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IMPLEMENTATION OF RESPECTFUL MATERNITY CARE IN OBSTETRIC EMERGENCY SETTINGS: A SYSTEMATIC REVIEW AND NARRATIVE SYNTHESIS

Ervianty Aprilia[1], Nike Arisandi[1], Lisa Triana Arlym[1]
[1]Master of Midwifery Program, Faculty of Health Sciences, Nasional University, Indonesia

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Abstract

Respectful maternity care is a rights-based component of safe and person-centred maternal services, but its implementation may be challenged during obstetric emergencies. This systematic review synthesized evidence on the implementation of respectful maternity care, barriers and facilitators, and provider behaviour and quality of care in obstetric and related maternity-care settings. Searches were conducted in ProQuest, PubMed, Springer Nature Link, and ScienceDirect for English-language publications from 2021 to 2025. Study selection followed predefined PICOS criteria and PRISMA 2020 guidance. Two reviewers independently screened the records, with substantial inter-reviewer agreement (Cohen's κ = 0.734). Methodological quality was assessed using design-appropriate JBI tools, supplemented by component-based appraisal for mixed-methods studies and structured appraisal of intervention-development studies. Of 998 records identified, 17 sources were included in the narrative synthesis; 13 underwent methodological appraisal, while four were retained solely for contextual interpretation. The appraised studies demonstrated good methodological quality, with no study classified as poor. The synthesis identified four interrelated themes: provider capability and learning, provider wellbeing and bias, communication and dignity during urgent care, and organizational and governance conditions. Training, mentoring, practical educational tools, and supportive supervision were associated with improved provider knowledge, confidence, preparedness, and respectful-care practices. Implementation was constrained by workload, staffing shortages, provider bias, limited resources, referral delays, and weak organizational support. Respectful maternity care during obstetric emergencies therefore depends on both provider capability and organizational systems that support timely clinical care while preserving dignity, privacy, communication, and informed choice. The review was registered in PROSPERO (CRD420261377995).

Corresponding author:
Ervianty Aprilia
Master of Midwifery Program, Faculty of Health Sciences, Nasional University, Jakarta, Indonesia
Email: erviantyaprilia@gmail.com

Introduction

Maternal emergencies require rapid clinical decision-making, coordinated referral, and timely life-saving interventions. In these high-pressure situations, communication, privacy, informed choice, and emotional support may receive less attention, although these dimensions remain integral to safe and high-quality maternity care. Respectful maternity care is a rights-based approach that promotes dignity, confidentiality, autonomy, freedom from mistreatment, informed decision-making, and supportive communication throughout pregnancy and childbirth (World Health Organization, 2021; International Federation of Gynecology and Obstetrics [FIGO], 2021).

Healthcare providers play a central role in translating respectful maternity care principles into clinical practice. The World Health Organization emphasizes that health workers' knowledge, skills, and attitudes are central to compassionate and respectful care, while their behaviour is also influenced by working conditions, staffing, organizational support, and health-system factors (World Health Organization, 2021). Similarly, FIGO emphasizes that maternity-care practitioners should provide respectful and dignified

care, communicate effectively with women and families, support informed choice and consent, and participate in effective consultation and referral when obstetric complications occur (FIGO, 2021). Empirical evidence further indicates that provider behaviour may be influenced by implicit bias, workload, stress, motivation, and the organizational environment, while provider-support interventions may strengthen person-centred maternity care (Afulani et al., 2021; Afulani et al., 2023).

Evidence from maternal-health programmes suggests that training, mentoring, supportive supervision, and quality-improvement strategies can strengthen provider competence and the quality of maternity services, although their effectiveness depends on implementation conditions and facility-level support (Anderson et al., 2022).

Communication and relational care are particularly important during emergency referral, as delays, uncertainty, and insufficient explanations may increase distress and reduce women's trust in healthcare services (Nabulo et al., 2023). These findings indicate that the implementation of respectful maternity care during obstetric emergencies is shaped not only by individual provider competence but also by organizational readiness, referral systems, staffing, and mechanisms that support respectful communication under time-sensitive clinical conditions.

