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Health professionals' perception of disrespectful and abusive intrapartum care during facility-based childbirth in LMIC: A qualitative systematic review and thematic synthesis

Akosua Agyenim-Boateng [a,*], Helen Cameron [a], Adwoa Bemah Boamah Mensah [b]

[a] University of Salford, UK
[b] Kwame Nkrumah University of Science and Technology, Ghana

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ABSTRACT

Background: The interest of the global community in improving women's experiences with childbirth has led to interventions such as facility-based childbirth and the use of skilled birth attendants. However, reports of low facility and skilled birth attendants use continue to exist in literature because of disrespectful and abusive care directed at women during childbirth.
The present systematic review examined the question "What are the understanding and justification for disrespect and abuse directed at women by Health Professionals during childbirth or intrapartum care?"
Methods: Electronic search was conducted from January 2000 to January 2021 across CINAHL, OVID, PUBMED, PSYINFO databases. The retrieved studies were then filtered through a stringent inclusion and exclusion criteria. Thirteen studies were included in this review; extracted and synthesized using Thomas and Harden's (2008) thematic synthesis method.
Results: Three key themes were identified- providers related factors, women related factors, health system related factors. Sub-themes included classification and description, authority and control, reciprocity, providers attitude, rationalization, socio-economic inequalities, lack of assertiveness and inadequate resources.
Conclusion: The study demonstrated that HPs were aware and understood the various forms of D&AC. However, they provided justifications such as an act to save mother and baby's life, lack of assertiveness from labouring women and inadequate work resources for their actions. This highlights the need for various stakeholders involved in care during childbirth to reignite commitments to international standards on respectful maternity care and patient safety, such as training of staff and education of women on the process of labour and birth.

1. Introduction

Women in remote areas of developing communities fall within the most fertile women but live in settings that seem to limit access and the effective use of Facility-Based Maternal Care (FBMC) (World Health Organisation, 2019). In fact, according to the WHO (2019), 86% (254, 000) of the estimated global maternal deaths in 2017 occurred in Low- and Middle-Income Countries (LMIC). Sub-goals 3.1 and 3.2 of SDG-3 aim at lowering Maternal Mortality Rates (MMR) to < 70 per 1000 live births and also end preventable deaths of newborns under five (5) years by 2030 through increased FBMC usage (World Health Organization, 2020). Efforts aimed at improving maternal health knowledge and reducing financial barrier through free maternal health care among others have been adopted in LMICs to help increase FBMC for expectant mothers (Agbanyo, 2020; Asante et al., 2017; Banke-thomas et al., 2020). This agreed with general propositions that FBMC is a key factor to reducing MMR in Low- and Middle-Income Countries (LMIC) (United Nations, 2019; Micah & Hotchkiss, 2020). However, despite policy interventions within the developing world and a general push for facility-based delivery, FBMC remains low in LMICs (Girum & Wasie, 2017).

The complex interactions of community socioeconomic variables, health system-related factors, limited access to facilities, and long travel time to facilities (>33mins) have been highlighted as facilitating barriers to seeking FBMC in LMICs (Micah & Hotchkiss, 2020). Following various interventions by the global community, a jump from 69% (2006–2012) to 81% (2013–2018) was realized in the proportion of

* Corresponding author at: University of Salford, 2 Pembroke Street M6 5GS, UK.
E-mail address: a.agyenim-boateng1@edu.salford.ac.uk (A. Agyenim-Boateng).

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births attended by skilled health personnel. However, LMICs witnessed a low global success. While Central and South Asia recorded a jump from 51% to 79%, in sub-Saharan Africa (SSA) the change was from 47% to 59% within the same period (United Nations, 2019).

International attempts to improve FBMC and delivery is however described in the context of a push for technological birth which ignores the psycho-social dimensions of intrapartum care (Bradley et al., 2016). Largely, FBMC and delivery has been described as full of disrespect and abuse; reported from the mothers' experiences. Studies report the medicalization of birth by midwives through focus on technical elements of care as a means of securing, and controlling of women's bodies and knowledge (Bradley et al., 2016; Dzomeku et al., 2020). Facility-Based childbirth is seen as dehumanizing, fraught with disrespect, mistreatment and lacking interpersonal and emotional care (Blaise & Kegels, 2004; Bohren et al., 2014; Kruk et al., 2018; Onchonga & Keraka, 2021; Van Lerberghe et al., 2014). Psycho-social aspects of FBMC is regarded as a reserve of highly resourced world and counted as unrelated to care quality (Bradley et al., 2016) from the perspective of women.

Health system failures, cultural and social variables and contextual elements, staff shortages, few trained staff, provider perception and victim blaming underlie midwives' disrespectful and abusive (D&AC) care (Bradley et al., 2016; Dzomeku et al., 2020; Naanyu et al., 2020; Onchonga & Keraka, 2021). The empirical evidence from midwives' perspective affirms existence of D&AC (Afulani et al., 2020; Dzomeku et al., 2020). A synthesis of empirical evidence from midwives' perspective on D&AC in SSA, Bradley et al. (2019) identified fear of blame, lack of awareness of the social neglect and othering as underlying elements of midwives' abuse and disrespect of women. From the foregoing, even though there is a growing body of empirical evidence on the perspective of health professionals (HPs) on D&AC, these studies have adopted a narrow view focusing on SSA and midwives. There is the need for an updated broader perspective on D&AC. Hence, the aim for this review, is to explore the understanding and justification of HPs on disrespectful and abusive intrapartum care in LMICs.

