged more than 2 years.

Data collection
Data were collected by using well-structured questionnaire completed by well-trained nurses under researcher observation during face-to-face interviews with the mothers. A pilot study was conducted on 30 women and the results were included in the study. The questionnaire was developed by the researchers and consisted of two parts;
1) Demographical data: This part included questions about socio demographic data such as age, marital status, educational status, occupation, date of hospital admission, and labor site.
2 (Dignity related included question related to three dimensions; hospital environment and privacy, personal communication and the processes delivery.

**Hospital environment and privacy
Mothers were questioned to evaluate if the location supported privacy and confidentiality, improved communication, and was hygienic for delivering labor and care. This was in line with objective number one: “To investigate the perspective of women on factors that influence dignity in relation to the physical environment of a health facility ”.

The mothers were questioned about their dignity and surroundings. They were asked if they experienced labor and delivery in a private room that ensured maximum privacy, as well as whether their beds were shielded to enhance privacy. All participants were also inquired if their medical history and personal questions were taken in a private setting where they felt comfortable discussing their personal matters. They were asked if they had access to a functional and clean bathroom and toilet. These inquiries aimed to assess if the women were treated with the respect that they deserved as human beings. Having access to a clean and operational bathroom, toilet, and washing area would reflect a form of respect that could uphold their dignity. They were questioned about the cleanliness of their labor and delivery room and bathroom to ascertain if they were offered a safe and hygienic environment.

** Personal communication
The analysis regarding dignity and individuals aligns with the second objective: to pinpoint the behaviors and attitudes that affect dignity in care from the women's perspective. The questions focused on how the women perceived the treatment they received and their overall experience during their stay at the healthcare facility. These included queries related to communication, attentiveness, and responsiveness.

**Processes delivery:
In this study, the term "processes" refers to how care activities and dignity were examined concerning the third objective: to determine care processes that affect dignity from the perspective of women.

The women were inquired about whether the medical personnel clarified all procedures prior to execution, if they provided explanations regarding treatments and their alternatives, and whether their views were considered.

Dignity scoring system. A validated tool containing 24 items related to three dimensions of dignity: hospital environment and privacy received, communication of hospital personnel and process of care delivery .

Some of responses measured by yes and no where the positive answered given 1 and negative given 0. Responses are evaluated on a 3-point scale with ratings of never (1), sometimes (2), and always (3). Consequently, a higher score for each question indicates better preservation of dignity. The score was transformed into a scale from 0 (lower) to 100 (higher), those women who scored 50 or more transformed score were categorized as “experienced RMC” and those women who scored less than 50 were categorized as “not experienced RMC.” **(Pathak and Ghimire, 2020).**

Ethical consideration

An approval was taken from the research ethical committee of the authors' institution and the local council of Sawada village to interview the participants. Following the ethical guidelines of epidemiological research, a written informed consent was taken from each participant.

Statistical analysis

The Statistical Program SPSS for windows version 21 had been used in data analysis. Quantitative data were presented as mean and standard deviation; qualitative data were presented as frequency distribution. Kruskal Wallis test for comparison of total dignity mean scores based on demographic profiles and its related factors was used. Linear regression analysis was used to detect the most demographic variables affecting total dignity scores. Statistical significance was set at $p < 0.05$.

Results

This study included 622 female participants; their age ranged from 18-53 years with mean age 27.9±6.8 year.

Table 1, showed the demographical profile of participants; a high percentage (80.7%) were in age group from 21-40 year. Majority of them (98.1%) were married and 28.3% had secondary education. The majority of participants were not working (92.8%) and about half (57.9%) of them had 3-5 child. Regarding labor site more than one two third (74.8%) of participant had their delivery in hospital, 17.5% in private clinic and the lowest rate in home (6.1%) and primary health care ,(%1.6)

Privacy

As shown in (table 2), the privacy during maternity care was undermined in more than half (56.3%) of studied women. About 33.6% had their history taking and personal questions in presence of others. 83.1% have screened bed .