Previous reviews have largely examined women's experiences of maternity care or respectful-care interventions across general childbirth settings. Evidence specifically addressing how healthcare professionals implement respectful maternity care in obstetric emergency settings remains limited and heterogeneous. Therefore, this review aimed to synthesize evidence on the implementation of respectful maternity care by healthcare professionals in obstetric emergency settings, identify barriers and facilitators influencing its implementation, and examine its implications for provider behaviour and quality of care. Because direct evidence from obstetric emergency settings remains limited, evidence from broader maternity-care contexts was considered only when it directly informed provider behaviour, communication, referral processes, or organizational conditions relevant to emergency obstetric care.

Methods

A systematic review with narrative synthesis was conducted and reported in accordance with the PRISMA 2020 guidelines (Page et al., 2021). The review protocol was prospectively registered in PROSPERO on 23 May 2026 (CRD420261377995). Eligibility criteria were defined using the PICOS framework, as presented in Table 1.

Table 1. PICOS-based eligibility criteria

Criteria	Inclusion	Exclusion
Population	Healthcare providers, women receiving maternity/obstetric care, and healthcare students when relevant to RMC implementation or education.	Populations unrelated to maternal or obstetric care.
Intervention/Exposure	RMC, person-centred care, dignity-based care, provider training, communication, or organizational strategies related to respectful maternal care.	Interventions unrelated to RMC or maternity-care quality.
Comparison	Standard/routine care, pre-intervention conditions, or no comparator where appropriate.	Not applicable when no comparison was required by design.
Outcome	RMC implementation, provider behaviour, quality of care, patient experience, barriers/facilitators, and organizational factors.	Outcomes unrelated to RMC implementation or maternity-care quality.
Setting	Hospitals, maternity wards, emergency departments, referral facilities, and other formal maternal/obstetric care settings.	Settings outside maternal or obstetric healthcare.
Study design / source type	Quantitative, qualitative, mixed-methods, intervention, educational, review, policy, and framework sources relevant to RMC.	Sources not directly relevant to RMC implementation or contextual interpretation.
Publication	English; 2021–2025.	Non-English or outside 2021–2025.

Selected contextual sources were retained when they directly informed provider behaviour, communication, education, referral processes, or organizational conditions relevant to RMC implementation.

The literature search was conducted in ProQuest, PubMed, Springer Nature Link, and ScienceDirect. The search strategy combined terms related to respectful maternity care, healthcare providers, and obstetric emergency care. The core Boolean search string was: ("respectful maternity care" OR "RMC" OR "person-centred maternity care") AND ("health care provider" OR "midwife" OR "nurse" OR "doctor" OR "physician") AND ("obstetric emergency" OR "emergency obstetric care") AND ("implementation" OR "practice" OR "behaviour" OR "behavior" OR "quality of care"). Search syntax was adapted to the functions of each database. Searches were

restricted to English-language publications published from 2021 to 2025. All retrieved records were exported to Mendeley, and duplicate records were removed before screening.

Two reviewers independently screened titles and abstracts according to the predefined eligibility criteria. Potentially relevant reports were retrieved for full-text assessment. Disagreements between reviewers were resolved through discussion and, when necessary, consultation with a third reviewer. Inter-reviewer agreement was assessed using Cohen's kappa coefficient. Reasons for exclusion at the full-text stage were recorded and summarized in the PRISMA flow diagram.

Data were independently extracted using a structured extraction form. Extracted information included author and year of publication, country, study design, participants, healthcare setting, RMC intervention or implementation focus, outcomes assessed, and principal findings.

Methodological quality was assessed using design-appropriate JBI critical appraisal tools (Aromataris & Munn, 2020). Mixed-methods studies were appraised based on the quality and integration of their qualitative and quantitative components, while intervention-development studies were assessed using structured development-process criteria. Each criterion was scored 1 if fulfilled and 0 if unmet; overall quality was classified as good (80–100%), moderate (50–79%), or poor (<50%).