2. Systematic search screening

This review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols guidelines, which is an evidence-based set of items used in reporting systematic reviews (Shamseer et al., 2015). A comprehensive search of qualitative literature was performed to retrieve articles published between January 2000 to January 2021 on HPs understanding and justification of disrespect and abusive care during facility-based care in LMICs. Electronic databases used were: CINAHL, OVID platforms, PsychINFO, and PubMed. Primary concepts such as "disrespectful and abusive care", "lower-and-middle-income countries", "Health professionals", "understanding", "knowledge", "perception", "justification" and "intrapartum" and their Medical Subject Headings (MESH) were used in searching. The subject search and text word search were performed separately in all databases and then combined with Boolean operators "OR" and "AND" as illustrated in Table 1. Additional articles were searched from google scholar and references of retrieved articles. This produced one additional study (Madhiwalla, Ghoshal, Mavani, & Roy, 2018).

3. Literature screening

Following the literature search, citations were imported into endnote reference manager for storage and literature screening and duplicates removal. Articles remaining were then screened independently by titles and abstracts. All citations were screened using inclusion and exclusion criteria. Any disagreements were discussed with supervisors.

4. Inclusion criteria

Studies with substantial qualitative elements that explored understanding and justification of HPs on disrespect and abuse during intrapartum care from January 2000 to January 2021. Other criteria were (1) HPs of all categories working in the maternity wards or giving intrapartum care to women in LMICs, (2) HPs had to be practicing and still in service at the time of data collection. (3) Articles had to be published in English Language.

5. Exclusion criteria

Studies were excluded from this review if they included: (1) Primarily quantitative, (2) HPs who worked outside the maternity wards such as community HPs or neonatal intensive care nurses (3) not published in English Language, (4) systematic reviews, abstracts, editorial reports, letters, conference articles, and grey literatures with no full text published articles were excluded because they were not counted as scientific published articles.

6. Description of quality appraisal tool

Main researcher independently assessed the methodological rigour of all included studies using the Mixed Methods Appraisal (MMAT) version 2018 (Hong et al., 2018). MMAT assess qualitative, quantitative, and mixed method studies with the use of two screening questions and four methodological criteria. The tool analyses whether the aim of the study is clear and appropriate, adequacy of methodology, study design, participant recruitment, data collection, data analysis, presentation of findings, authors' discussions, and conclusions (Hong et al., 2018). Each question is assigned three possible responses: "yes," "no," or" can't tell." A maximum of four points is assigned each question and each point carries a percentage of 25% i.e. (0–25% is regarded as weak, 50% is regarded as moderate, 75% is regarded is moderate-strong and 100% is strong). Studies were rated strong, moderate-strong, moderate, or weak for each domain and assigned an overall quality score. However, study quality was not used to exclude studies with the potential to answer the review question. Table 2 shows quality appraisal

7. Data extraction and synthesis

The extraction and synthesis of data followed Thomas and Harden (2008) thematic synthesis method, which enables the synthesis to exceed the content of the original findings of the studies to develop themes and bring fresh interpretations to each study. This enables conclusions to be drawn based on common elements across heterogenous studies. All text labelled as results or findings and quotations were imported verbatim into QSR's NVivo 11 version and coded line-by-line to capture what each sentence means. The initial codes were compared to allow the formation of sub themes which describe their characteristics. The descriptive sub themes led to the formation of analytical themes.

8. Literature search results

Electronic search identified 584 papers with 380 duplicates removed. After screening titles/abstracts, 48 papers were selected for full text review. Of these, 32 papers were from database searches and 16 identified from bibliographies. A total of 35 papers were excluded from final review because majority of these articles focused on women experiences of D&AC, while a few focused on HPs perception of intrapartum care without specific mention of D&AC. All solely quantitative papers exploring HPs experience with D&AC were excluded. Fig. 1 (Prisma Flow Diagram) presents a stepwise from identification to the inclusion of accepted papers. At the end of the screening, 13 peer-reviewed citations remained for final inclusion in the review

Table 1
Characteristics of included studied.