Cleanliness

Cleanliness was considered as a sign of respect by patients. The majority of the postnatal mothers utilized a clean delivery room, while 26% did not give birth in such a room and 6.3% lacked access to a clean and functioning bathroom.

Communication

Table (2) indicated that 34.7% of the mothers did not receive guidance or accompaniment to the labor ward. More than half of women said that medical staff didn't introduce them self, 41.5% of mothers never greeted before procedure, 20% of the mothers did not meet an attention during labor and delivery .

The medical staff sometimes (14%) or never (20.4%) listened to the women carefully. Almost 14.1% of mothers did not receive help as soon as they required it. More than one third (39.1%) of women were never asked about their needs. More than two third (76.8%) of women pinched during delivery. 14% of the mothers were asked to clean the delivery bed and to mop the floor.

Dignity and processes

Approximately 37.6% of women reported that the staff never provided explanations of all the procedures prior to performing them. 22% did not receive explanations regarding their treatment and available alternatives, while 23.4% were consulted about their opinions at some point during labor and delivery.

Table 3 indicated that the average score for overall patients' dignity was 36.004±6.2, with total scores ranging from 21 to 69. There was significant relation between non respectful care and increasing mother age; 51.9% of women more than 25years old experienced non-RMC compared to 48.1% of less than 25 years (OR= 1.4, p=0.02) .

Regarding education level; participant with lower education (49.5%) were more likely to experience non-RMC than higher education (26.2%) and this difference was statistically significant (p=0.004*, OR=2.07). Those with child number more than 3 were significantly (p=0.04*) exposed to non-RMC than others.

Participants had delivery in private clinics had the highest RMC than others (75.2%), delivery in general hospitals expose the participant 3.7 times for non-RMC than others (p=0.001*) .

None married and house wife mothers had more frequency to experience non-RMC more than others put these differences were not significant.

Table 4 shows more than two third (478, 76.8%) of the studied participants reporting physical violence. Women with greater odds of

physical violence have characteristics of young age (OR=1.4), married status (OR= 1.6), lower education (OR=1.5), not working (OR=1.08), lower parity (OR=1.5) and MCH site of delivery (OR=1.3).

Table (1): demographic character of the studied participants (n=622):

Variable	No	%
Age (years):		
≤25	297	44.9%
>25	343	55.1%
Marital state		
Married	610	98.1%
Not married	12	1.9%
Education		
Illiterate and read and write	272	43.7%
Primary	132	21.2%
Secondary	176	28.3%
College	42	6.8%
Occupation		
House wife	577	92.8%
Working	45	7.2%
Labour sites		
Hospital	465	74.8%
Clinic	109	17.5%
Home	38	6.1%
Primary health centre	10	1.6%
Child number		
<3	244	39.2%
≥3	378	60.8%

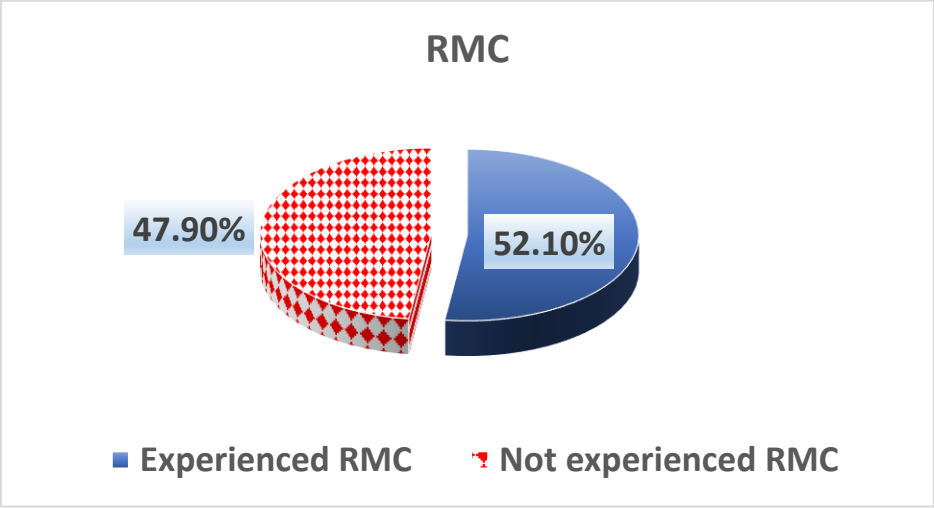

Figure 1: Perceived respectful Maternity Care

Table (2): Perception regarding respectful maternity care among respondents (n=622):