Owing to heterogeneity in study design, population, setting, intervention, and outcome measurement, statistical pooling was not considered appropriate. The findings were therefore synthesized narratively. Studies were compared to identify similarities, differences, and recurrent patterns related to RMC implementation, barriers and facilitators, and provider behaviour and quality of care.

Results

The database search identified 998 records, including 453 from ProQuest, 35 from PubMed, 367 from Springer Nature Link, and 143 from ScienceDirect. After removing 64 duplicates, 934 records were screened by title and abstract, of which 870 were excluded. Sixty-four reports were sought for retrieval; eight could not be retrieved, leaving 56 full-text reports for eligibility assessment.

Following full-text assessment, 39 reports were excluded because of an ineligible population (n = 12), intervention or exposure unrelated to RMC or person-centred maternity care (n = 9), irrelevant outcomes (n = 8), or ineligible study design (n = 10). Following final eligibility verification, 17 sources were included in the narrative synthesis. Inter-reviewer agreement was substantial (Cohen's κ = 0.734**).**

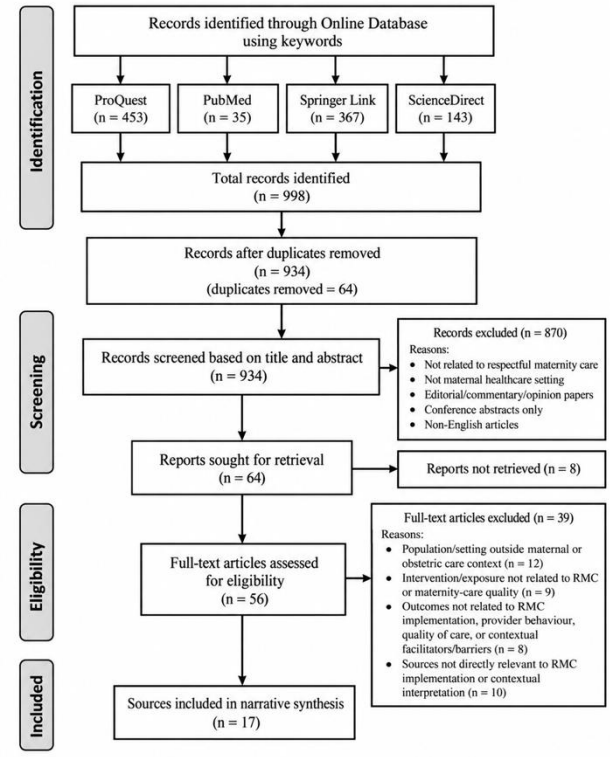


Figure 1. *PRISMA 2020 flow diagram*

Methodological Quality Appraisal

Of the 17 included sources, 13 underwent methodological appraisal, while four were retained for contextual interpretation. Design-specific JBI tools were applied to qualitative, analytical cross-sectional, and quasi-experimental studies, whereas mixed-methods and intervention-development studies were evaluated using component-based and structured appraisal criteria. Overall, the appraised studies demonstrated good methodological quality, with no study classified as poor.

Appraisal Criteria	Dhakal et al. (2022)
1. Is it clear in the study what is the 'cause' and what is the 'effect'?	1
2. Were the participants included in any comparisons similar?	1
3. Were the participants included in any comparisons receiving similar treatment/care, other than the intervention?	1
4. Was there a control group?	1
5. Were there multiple measurements of the outcome both pre and post the intervention?	1
6. Was follow-up complete and, if not, were differences adequately described and analyzed?	1
7. Were outcomes of participants included in comparisons measured in the same way?	1
8. Were outcomes measured in a reliable way?	1
9. Was appropriate statistical analysis used?	1
Total score	9/9
Percentage	100%
Quality category	Good