Author/Year	Country	Aim	Study Design	Findings	Conclusion
Dzomeku et al. (2020)	Ghana	To explore the views of midwives on disrespect & abusive care and their occurrences in professional practice	Exploratory descriptive design	All midwives acknowledged D&AC and categorised it as 1. Provision of inadequate care 2. Verbal, physical, and psychological abuse 3. Discriminatory care. This was attributed to provider perception of clients, non-evidenced based practices intended to prevent adverse outcomes and problems of the health system such as inadequate staff and inadequate equipment to work.	Frequent in-service training on respectful maternity care and monitoring of care provision in healthcare facilities are needed to eliminate the incidence of D&AC.
Yakubu et al. (2014)	Ghana	This study set out to explore the attitudes, beliefs, and self-reported behaviours of a small group of midwives inGhana to improve understanding of maltreatment during facility delivery	Cross-sectional design	Participants classified abuse as humiliating clients, screaming, hitting, yelling, neglecting and slapping clients.Situations that precipitated abuse was significantly failure to push in the second stage, disrespect of the midwife by women, midwives' accountability and midwife as a motherly figure.	This study calls for the introduction of other alternatives or interventions for midwives in their relationship with women/ roles such as in-service training for midwives on problem solving to handle difficult women
Rominski et al. (2017)	Ghana	1.Discuss the various domains of disrespectful and abusive care with midwifery students to assesstheir experience with them 2.To assess how these future providerscontextualize and conceptualize the treatment they have witnessedand participated in during their educational program	Exploratory descriptive design	Students conceptualized disrespectful care as physical abuse, non-dignified care, humiliation, scolding, blaming, shouting, discrimination, abandonment, and detention in facilities.D&AC was rationalised as attributed Stress of midwives, midwives' own attitudes, women disrespect of midwives, and the culture of blame of midwives. Students believed there was no alternative to D&AC	The study provides an important starting point for policy makers and educators to rethink how students need to be prepared to practice what is taught them.
Orpin et al. (2019)	Nigeria	1. Explore how maternity careproviders perceived D&A of women during maternity carein Benue State, Nigeria 2. Explore how maternity care providersviewed its impact on women's health and well-beingand their utilisation of maternity services	Interpretative phenomenological design	Participants described D&AC as the failure to provide quality care to women. HPs described facilitators of D&AC as a sought for safety of client and baby especially when the woman refuses to push in second stage.	The findings reflect the need for sensitising healthcare providers through training on respectful care in its incorporation into everyday practice keeping in mind the cultural diversity of women.
Burrowes et al. (2017)	Ethiopia	1. Examine women's experiences of care frommidwives during labour and delivery, including anydisrespect or abuse.2. Explore midwives' understandings of patients' rightsand patient-centred care.3. Describe midwives' experiences of patient abuse anddisrespect.4. Identify patient and midwife recommendations forstrengthening the quality of labour and delivery care.		HPs verbalised D&AC as abuse of privacy and non-consented care. They attributed this to a quest to save baby's life, as well as increased workload leading to stress, poor renumeration and hence low commitment, poor education of clients and language barrier between clients and HPs.	The study highlights the need collaboration and dialog between the policymakers who are concerned with patients' rights, and those working to improve the quality of RMNCH care, when designing curricula and guidelines for health professional education as well as devising ways to empower women about birth.
Adolphson et al. (2016)	Mozambique	Explore midwives' perspectives of working conditions, professional role andattitudes towards women	A descriptive qualitative design	Participant verbalised supportive and committed to women. However, this was inhibited by inadequate physical and human resources in the sector. Also, midwives verbalised the lack of renumeration as a demotivation	The potential and trainings midwives possess need to be matured and valued through re-trainings, provision of working equipment and motivations.
Balde et al. (2017)	Guinea	This paper presents the qualitative findings on perceptions and experiences of mistreatment of women during childbirth in health facilities in Guinea.	An exploratory descriptive qualitative design	Health workers acknowledged D&AC as lack of privacy and bribery. However, this was attributed to inadequate resources.	The study calls for stakeholder involvement in tackling D&AC.
Madhiwalla et al. (2018)	India	This study focuses on domains of practice where violations or ethical problems had been commonly observed, namely, provider patient interactions, cultural and social issues encountered in caregiving, management of labour pain, routine practices and procedures associated with normal vaginal deliveries, management of complications and post-delivery contraception.	Exploratory qualitative study	There was acknowledgement of mistreatment in forms such as shouting and coercion at women. However according to professionals, this was done for the good of both mother and baby.	Addressing D&AC requires the engagement of stakeholders to understand the organisational culture of the health system.
Bohren et al. (2017)	Nigeria	To explore women and healthcare providers' experiences and perceptions	Interpretative exploratory study	Providers reported experiencing or witnessing physical abuse including	Measurement tools to assess how often mistreatment occurs and in

(*continued on next page*)

Table 1 (*continued*)

Author/Year	Country	Aim	Study Design	Findings	Conclusion
		of mistreatment during childbirth in facilities in the Abuja metropolitan area of Nigeria.		slapping, physical restraint to a delivery bed, and detainment in the hospital and verbal abuse, such as shouting and threatening women Participants identified three main factors contributing to mistreatment: poor provider attitudes, women's behaviour, and health systems constraints.	what manner must be developed for monitoring and evaluation. Interventions to prevent mistreatment will need to be multifaceted, and implementers should consider lessons learned from related interventions, such as increasing audit and feedback from women. Also promoting labour companionship and encouraging stress-coping training for providers.
Afulani et al. (2020)	Kenya	To examine the extent and drivers of disrespect and abuse during facility-based childbirth from the perspectives of maternity care providers in a rural county in Kenya.	Explorative study	Participants categorised disrespectful maternity care as verbal abuse, physical abuse, lack of privacy, detention in health facility and discrimination. Drivers of disrespect and abuse included perceptions of women being difficult, stress and burnout from work overload, facility culture and lack of accountability, poor facility infrastructure and lack of medicines and supplies as well as provider attitudes.	Interventions to address disrespect and abuse need to tackle the multiplicity of contributing factors.
Kruger and Schoombee (2010)	South Africa	Explores nurses and patients experience of abuse in maternity	Explorative qualitative design	HPs verbalised leaving women unattended to during labour as a form of abuse, shouting and physical abuse. However these were referred in a separate paper of the authors (Stress of Caring, 2005) Schoombee et al. (2005)	The study implores mental health practitioners to create safe spaces where HPs can destress.
Lambert et al. (2018)	South Africa	1.Explore the lived experiences of maternity care providers as well as women who had received care at the time of birth. 1. The study sought to identify barriers and facilitators to provision high quality women centred care in low-and-middle income countries (LMICs)	Qualitative descriptive phenomenological study	HPs verbalised their knowledge on maltreatment such as restricting women to one position during labour. However, facilitators such as lack of professional support was stated	Midwives' attitudes and how they speak to women is more important than the the content of what is being said. Health facilities may need to highlight on the level of care they can provide to women and the how they endeavour to mitigate their short comings. This may take the blame game away from HPs and improve the relationship between women and HPs
Schoombee et al. (2005)	South Africa	Explores maternity nurses psychological and emotional experiences	Exploratory descriptive design	Participants verbalised being stressed from factors such as the work environment, resistant patients, and hospital hierarchies	Mental health professionals working with nurses in the public sector should on the one hand focus on being advocates for changing the working conditions of nurses and midwives (which is characterised by a high workload, lack of adequate support, and a dearth of technical and financial resources), but on the other hand that they should be working on creating safe spaces where issues related to the stressfulness of caring can be explored and addressed.