RMC items		No	%
Labor room	In a separate room with other women	272 350	43.7% 56.3%
Bed screened	Screened Not screened Partly screened	517 103 2	83.1% 16.6% 0.3%
Bed covered	Never Some times Always	84 90 448	13.5% 14.5% 72%
History taking and personal questions	Private room In the presence of others	413 209	66.4% 33.6%
Private Bathroom	Yes No	521 101	83.8% 16.2%
Toilet	Functioning Not Functioning Functioning but dirty	505 39 78	81.2% 6.3% 12.6%
Room cleaning	Never Some times Always	162 377 83	26% 60% 13.3%
Point of entry escort	Never Always	216 406	34.7% 65.3%
Staff introduce them selves	Never Some times Always	331 29 262	53.2% 4.7% 42.1%
Greeting you with name	Never Some times Always	258 101 263	41.5% 16.2% 42.3%
Exposed unnecessarily	Never Some times Always	519 85 18	83.4% 13.7% 2.9%
careful listening	Never Some times Always	127 87 408	20.4% 14% 65.5%
Asking about needs	Never Some times Always	243 156 223	39.1% 25.1% 35.9%
Pinched	Never Some times	144 478	23.2% 76.8%
Provided assistance as soon as needed	Never Sometimes Always	88 223 311	14.1% 35.9% 50%
Asked to clean delivery bed	Yes No	91 531	14.6% 85.4%
Asked to Mop	Yes No	91 531	14.6% 85.4%
Asked to clean bed coverage	Yes No	86 536	13.8% 86.2%
Asked to pay tips	Yes No	297 325	52.3% 47.7%
Procedure explained	Never Some times Always	234 191 197	37.6% 30.7% 31.7%

Treatment and its alternative explained	Never Some times Always	137 145 340	22% 23.3% 54.7%
Opinion sought	Never Some times Always	159 249 214	25.6% 40% 34.4%

Table (3): Relation between demographic character of the studied participants and respectful maternity care (RMC) (n=622):

Variable	**RMC No=324 n (%)**	**Non-RMC No=298 n (%)**	**Total No=622**	**χ^2 p value**	**Odds ratio (95% CI of OR)**
Age (years):					
≤25	159(57%)	120(43%)	297	4.8	Reference
>25	165(48.1%)	178(51.9%)	343	0.02*	1.4(1.04-1.9)
Marital state					
Married	318(52.1%)	292(47.9%)	610	0.02	Reference
Not married	6(50%)	6(50%)	12	0.8	1.08(0.34-3.4)
Education					
≤secondary level	293(50.5%)	287(49.5%)	580	8.5	2.07(1.3-5.5)
> secondary	31(73.8%)	11(26.2%)	42	0.004*	Reference
Occupation					
Working	27(60%)	18(40%)	27	1.2	Reference
House wife	297(51.5%)	280(48.5%)	577	0.2	1.4(0.7-2.6)
Child number					
<3	139(57%)	105(43%)	244	3.8	Reference
≥3	185(48.9%)	193(51.1%)	378	0.04*	1.3(0.9-1.9)
Labor site				40.2	
Home	27(71.1%)	11(28.9%)	38	0.001*	1.2(0.54-2.8)
PHC	7(70%)	3(30%)	10		1.3(0.31-5.3)
General Hospital	208(44.7%)	257(55.3%)	465		3.7(2.4-6.01)
Private clinic	82(75.2%)	27(24.8%)	109		Reference
Total dignity score					
Range	36-69	21-35	21-69		
Mean ±SD	40.8±4.04	30.7±3.1	36.004±6.2		