Figure 2. *JBI critical appraisal of quasi-experimental study*

Appraisal Criteria	Dzomeku et al. (2021)	Hanrahan (2021)	Megersa et al. (2021)	Muhayimana et al. (2025)	Nabulo et al. (2023)
1. Is there congruity between the stated philosophical perspective and the research methodology?	1	1	1	1	1
2. Is there congruity between the research methodology and the research question or objectives?	1	1	1	1	1
3. Is there congruity between the research methodology and the methods used to collect data?	1	1	1	1	1
4. Is there congruity between the research methodology and the representation and analysis of data?	1	1	1	1	1
5. Is there congruity between the research methodology and the interpretation of results?	1	1	1	1	1
6. Is there a statement locating the researcher culturally or theoretically?	0	0	0	1	0
7. Is the influence of the researcher on the research, and vice-versa, addressed?	0	0	0	1	0
8. Are participants, and their voices, adequately represented?	1	1	1	1	1
9. Is the research ethical according to current criteria, or is there evidence of ethical approval?	1	1	1	1	1
10. Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?	1	1	1	1	1
Total score	8/10	8/10	8/10	10/10	8/10
Percentage	80%	80%	80%	100%	80%
Quality category	Good	Good	Good	Good	Good

Figure 3. *JBI critical appraisal of qualitative studies*

Appraisal Criteria	Yirga et al. (2025)
1. Were the criteria for inclusion in the sample clearly defined?	1
2. Were the study subjects and the setting described in detail?	1
3. Was the exposure measured in a valid and reliable way?	1
4. Were objective, standard criteria used for measurement of the condition?	1
5. Were confounding factors identified?	1
6. Were strategies to deal with confounding factors stated?	1
7. Were the outcomes measured in a valid and reliable way?	1
8. Was appropriate statistical analysis used?	1
Total score	8/8
Percentage	100%
Quality category	Good

Figure 4. *JBI critical appraisal of analytical cross-sectional study*

Appraisal Criteria	Roane (2024)	Afulani et al. (2021)	Anderson et al. (2022)	Moyer et al. (2021)
Research question was clearly stated	1	1	1	1
Data collection was appropriate to the research objectives	1	1	1	1
Integration of methods was adequately conducted	1	1	1	1
Integrated interpretation of findings was provided	1	1	1	1
Methodological limitations were described	1	1	1	1
Qualitative component was adequate	1	1	1	1
Quantitative component was adequate	1	1	1	1
Total score	7/7	7/7	7/7	7/7
Percentage	100%	100%	100%	100%
Quality category	Good	Good	Good	Good

Figure 5. *Mixed-methods component appraisal*

Appraisal Criteria	Afulani et al. (2023)	Craemer et al. (2024)
1. Development objective was clearly stated	1	1
2. Intervention/tool development process was clearly described	1	1
3. Development was informed by relevant evidence, theory, or data	1	1
4. Relevant stakeholders were involved in the development process	1	1
5. Methods for gathering stakeholder input or feedback were appropriate	1	1
6. Development findings or stakeholder feedback were transparently reported	1	1
7. Limitations and/or next steps were described	1	1
Total score	7/7	7/7
Percentage	100%	100%
Quality category	Good	Good

Figure 6. *Structured methodological appraisal of intervention-development studies*