(Adolphson, Axemo, & Högberg, 2016; Afulani et al., 2020; Balde et al., 2017; Bohren et al., 2017; Burrowes, Holcombe, Jara, Carter, & Smith, 2017; Dzomeku et al., 2020; Kruger & Schoombee, 2010; Lambert, Etsane, Bergh, Pattinson, & Van den Broek, 2018; Madhiwalla et al., 2018; Orpin, Puthussery, & Burden, 2019; Rominski, Lori, Nakua, Dzomeku, & Moyer, 2017; Schoombee, van der Merwe, & Kruger, 2005; Yakubu et al., 2014)

9. Methodological characteristics or consideration of included studies

Thirteen papers were eligible for inclusion. All included studies used qualitative methodology except one (Afulani et al., 2020) which adopted a mixed methodology. The review included one mixed methodology due to its significant exploratory aspect. The geographical spread of papers were, six studies from West Africa (Balde et al., 2017; Bohren et al., 2017; Dzomeku et al., 2020; Orpin et al., 2019; Rominski et al., 2017; Yakubu et al., 2014), three from South Africa (Kruger & Schoombee, 2010; Lambert et al., 2018; Schoombee et al., 2005) three from East Africa (Adolphson et al., 2016; Afulani et al., 2020; Burrowes et al., 2017), one from South Asia (Madhiwalla et al., 2018). Table 1 shows the summary of included studies.

10. Quality appraisal or assessment of included studies

Quality appraisal of the included articles using MMAT ranged from

Table 2
Quality appraisal table (MMAT).

Author/year	Appropriate Methodology Used	Appropriate Data Collection	Findings adequately derived from data	Interpretation of results sufficiently substantiated by data	Coherence between research processes	Relevant Sampling strategy	Sample representative of target population	Appropriate measurements	Risk of low nonresponse bias	Appropriate statical analysis	Total points	Score %	Quality
	1	1	1	1	1						5/5	100%	Strong
Yakubu et al. (2014)	1	1	1	1	1						5/5	100%	Strong
Lambert et al. (2018)	1	1	0	0	1						3/5	60%	Moderate
Rominski et al. (2017)	1	1	1	1	1						5/5	100%	Strong
Orpin et al. (2019)	1	1	1	1	1						5/5	100%	Strong
Burrowes et al. (2017)	1	1	0	1	1						4/5	80%	Moderate-Strong
Kruger and Schoombee (2010)	1	1	0	1	1						4/5	80%	Moderate- Strong
Adolphson et al. (2016)	1	1	0	0	1						3/5	60%	Moderate
Balde et al. (2017)	1	1	1	1	1						5/5	100%	Strong
Madhiwalla et al. (2018)	1	1	1	0	0						3/5	60%	Moderate
Bohren et al. (2017)	1	1	1	1	1						5/5	100%	Strong
Afulani et al. (2020) Schoombee et al. (2005)	11	11	10	01	11						4/54/5	80% 80%	Moderate-StrongModerate-Strong

Indicators: 0 criteria not met, 1 criteria met- Scale 20% (Weak), 2 criteria met- scale 40% (weak), 3 criteria met-scale 60% (Moderate), 4 criteria met-scale 80% (Moderately-Strong), 5 criteria met-scale 100% (Strong).