RMC (respectful Maternity Care), χ^2= chi square, OR Odds ratio, *= significant

Table (4): labor residence and exposure to physical violence among the studied participants (n=622):

Variable	**No Physical violence exposure No=144 n (%)**	**Physical violence exposure No=478 n (%)**	**χ^2 p value**	**Odds ratio (95% CI of OR)**
Age (years):			4.9	
≤25	54(19.4%)	225(80.6%)	0.04*	1.4(1-2.1)
>25	90(26.2%)	253(73.8%)		Reference
Marital state			0.7	
Married	140(23%)	470(77%)	0.3	1.6(0.4-5.6)
Not married	4(33.3%)	8(66.7%)		Reference
Education			1.5	
Up to secondary level	131(22.6%)	449(77.4%)	0.2	1.5(0.7-3.4)
More than secondary	13(31%)	29(69%)		Reference

Occupation			0.04	Reference
Working	11(24.4%)	34(75.6%)	0.8	1.08(0.5-2.1)
House wife	133(23.1%)	444(76.9%)		
Child number			4.1	1.5(1.01-2.2)
<3	46(18.9%)	198(81.1%)	0.04*	Reference
≥3	98(25.9%)	280(74.1%)		
Place of labour			14.9	1.3(1.03-1.7)
Home	11(28.9%)	27(77.1%)	0.002*	
MCH	0	10(100%)		
General hospital	121(26%)	344(74%)		
Private clinic	12(11%)	97(89%)		

Discussion

Privacy

Privacy as documented by the participants experiences was not maintained in more than half (56.3%) of cases during childbirth, where 33.6% reported that the history taking and the related personal questions have been asked for in the presence of others. Abuya, et al. 2015 who studied prevalence of disrespect and abuse during childbirth in kenya and Freedman et al. 2014 who studied disrespect and abuse of women in childbirth have found that as many as 19% to 28% of women will experienced disrespectful and/or abusive treatment from health providers in healthcare facilities during childbirth in low- and middle-income nations.

This finding was also in agreement with Chigwenembe et al., 2011 who studied Dignity in maternal health care service In Southern Malawi and found that 32% of the postnatal mothers 'privacy was not maintained. Their labor and delivery beds were partly screened (12%) or not screened at all (20%). A study conducted in India, women complained of being exposed, that they were examined and delivered in crowded places where curtains or blinds were not used regularly to shield women during the procedures (Hulton et al 2007). Banks et al. 2018 who studied prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia found Disrespect and abuse experienced by 83.9% of the studied women .

Cleanliness

Cleanliness was regarded as a sign of respect by patients. In this study, the majority of the

postnatal mothers used a clean delivery room, 26% did not deliver in a clean room and 6.3 % were not provided with a functioning and clean bathroom. Chigwenembe et al., 2011 found that 33% did not deliver in a clean room and 10% were not provided with a functioning and clean bathroom.

Communication

The current study shows that 34.7 % of the mothers were not given directions to the labor ward. These finding was in agreement with Chigwenembe et al., 2011 who found the same by 34.1%, maternity entrances need to have understandable directions that can help one arrive to the unit. They need to have an information desk with members of staff that are helpful over 24 hours .

More than half of women said that medical staff didn't introduce them self, 41.5% of mothers never greeted before procedure, 20% of the mothers did not meet an attention during labor and delivery. The medical staff sometimes (14%) or never (20.4%) listened to the women carefully. Nearly 14.1% of the mothers were not given assistance as soon as they needed the help.

More than one third (39.1%) of women were never asked about their needs and (76.8%) of women pinched during delivery, 14% of the mothers were asked to clean the delivery bed and to mop the floor. Bohren, et al. 2015 have also developed an evidenced based mistreatment to include physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standard of care, poor rapport between women and providers, and health system conditions and constraints. To facilitate communication and provision of appropriate care, the postnatal mothers must be asked about their needs and wellbeing, in

communication with patients, to neglect their needs is to fail to maintain dignity in care (Matiti et al. 2007). Clark indicates that maintaining dignity is not a science, but relies on understanding, and having empathy and compassion (Clark, 2010), which is manifested in the act of listening attentively and carefully.