Table 2. Characteristics of studies included in the narrative synthesis

No	*Author (Year)*	*Study Design*	*Setting/ Country*	*Participants / Source*	*Intervention / Focus of RMC*	*Outcome Measured*	*Key Findings*
1	Lynnee Adele Roane (2024)	Mixed-methods doctoral dissertation	USA	Black women and birthing persons	Respectful maternity care experiences	Psychosocial and clinical outcomes	Greater respect was associated with better psychosocial experiences and childbirth satisfaction.
2	Patience A. Afulani et al. (2023)	Intervention development study	Kenya	Healthcare providers	Caring for Providers to Improve Patient Experience (CPIPE)	Intervention development process	Provider-focused support and behaviour-change mechanisms were incorporated to strengthen respectful care.
3	Patience A. Afulani et al. (2021)	Mixed-methods study	Kenya	Maternity-care providers	Provider implicit and explicit bias and person-centred maternity care	Disparities in person-centred maternity care	Provider implicit and explicit bias were associated with inequities in person-centred maternity-care experiences.
4	Rondi Anderson et al. (2022)	Mixed-methods observational study	Bangladesh	Midwives and maternity facilities	Professional midwives and facility mentoring	Quality and availability of maternity care	Professional midwifery and mentoring were associated with improved availability and selected dimensions of service quality.
5	Abena Asefuaba Yalley et al. (2023)	Cross-sectional study (contextual evidence)	Ghana	Women with facility-based childbirth experience	Obstetric violence and mistreatment	Prevalence and associated factors	The study documented obstetric violence and factors relevant to dignity and respectful-care interpretation.
6	Abena Asefuaba Yalley et al. (2024)	Contextual scoping review	Global	Published intervention literature	Interventions addressing obstetric violence	Maternal-care quality	Multicomponent interventions showed potential to reduce mistreatment and obstetric violence.
7	Katherine A. Craemer et al. (2024)	Development study	USA	Emergency department healthcare personnel	Maternal health toolkit for emergency departments	Toolkit development and stakeholder feedback	A five-module maternal health toolkit was developed through interdisciplinary stakeholder engagement to address gaps in emergency-department maternal health education.
8	Prativa Dhakal et al. (2022)	Quasi-experimental study	Nepal	Nursing students	Online respectful maternity care education	Perceptions and understanding of RMC	Online education improved students' perceptions of RMC; findings provided indirect evidence for provider training.

No	*Author (Year)*	*Study Design*	*Setting/ Country*	*Participants / Source*	*Intervention / Focus of RMC*	*Outcome Measured*	*Key Findings*
9	Veronica Millicent Dzomeku et al. (2021)	Qualitative study	Ghana	Midwives	Four-day RMC training	Experiences of implementing RMC	Midwives described translating RMC training into routine maternity-care practice.
10	Barbara Anne Hanrahan (2021)	Multi-method qualitative intervention-development study	South Africa	Midwives in public midwife obstetric units	RMC intervention programme	Intrapartum communication and respectful-care practice	The programme addressed interpersonal communication and work-related stress to support respectful maternity care.
11	Hirut Megersa et al. (2021)	Qualitative observational study	Ethiopia	Women and maternity-care encounters	Respect and disrespect during childbirth	Childbirth-care experiences	Respectful and disrespectful behaviours coexisted within the same service environment.
12	Cheryl A. Moyer et al. (2021)	Mixed-methods study	Ghana	Maternity-care providers	Provision of respectful maternity care	Provider perspectives and practices	Providers valued RMC but identified stress, communication gaps, and resource constraints affecting consistent practice.
13	Alice Muhayimana et al. (2025)	Qualitative appreciative-inquiry study	Rwanda	Mothers after facility childbirth	Experiences and perceptions of RMC	Perceptions of respectful maternity care	Compassionate communication, autonomy, privacy, and supportive interactions were valued.
14	Harriet Nabulo et al. (2023)	Qualitative study	Uganda	Women referred with obstetric emergencies	Emergency referral experiences	Respectful emergency maternity care	Referral delays and communication gaps affected dignity, reassurance, and trust.
15	World Health Organization (2021)	Contextual policy report	Global	Health-workforce systems	Policy levers for compassionate and respectful care	Workforce performance and governance	Workforce policy, leadership, accountability, and enabling systems were identified as conditions for respectful care.
16	Giorgio Cometto et al. (2022)	Contextual framework and policy analysis	Global	Health-workforce systems	Governance for compassionate and respectful care	Policy and practice framework	Sustainable respectful care requires workforce governance and organizational support beyond individual training.
17	Gebrie Kassaw Yirga et al. (2025)	Multicentre cross-sectional study	Ethiopia	Healthcare workers	Respectful care for human dignity	Factors associated with respectful care	Professional attitude, prior CRC training, and monthly income were significantly associated with respectful-care practice; continued training, adequate supplies, and monitoring were recommended.