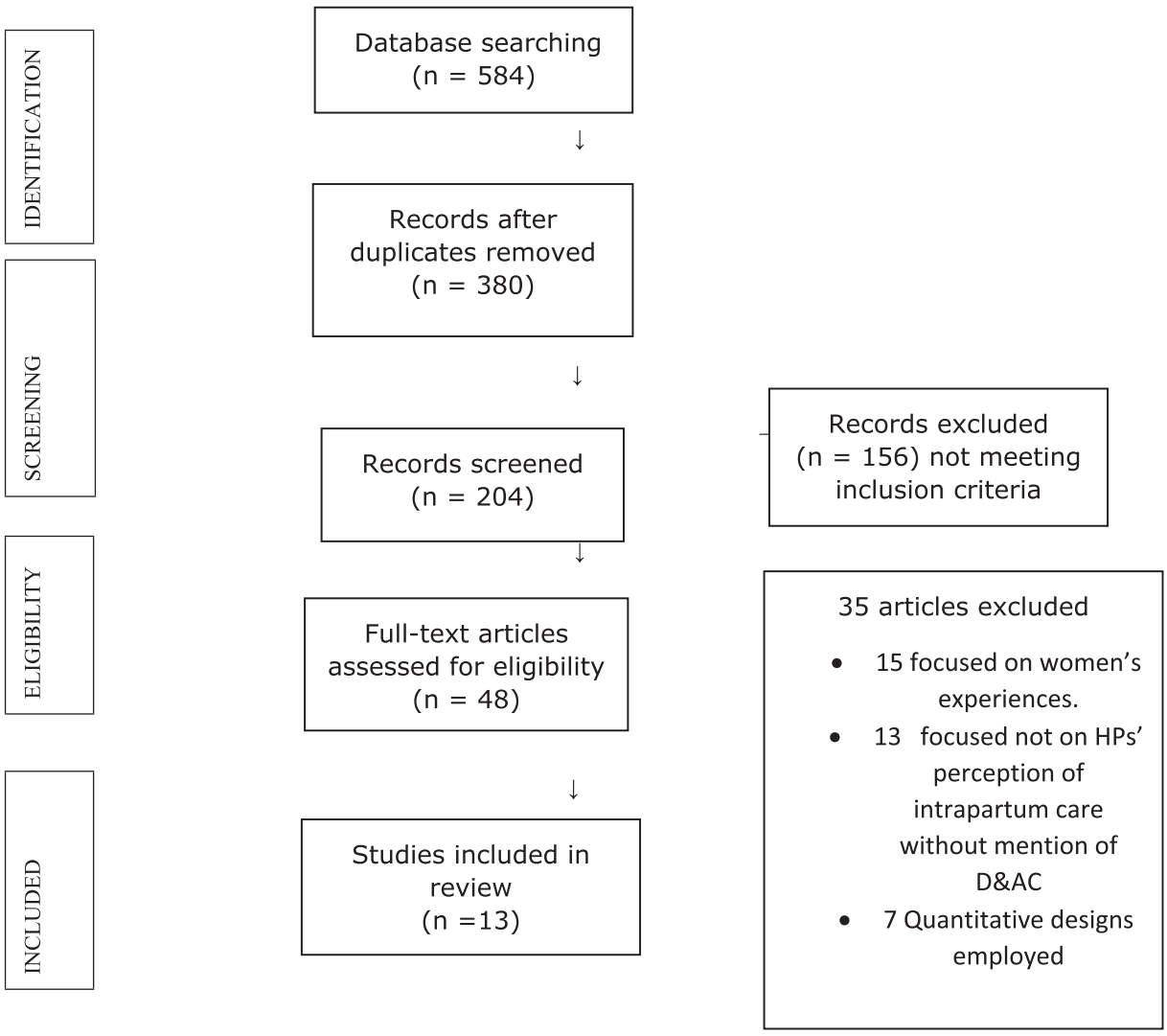

Fig. 1. Prisma flow diagram.

moderate (50%) to strong quality (100%). Six studies were rated as strong quality (Balde et al., 2017; Bohren et al., 2017; Dzomeku et al., 2020; Orpin et al., 2019; Rominski et al., 2017; Yakubu et al., 2014). Four studies were scored as moderate-strong quality (Afulani et al., 2020; Burrowes et al., 2017; Kruger & Schoombee, 2010; Schoombee et al., 2005). Three studies were scored as moderate quality (Adolphson et al., 2016; Lambert et al., 2018; Madhiwalla et al., 2018). No study was excluded based on its quality appraisal.

11. Results

All the findings of studies used for this review were imported verbatim into NVivo 11 software and coded line-by-line to capture the meaning of each sentence. The codes were compared and entered a common group with a descriptive theme. To answer the aims of this review which are understanding and justification for D&AC, this study identified three (3) main themes and eight (8) sub-themes. Table 3 shows Themes and Sub-themes.

12. Provider's related factors

This theme sought to explore HPs awareness of D&AC and how specific factors concerning HPs cause D&AC.

Table 3
Results.

Theme	Sub-Theme
Providers related factors	Classification and Description
	Authority and Control
	Reciprocity
	Providers Attitude
	Rationalization
Women related factors	Socio-economic Inequalities
	Lack of assertiveness
Health System related factors	Inadequate resources

12.1. Classisfication and description of abuse

This analytical sub-theme describes how HPs classified and gave clear illustrations of abuse. All included studies reported HPs mentioning and describing at least one form of abuse except Adolphson et al. (2016) reported on barriers to humanized care hence did not have participants mention or describe D&AC. D&AC has been made into seven categories identified by (Bowser & Hill, 2010). These included physical abuse, discrimination, non-dignified care, non-consented care, abandonment or neglect, non-confidential care, and detention in health facilities. Only one study (Dzomeku et al., 2020) had participants classifying the forms of abuse.

"I know of physical abuse, psychological, verbal, erm…Yeah. It starts with the verbal abuse whereby you are talking harshly with the patient or insulting the patient and their relatives… (Dzomeku et al., 2020).

Description of abuse was a common occurrence in the eleven included studies except (Adolphson et al., 2016). The commonest form of description was verbal abuse which was noted in seven studies (Afulani et al., 2020; Bohren et al., 2017; Dzomeku et al., 2020; Kruger & Schoombee, 2010; Madhiwalla et al., 2018; Rominski et al., 2017; Yakubu et al., 2014).HPs mentioned shouting as the commonest form of Verbal abuse.

"And with the verbal, that is where HPs falter lot; when we talk, we don't think of the impact it has on the patient, but sometimes we talk anyhow to the patient. And sometimes people, some people are more hurt with words. Some people don't care, but some people are more hurt with words as compared to maybe the physical one."-(Dzomeku et al., 2020)

"At times when… you can see the baby is coming and you ask the mother to push she won't push. During that time, if you don't raise your voice a little you may lose the baby. So you have to raise your voice at the mother so that she will be active and push and will get the baby out."(Yakubu et al., 2014)

".. and then I have to raise my voice to her … You don't mean to.. but sometimes it is the only thing that works … You just have to raise your voice, that's all you can do. I mean you can't, what else are you going to do?"(Kruger & Schoombee, 2010)

Lack of privacy (non-dignified care) was identified as a significant theme in Balde et al. (2017) and Burrowes et al. (2017).

"Yes, mainly patient privacy is the primary one[rule]…"-(Burrowes et al., 2017)

Denying women different positions was identified by (Lambert et al., 2018). This type of abuse although not listed in the generic classification of abuse by (Bowser & Hill, 2010) may be a common form of abused which is overlooked by both women and HPs.

"We tend to tell them what position they should be in, to be in for delivery for our own comfort" (Lambert et al., 2018).

12.2. Authority and control

This theme focuses on the HPs' relationship and interaction with women, which portrays as a master-servant or a mother-daughter relationship as reported by (Yakubu et al., 2014). This control involved the HP solely deciding what was right for the woman especially during the second stage of labour. Failure of the woman to comply may results in verbal abuse, physical abuse, or abandonment of care. This indirect form of control according to HPs was necessary to prevent bad outcomes during labour. However, student HPs in (Rominski et al., 2017) verbalised that there was no excuse for D&AC.