Dignity and processes

The finding of current study revealed that 37.6% of women reported that care-providers never explained to them any of the procedures before carrying it out, and 22% of them not provided an explanation for the needed treatment and available alternatives, whereas 23.4 % were inquired about their opinions at a certain stage during delivery. Sufficient Explanations and provision of related information are important for women to make decisions with the feeling of their own control on their situation (Baillie, 2007). Hulton stresses the importance of explanations that, whether or not a woman in labor clearly understands what is happening, why, and any specific instruction, it will determine her subsequent behavior (Hulton, 2007).

The current study shows that 47.9% of the studied participants confronted with disrespectful treatment during hospitalization. Hajizadeh et al., 2020 who studied perception of Women regarding Respectful Maternity Care during Facility-Based Childbirth found that majority of the women reported one or several types of perceived disrespectful maternity care. Pathak and Ghimire, 2020 found that participants experienced disrespectful care in various forms such as being shouted upon (30.0%), being slapped (18.7%), delayed service provision (22.7%), and not talking positively about pain and relief during childbirth (28.0%). Ogunlaja et al., 2017 who studied "Respectful Maternity Care in South West Nigeria, found that majority of respondents experienced disrespect and abuse during maternity care.

Rosen et al., 2015 who studied direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa found that inadequate interpersonal communication by providers, abandonment and delays in care including a lack of routine monitoring, inadequate privacy protection, and in some cases, physical and verbal abuse. Provider communication and information sharing skills were lacking during the study and prevented women from fully realizing their right to information, informed consent and refusal, and respect for their choices and preferences. Many women did not have procedures or the labor process explained to them and did not hear about the findings of exams .

The results of this study showed significant relation between non respectful care and increasing mother age; 51.9% of women more than 25years old experienced non-RMC compared to 48.1% of less than 25 years (OR= 1.4, p=0.02) .

Regarding education level; participant with lower education (49.5%) were more likely to experience non-RMC than higher education (26.2%) and this difference was statistically significant (p=0.004*, OR=2.07). Those with child number more than 3 were significantly (p=0.04*) exposed to non-RMC than others (51.1% vs 43% respectively, OR=1.3) .

Participants had delivery in private clinics had the highest RMC than others (75.2%), delivery in general hospitals expose the participant 3.7 times for non-RMC than others (p=0.001*)

None married and house wife mothers had more frequency to experience non-RMC more than others put these differences were not significant. Pathak and Ghimire, 2020 found that higher age (OR= 1.08), high parity (OR=1.3) related to perceived disrespectful maternal care. Being unmarried, poor socioeconomic status, women with HIV, higher parity, and childbirth complications have been related with higher levels of disrespectful maternity care (WHO, 2018 and Abuya T, 2015).

The current study shows more than two third (478, 76.8%) of the studied participants reporting physical violence. Women with greater odds of physical violence have characteristics of young age (OR=1.4), married status (OR= 1.6), lower education (OR=1.5), not working (OR=1.08), lower parity (OR=1.5) and MCH site of delivery (OR=1.3). These findings approximate what founded by Mihret, 2019 who studied Obstetric violence and its associated factors among postnatal women in a

Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia and found that three in four (75.1%) women reported that they had been subjected to at least one form of obstetric violence during labor and delivery. The reported forms of obstetric violence include non-consented care (63.6%), non-dignified care (55.3%), physical abuse (46.9%), non-confidential care (32.3%, neglected care (12.7%) and discriminated care (9.3%).

Conclusion:
This analysis identified insufficient communication and information sharing by providers as well as delays in care and abandonment of laboring women as deficiencies in respectful care. The results showed high levels of perceived disrespectful maternity care in postpartum women. Therefore, appropriate interventions, such as encouraging spouses' presence, increasing the number of night shift staff, and training obstetric residents and midwives by holding ethics classes, with particular emphasis on empathy with patients.