The included sources represented diverse geographical and methodological contexts. Most evidence originated from African settings, particularly Ghana, Kenya, Ethiopia, Rwanda, Uganda, and South Africa, with additional evidence from Asia, the United States, and global sources. Study designs included qualitative, cross-sectional, mixed-methods, quasi-experimental, intervention-development, and development studies. This diversity broadened the contextual evidence on RMC implementation but also contributed to methodological heterogeneity and limited direct comparison across studies.

Thematic Synthesis

Narrative synthesis identified four interrelated themes: provider capability and learning, provider wellbeing and bias, communication and dignity during urgent care, and organizational and governance conditions. These themes were not independent; rather, the evidence suggested that provider-level capability interacted continuously with the clinical and organizational environment in which respectful care was delivered. The four themes identified in the existing synthesis were supported by different combinations of intervention, observational, qualitative, and contextual evidence.

Table 3. Thematic Synthesis of RMC Implementation

Theme	*Evidence Pattern*	*Analytical Interpretation*	*Representative Studies*
Provider capability and learning	Training, mentoring, education, and practical tools improved knowledge, confidence, and preparedness.	Evidence was stronger for short-term educational outcomes than for sustained changes in clinical behaviour.	Afulani et al. (2023); Anderson et al. (2022); Craemer et al. (2024); Dhakal et al. (2022); Dzomeku et al. (2021); Hanrahan (2021)
Provider wellbeing and bias	Stress, working conditions, and provider bias influenced interpersonal behaviour and patient experience.	Provider behaviour was shaped not only by individual attitudes but also by organizational and psychosocial conditions.	Afulani et al. (2021, 2023); Moyer et al. (2021)
Communication and dignity during urgent care	Communication, privacy, reassurance, autonomy, and emotional support influenced women's experiences of care.	Clinical urgency increased the vulnerability of relational aspects of care but did not reduce their importance.	Megersa et al. (2021); Muhayimana et al. (2025); Nabulo et al. (2023)
Organizational and governance conditions	Staffing, resources, leadership, referral systems, supervision, protocols, and monitoring influenced implementation.	Sustained RMC required organizational support in addition to provider-level knowledge and skills.	Anderson et al. (2022); Yirga et al. (2025); WHO (2021); Cometto et al. (2022)

The first theme concerned provider capability and continuing professional development. Training, mentoring, online education, and practical tools were consistently associated with improvements in knowledge, perceptions, confidence, or preparedness. Dzomeku et al. (2021) demonstrated how RMC training could be translated into routine midwifery practice, while Hanrahan (2021) developed an RMC intervention programme addressing interpersonal communication and work-related stress. Anderson et al. (2022) extended this pattern by showing that professional midwifery and mentoring were associated with improved availability and dimensions of maternity-care quality. Craemer et al. (2024) demonstrated the relevance of structured educational resources to maternal-emergency preparedness. However, the outcomes across these studies were not equivalent. Some measured knowledge or preparedness, whereas others examined reported or observed

practice. Consequently, evidence supporting improvements in proximal educational outcomes was stronger and more consistent than evidence demonstrating sustained changes in clinical behaviour.

The second theme involved provider wellbeing, working conditions, and bias. Afulani et al. (2023) identified stress, motivation, psychological wellbeing, and working conditions as relevant mechanisms through which provider support may influence patient experience. Afulani et al. (2021) additionally demonstrated an association between provider bias and disparities in person-centred maternity care. Moyer et al. (2021) showed that providers recognized the importance of respectful care but experienced organizational and resource constraints that affected consistent implementation. Taken together, these studies suggest that provider knowledge and attitudes operate within a broader work environment. Interventions focused solely on provider attitudes may be insufficient when systemic barriers such as staff shortages, emotional exhaustion, inadequate supplies, or unsupportive organizational conditions persist.