"When you hit, you know it's not right… You have to discipline her to do the right thing. So it's a kind of discipline that we are doing." (Yakubu et al., 2014)
"Encourage her, talk to her, be friendly with her. If you are very close to the patient… I think, she will not be naughty. Talk to her friendly, as a mother or a sister, hey this is, you can do this, you can go like this." (Yakubu et al., 2014)
"If a woman is really in the second stage of labour […] and close her legs, they can even kill the baby. […] You will go the extra mile to make sure […] even if it means you shouting…you have a safe delivery.'(Orpin et al., 2019)

"…Yelling and beating is an abuse, so, I am not in support of that. "(Rominski et al., 2017)

Information sharing was identified as means by which HPs controlled women. It was noticed that, sharing information with women was not regarded as the right of the woman but a way to compel women to comply. Some HPs expressed awareness to the need for information sharing, however this was identified as a challenge due to time constraints (Adolphson et al., 2016).

"As they are in pain, mostly the clients do not listen to the HPs when they advise them…They don't even listen at all…" (Burrowes et al., 2017)
"they must **just listen to what I say, and do as I tell them**, but they… Ok, I don't know what it feels like to go through labour, I don't have children yet, so… Sometimes **I just leave them**, let them do their own thing, **but usually I prefer** for them to know…**so I explain to them** before labour what to expect and **how they must behave**. Then things go well. Otherwise, it is a complete mess, and… and a stressful experience. (authors' emphasis)" (Schoombee et al., 2005).

12.3. Reciprocity

D&AC to women, according to HPs was the results of rude women who disrespects them (HPs) first. Three (3) studies (Rominski et al., 2017; Schoombee et al., 2005; Yakubu et al., 2014) identified that, mutual disrespect precipitates D&AC.

"They are so naughty that you shout on them, some like, look what you have done to me?" (Yakubu et al., 2014)
"It is only when someone upsets me, or makes me angry… Sometimes, the patients, they are unruly, yes. Or, you'll ask them a question and they'll give you a disrespectful answer, or they don't do what you, or they are just plain rude. (authors' emphasis)" (-Schoombee et al., 2005)

Student HPs in Rominski et al. (2017) identified that this initial disrespect from women may be attributed to the physical characteristics of the midwife.

"Sometimes it becomes difficult because … we the young ones … - when some of the old ones [patients] come and they see us, they think that we are young and for that matter everything that you tell them to do…they don't comply; they see you as their kid so … when you talk to them the way and manner they behave to you, it is like they tend to pick a bone with you and…you tell them do … they will be quarreling with you and everything be- comes messed up."

12.4. Providers attitude

This sub-theme explores how some HPs in Rominski et al. (2017), (Afulani et al., 2020) and Burrowes et al. (2017) explained how their colleagues behaved towards women. According to HPs, D&AC to women may not be caused by what the woman does or what HPs want women to do but the providers attitude.

"… If I am a quick-tempered person, then it would be a little bit difficult for me to provide this kind of respectful care…" (Rominski et al., 2017)
"Sometimes providers get upset for no reason…" (Burrowes et al., 2017)

12.5. Rationalization

This sub-theme describes non-evidenced based practices that HPs use

in preventing adverse outcomes. All included except (Adolphson et al., 2016) studies identified that HPs resorted to abuse especially during the pushing stage. This action according to HPs is not intended to cause harm.

> "In the second stage when the baby is crowning and the mother is expected to give it way, due to the pain, she may not even know what she is doing and might be closing her legs up and thus hurting the baby. In such a situation, you may involuntarily hit her on the thighs and shout 'open up!' (Laughing at the recollections) …As for that one, we frequently do that. Sometimes it happens. It is not always the case though. Here, we have a belt that we use to strap the legs to the bedposts, so you can't close your legs. In the absence of such devices and an expectant mother closes her legs, you can be distressed because she would be physically hurting the baby and a midwife may involuntarily hit the thighs and shout at her to open the legs wide"-(Dzomeku et al., 2020).
>
> "……. When the mother is uncooperative especially during second stage, yes like in my instance why I was forced to pinch, we had a tight cord around the neck, this mother was a para six [six prior births] and after the head had crowned you are telling her not to push so that you can clamp the cord and cut but she insisted on pushing so I had to pinch her kidogo [a little]"(Afulani et al., 2020)

13. Women related factors

This theme explores the women specific factors that may result in HPs "abusing and disrespecting women."

13.1. Socio-economic inequalities

A trigger point that was identified as a cause of D&AC was the use of socio-economic disparities to render service to women. This was mentioned by (Afulani et al., 2020; Burrowes et al., 2017; Dzomeku et al., 2020; Schoombee et al., 2005). According to some HPs, they may use a woman's economic status, physical appearance, or relation with provider to give discriminatory care.

> "The staff can sometimes look at the way someone [childbearing woman] will present herself and use that as a yardstick to respect her or not. But this can also create issues. But some of these patients are troublesome too, and that in turn cause some of the HPs to misbehave. "(Dzomeku et al., 2020)
>
> "Some is just physical appearance, you just get in and everybody is in love with her and the other one comes in and everyone is like oooh [laughs] nobody bothers to attend to her, but mostly it is race and financial status"(Afulani et al., 2020)

An important factor that was mentioned by Schoombee et al. (2005) was discrimination in care based on the skin colour of women.

Black women were described as disobedient and independent.

> "…they don't listen to you; they just do their own thing. Especially, and I don't want to discriminate, but the black people…… I don't think, I don't think it is an issue of language, I think they are just like...they all have that same manner where they go sit on the bed on all fours...And they push like there's no tomorrow."