Respectful maternity care should be integrated into the education of health professionals involved in obstetric and newborn services, alongside the training of community health workers, while also raising community awareness regarding the significance of respectful care during childbirth. Furthermore, it is crucial to create channels that allow women to confidentially report any instances of mistreatment.

References

1. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N and Warren E. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC Pregnancy and Childbirth. 2015; 15(224); 2-14.

2. Asefa, A.; Bekele, D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reprod. Health. 2015; 12, 33.

3. Bohren, M., Vogel J., Hunter E., et al., . The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. PLoS Med. 2015;12: e1001847.

4. Chigwenembe, L., Sundby, J., Maleta, K., & Thorsen, V. (2011). Dignity in maternal health service delivery: Cross-sectional survey on factors that promote or compromise dignity in maternal health service delivery. Master's thesis, Institute of Health and Society, Department of Community Medicine. Retrieved from https://www.duo.uio.no

5. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. Lancet. 2014; 384(9948):e42–4.

6. Freedman L, Ramsey K, Abuya T, Bellows B, Ndwiga C, Warren E , Kujawski S Moyo W, Kruk M, Mbaruku G. Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. Bull World Health Organ. 2014;92(12): 915–917.

7. Hajizadeh K, Vaezi M, Meedya S, Mohammad S, Charandabi A and Mirghafourv M. Prevalence and predictors of perceived disrespectful maternity care in postpartum Iranian women: a cross-sectional study. BMC Pregnancy and Childbirth 2020;20(463): 2-10

8. Hulton L Matthews Z and Stones R. Applying a framework for assessing the quality of maternal health services in urban India. Social Science & Medicine 2007; 64(10): 2083-2095.

9. Malatji R and Madiba S. Disrespect and Abuse Experienced by Women during Childbirth in Midwife-Led Obstetric Units in Tshwane District, South Africa: A Qualitative Study Int. J. Environ. Res. Public Health, 2020;17(3667): 2-14.

10. Mihret M. Obstetric violence and its associated factors among postnatal women in a Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia. BMC Research Notes. 2019;12(600): 1-7.

11. Ogunlaja A, Fehintola O, Ogunlaja I, Popoola G, Idowu A, Awotunde O, Durodola M and Fehintola O. “Respectful Maternity Care” or “Disrespect and Abuse during Maternity Care”; Experience of Pregnant Women in Ogbomoso, South West Nigeria. Rwanda Medical Journal / Revue Médicale Rwandaise 2017; 74 (3); 6-9.

12. Pathak P, Ghimire B. Perception of Women regarding Respectful Maternity Care during Facility-Based Childbirth. Obstet Gynecol Int. 2020;2020:5142398.

13. Rosen H, Lynam P, Carr C, Reis V, Ricca J ,Bazant E , Bartlett L. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy and Childbirth 2015; 15(306); 2-11.

14. Say L, Chou D, Gemmill A, Tunçalp O, Moller A, Daniels J, Metin Gülmezoglu A, Temmerman M, Alkema L. “Global causes of maternal death: a WHO systematic analysis,” 4e Lancet Global Health 2014;2(6)e323–e333, 2014.

15. Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi V, et al., Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. BJOG 2018;125(8):932-42

16. Vogel JP, Bohren MA, Tuncalp, Oladapo OT and Gulmezoglu AM. Promoting respect and preventing mistreatment during childbirth. BJOG 2016;123(5):671-4

17. WHO (2012): Respectful maternity care: the universal rights of childbearing women. https://www.who.int/woman_child_accountability/ierg/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf Accessed at 24-8-2021.

18. World Health Organization (2014): The prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva: World Health Organization; 2014. available at: https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-govnts-support/en/. [Last accessed on 2018 June 15].

19. World Health Organization (2016): Maternal Mortality: Fact Sheet 2016, WHO, Geneva, Switzerland, 2016. [Last accessed on 2018 June 15].

20. WHO. (2018): Standards for improving quality of maternal and newborn care in health facilities. Geneva: World Health Organization, https://www.who.int/docs/default-source/mca Accessed at 24-8-2021.