The third theme concerned communication, privacy, dignity, autonomy, and emotional support during urgent care. Qualitative and observational evidence indicated that women's experiences were influenced by explanations from healthcare personnel, privacy protection, listening, reassurance, and involvement in decision-making. Megersa et al. (2021) demonstrated that respectful and disrespectful behaviours could coexist within the same maternity-care environment. Muhayimana et al. (2025) identified compassionate communication, autonomy, privacy, and emotional support as important components of positive childbirth experiences. Nabulo et al. (2023) showed that communication became particularly important during obstetric referral, where delays and uncertainty could undermine reassurance and trust. These findings suggest that clinical urgency does not eliminate the relevance of relational care; instead, emergency maternity services require communication processes that are sufficiently brief and structured to remain feasible during time-sensitive treatment.

The fourth theme concerned organizational readiness and governance. Across the evidence, staffing, workload, availability of supplies, leadership, referral coordination, supervision, protocols, and monitoring repeatedly appeared as conditions influencing whether RMC could be implemented consistently. Yirga et al. (2025) reported significant associations between respectful-care practice and professional attitude, prior CRC training, and monthly income; the authors also emphasized continued training, adequate supplies, and monitoring as implementation priorities. Anderson et al. (2022) demonstrated that mentoring occurred within a broader facility-level improvement context, while the policy and governance literature emphasized leadership, workforce support, accountability, and enabling organizational systems. Rather than indicating that provider training is ineffective, these findings suggest that the sustainability of provider-level improvements may depend on whether the surrounding health system enables respectful practices to be maintained.

Overall, the thematic synthesis indicates that RMC implementation in obstetric and maternity-care settings is a multilevel process. Provider capability influences the ability to communicate respectfully and preserve dignity, but its translation into routine practice is shaped by wellbeing, workload, organizational support, referral systems, and governance. The convergence of findings across diverse methodologies strengthens the interpretation that respectful maternity care should not be understood solely as an interpersonal behaviour. However, the heterogeneity of designs and settings means that the relative contribution of individual and organizational determinants cannot be quantified from the current evidence.

Discussion

Regarding the implementation of respectful maternity care, the findings indicate that respectful care in obstetric and maternity-care settings is shaped by the interaction between provider capability, relational communication, provider wellbeing, and organizational readiness. Educational and implementation strategies, including training, mentoring, online learning, and practical emergency-care tools, were associated with improvements in provider knowledge, confidence, preparedness, and reported respectful-care practices

(Anderson et al., 2022; Craemer et al., 2024; Dhakal et al., 2022; Dzomeku et al., 2021; Hanrahan, 2021). However, the outcomes assessed across these studies were heterogeneous. Some studies primarily measured knowledge, perceptions, or preparedness, whereas others examined provider practices or dimensions of service quality. Therefore, the evidence more consistently supports improvements in proximal educational and implementation outcomes than sustained changes in provider behaviour or clinical quality. This interpretation is consistent with the methodological appraisal, which demonstrated good overall quality but also showed that much of the intervention-related evidence was development-focused rather than based on controlled effectiveness evaluations.

The systematic synthesis further suggests that implementation is more likely to be sustained when education is embedded within broader mechanisms such as mentoring, supervision, feedback, and facility-level support. Dzomeku et al. (2021) described how midwives translated respectful-maternity-care training into routine practice, while Hanrahan (2021) developed a structured intervention programme addressing interpersonal communication and work-related stress among midwives. Anderson et al. (2022) demonstrated that professional midwives and facility mentoring were associated with improvements in the availability and selected dimensions of maternity-care quality. Craemer et al. (2024) additionally showed the relevance of standardized educational resources to preparedness for maternal emergencies. Taken together, these findings suggest that implementation should be interpreted as an ongoing organizational process rather than as the direct consequence of a single educational intervention.