14. Lack of assertiveness

This sub-theme explores the dependence of labouring women on HPs. Some HPs reported that, the outcome of abuse during childbirth, thus having the baby is more important to the women. Women tend not to complain after delivery hence it is an acceptable behaviour of HPs and has become an everyday occurrence.

> 'Some of the women when they come here to deliver their babies, the labour room is not covered, like no screens but they are okay and happy because they deliver their babies safely.'' Orpin et al. (2019).

The dependence of women on healthcare staff may mean to women that, the midwife knows best and hence whatever the midwife does is right, even if they are abused.

15. Health system related factors

This theme explores the most significant justification for D&AC mentioned by HPs. HPs in all included studies attributed abuse to the results of the status of their working environment or working conditions.

15.1. Inadequate resources

Inadequate resources mentioned by HPs cut across the management and architectural structure of health facilities to human resources. HPs in all included studies mentioned that job distress from inadequate working tools and unrealistic client to staff ratio caused increased workload. The pressure and distress from increased workload may sometimes cause them to act in an unprofessional manner by disrespecting clients. The magnitude of client to staff ratio was mentioned by HPs in Dzomeku et al. (2020) as 4 HPs to 30 childbearing women.

> "We have on this ward, this night, thirty-three patients to four HPs, some [childbearing women] are in labour, some are eclamptic, some are having respiratory distress, and then you have the pressure, you feel the pressure, so sometimes you would react in a way which you are not supposed to, because of that pressure that is mounting on you, you might act in a weird way which you are not supposed to… sometimes, too, you would not mind the patient [ignore the childbearing woman]." (Dzomeku et al., 2020)

Inadequate resources, mostly poor staffing was one of the reasons attributed to the use of strict birthing positions mentioned by Dzomeku et al. (2020).

> "I am not really satisfied, especially with the birthing position. It would have been easier if patients had the option of squatting [during delivery] …the delivery couch has been shaped in a certain way that you have to lie down, on your back, and it is not easy… One time, I was talking with my colleagues about it [the squatting position], and one doctor [reproachfully] responded that 'even delivery couch, you are not getting it, and you want to deliver in that position?" (Dzomeku et al., 2020)
>
> "They (the women) always want the midwife to be on their side when they are in labor. And there are only so many HPs on duty… That is why… we can't stand by the patient until the time she delivers." -(Yakubu et al., 2014)

This stress from insufficient human resource leading to overworked HPs leave them frustrated. According to (Adolphson et al., 2016), this leads HPs less committed or devoted to their role.

> "If I wasn't a midwife, I could find another job and be happy."

16. Discussion

The aim of this study was to explore HPs' understanding and justification of D&AC. The findings indicated that the HPs were aware and understood D&AC in relation to the classification by Bowser and Hill (2010), and their experiences confirm that D&AC has become part of the routine for maternity care. HPs description of disrespectful maternity care encompasses the provision of inadequate physical and psychological care. The HPs noted that violation of childbearing women's rights (privacy, confidentiality, quality care, etc.), non-consented care, verbal

abuse (shouting at, insulting), physical abuse (beating, slapping, kicking, restraining, and detaining), and psychological abuse (ignoring, neglecting, provision of non-person-centred care) constituted D&AC. These descriptions agree with existing scholarly descriptions of D&AC (Bohren et al., 2017; Bowser & Hill, 2010).

The findings of this systematic review suggest that HPs do not intend to cause harm to women however, HPs being aware of maternal mortality rates and the interest of the world in maternal and neonatal health are constantly reminded to cause safe delivery. This review established that, ensuring safe delivery does not come easy to HPs as some women are viewed as non-compliant and disobedient. This may cause the midwife to involuntarily disrespect and abuse the labouring woman with the intention of preventing complications or even death. Disrespect of women disagrees with the standards of some professional organizations such as the Nursing and Midwifery Council (Dobrowolska, Wrońska, Fidecki, & Wysokiński, 2007). The Nursing and Midwifery Council (NMC) of United Kingdom's (UK) standard of proficiency for HPs' domain c encourages the midwife to optimise normal physiological processes and work to promote a positive pregnancy and labour outcome devoid of complications (NMC, 2019). According to the Royal College of Midwifery (RCM), a healthy mother, a healthy baby, and family integrity must be the focus of a high-quality maternity service (RCM, 2014). It appears however, that HPs have lost the meaning of key phrases such as "normal physiological process" or "family integrity" focusing on the mere physical health of women after delivery. In their study (Jones, Creedy, & Gamble, 2012) to assess Australian HPs attitudes towards care for women with emotional distress, 42% of 815 participants reported that their workload prevented them from addressing the emotional needs of women, 42.6% of HPs reported that their facilities prevented their ability to know women intimately and explore their underlying emotional issues while 42.5% reported that, the priority of their organisation is focused on the physical problem presented by women than emotional and psychological problems. HPs in this Australian study reported that assessing the emotional and psychological issues of women is not time consuming, however the above-mentioned constraints prevent them from doing so routinely. This systematic review has shown to agree with the 42.5% Australian HPs who reported the focus of health system on physical conditions. Thus, HPs in LMICs are more likely to disregard the overall experience of women and focus on the physical health when facilitating birth due to fear of losing either mother, baby, or both. To HPs in this systematic review, the process of labour and delivery means a task to save lives. Hence, any behaviour from women that put their lives and that of their babies at stake must not be tolerated and be dealt with.

While most of the HPs in this systematic review verbalised that disrespect and abusive care was their way of saving lives and preventing complications, others claimed that some HPs are naturally hot tempered and rude without any trigger causing them to be abusive with no intention of saving lives. Although this review did not mention what causes their anger, Agthe, Spörrle, and Maner (2010) suggests that women sometimes despise each other simply because one is better than the other. As childbirth is a women-dominated profession, this form of hatred may be noticed between labouring women and HPs.

"Patience is stale, and I am weary of it." (Richard II, Act V, Sc 5, line 103). Slapped, pinched, spat on and punched: many health professionals have experienced enough (Vogel, 2016). Evidence suggest that, health professionals are victims of abuse directed at them from patients (Magin et al., 2006, 2008). In Australia, it was estimated that, in 2004, 64% of general practitioners experienced violence in practice (Magin et al., 2006). Health professionals are increasingly arguing for zero tolerance of abuse, violence, and disrespect by clients to them. The question of what happens when an abuse comes from a client who needs care needs to be critically looked at. Abusive encounters from patients may have effect on health care professionals causing them to either retaliate or poorly perform (Fernandes et al., 1999). To prevent women from dominating the birth environment and making the HPs less relevant and less in-charge, these HPs would prefer to show their dominance and take charge of their work and environment by being abusive women. However, health workers should understand that, a patient who is in pain may be full of emotions which may cause disrespect towards professionals. Retaliation may not be the effective way to address such situations. Open and honest communication between patients and HPs may be helpful in addressing mutual disrespect. According to the World Health Organization (WHO), a woman's experience of care should firstly include effective communication – a woman and her family should know and understand what is happening, what might happen, what to expect and her rights at any point in time (Tunçalp et al., 2015).

The client or woman is not just a group of symptoms, damaged organs, and altered emotions. The client is a human being who is worried and hopeful, looking for some relief, trust, and assistance. The work of (Szasz & Hollender, 1956) demarcated three fundamental models of a doctor- patient relationship: activity-passivity, guidance-co-operation, and mutual participation. The activity-passivity and guidance-co-operation models are paternalistic and thus health professional cantered. In recent years, the latter, mutual participation has gained emphasis and led to patient-centred medicine. Also, the increase use of internet by patients in this era has meant that, patients are well informed especially in affluent communities (Mason, Laurie, & Smith, 2013). However, the known history of professional relationship between a patient and health care professionals has over the years led to patients mostly depending on the professional (activity-passivity) and believing that, the health worker knows best (Hellin, 2002) especially in LMICs where majority of women are uneducated to defend their rights (Chikalipah, 2017). This systematic review has shown that some women completely entrust their health to HPs making the HPs superior hence causing a medium for abuse.

Health system failures such as job distress, staffing problems and hospital protocols have been established by evidence as some of the major drivers of disrespectful and abusive maternity care (Dzomeku et al., 2020; Yakubu et al., 2014). Evidence suggests that, inadequate clinical and support staff leading to increased workload prevented HPs from translating their knowledge on respectful maternity care into practice (Burrowes et al., 2017; Rominski et al., 2017). Practicing HPs and student HPs in Ghana stated that, increased workload, job related stress from unrealistic HPs-to-women ratio and the internal pressures to save two lives during delivery may compel HPs to engage in practices and behaviours that may be deemed as disrespectful to women (Dzomeku et al., 2020). In the National Health Service (NHS) of the UK, it is known that, depression, burnout, stress, and anxiety form about a quarter of all cases of sick absence (Black, 2012). The Francis report shows the extent to which poor wellbeing of staff can relate directly to poor medical services (Francis, 2013). Poor staff wellbeing can result from inadequate staff leading to the available staff being overworked. This can lead to increase in medical errors morbidity, and mortality (Keogh, 2013)rates as well as neglect of patients. HPs are known to experience higher levels of distress and trauma than the general working population because of the relation of their job to human pains, sufferings and relatively frequent deaths in the developing countries such as sub-Saharan Africa (Keogh, 2013; Leinweber & Rowe, 2010). Therefore, HPs in psychological distress may display attitudes that are out of character, secondary trauma, and compassion fatigue (Rice & Warland, 2013). However, in recent years, health organizations have put measures in place to help HPs deal with occupational stress. One of such measures is the introduction of Professional Midwifery Advocate (PMA) in the NHS. According to the Advocating for Education and Quality Improvement (A-Equip) model, the restorative function enables the PMA to address the emotional needs of staff by creating a safe thinking space, supporting staff to slow down through discussion, reflection and open feedbacks (Dunkley-Bent, 2017). This laudable measure is however available only in the UK and not in LMICs health system. Hence HPs in LMICs continue to be distressed by lack of appropriate health systems resulting in their mistreatment of clients. This systematic review has

shown that, although HPs may be willing to be nice and gentle with women, increased workload because of inadequate staff may hinder such act.

17. Conclusion and implication for practice

The findings of this study have implications that are worth mentioning and considering. Having mentioned the complexities that surround the working environment and practice of HPs in this study, any measure that forces HPs to practice respectful maternity care may yield minimal to no results. Thus, health facilities should revisit their commitments to protocol and guidelines which meet global guidelines on patient safety, respect, and autonomy, and ensure that these measures are complied with by HPs to promote safe and respectful intrapartum care.

Also, the settings for labour and delivery should be well equipped to enable women the ability to freely use their environment. Public awareness and education of the general population on the role of the HPs and what to expect during labour and delivery may be necessary to dispel the idea that HPs are solely responsible when there are poor outcomes of labour. This might also earn HPs the compliance and obedience they expect from women.

Further, health facilities may need to address the issue of understaffing as this will help relieve HPs of long working hours, stress and compassion fatigue which show them to the public as mean and disrespectful.

HPs may need to be educated on respectful maternity care and be made aware of the uniqueness of labour and pain response of each woman. A general education of hospital staff on the need for teamwork, the extent of their different roles and elimination of unnecessary chore division may be important to prevent the disrespect of midwives by fellow health workers in cases of poor labour outcomes.

Lastly, through public education and media campaigns, women should be enlightened about their rights during childbirth and empowered to demand for better and respectful care in their relationship with HPs.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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