Regarding barriers and facilitators, the review identified provider wellbeing, working conditions, bias, staffing, resource availability, leadership, supervision, and institutional monitoring as recurrent influences on respectful-care implementation. Afulani et al. (2023) highlighted provider stress, motivation, psychological wellbeing, and working conditions as relevant mechanisms influencing patient experience, while Afulani et al. (2021) identified associations between implicit and explicit provider bias and disparities in person-centred maternity-care experiences. Moyer et al. (2021) similarly reported that maternity-care providers valued respectful practice but encountered resource and organizational constraints that limited consistent implementation. Interventions focused solely on provider attitudes may therefore be insufficient if systemic barriers such as staff shortages, emotional exhaustion, inadequate supplies, or unsupportive organizational conditions persist.

These barriers and facilitators should also be interpreted in light of the methodological quality of the evidence. The analytical cross-sectional study met all reported appraisal criteria, although its design does not establish temporal or causal relationships. Qualitative studies generally demonstrated methodological coherence, but researcher positioning and reflexivity were not consistently reported. Mixed-methods studies showed good integration of qualitative and quantitative components, although their transferability varied by setting. Consequently, the convergence of findings across different study designs strengthens the interpretation that provider- and system-level factors interact, but the relative contribution of each factor cannot be quantified from the current evidence.

Regarding provider behaviour and quality of care, communication, privacy, dignity, autonomy, reassurance, and emotional support emerged as particularly important dimensions of women's experiences during maternity care and emergency referral. Megersa et al. (2021) showed that respectful and disrespectful practices could coexist within the same service environment, while Muhayimana et al. (2025) identified communication, autonomy, privacy, and supportive interactions as important components of respectful childbirth care. Nabulo et al. (2023) extended these findings to emergency referral, where delays and communication gaps affected dignity, reassurance, and trust. Roane (2024) likewise contributed evidence that respectful-care experiences were associated with more positive psychosocial and childbirth experiences. These patient-perspective studies do not provide direct estimates of provider-level intervention effectiveness, but they clarify which aspects of provider behaviour are most visible and meaningful during urgent maternity care.

The synthesis therefore suggests that clinical urgency and respectful care should not be

viewed as competing priorities. Rather, obstetric emergency services may require communication and consent processes that are brief, structured, and feasible within time-sensitive clinical conditions. Clear explanations, privacy safeguards, acknowledgement of women's preferences, emotional reassurance, and communication with accompanying family members when appropriate may be incorporated into emergency pathways without replacing or delaying life-saving clinical interventions. Because much of this evidence is qualitative or contextual, these implications should be interpreted as practice-oriented findings rather than definitive estimates of intervention effectiveness.

Within the barriers and facilitators domain, organizational-level factors were also important. Respectful maternity care appeared to depend on whether healthcare systems enabled providers to apply respectful-care principles consistently. Yirga et al. (2025) reported associations between respectful-care provision and provider training, attitudes, resource availability, staffing, and institutional monitoring. Anderson et al. (2022) showed that mentoring operated within a broader facility-strengthening context, while Cometto et al. (2022) emphasized workforce governance, leadership, accountability, and supportive policy as enabling conditions for compassionate and respectful care. The thematic synthesis therefore indicates that provider capability alone is unlikely to determine implementation outcomes; organizational readiness may facilitate or constrain whether respectful behaviours can be maintained under clinical pressure. The four themes identified in the synthesis—provider capability and learning, provider wellbeing and bias, communication and dignity during urgent care, and organizational and governance conditions—were consistently represented across different types of evidence.

An important contribution of this review is that it integrates evidence on implementation strategies with evidence describing barriers, facilitators, provider behaviour, and service-level conditions. Rather than treating these domains separately, the synthesis suggests a multilevel relationship in which provider knowledge and skills influence respectful-care practices, while workplace conditions and organizational systems determine the extent to which these practices can be consistently applied. This interpretation is strengthened by convergence across intervention, qualitative, cross-sectional, and mixed-methods studies, although methodological heterogeneity limits the strength of causal conclusions.

From a practice perspective, the findings support the integration of respectful-care principles into emergency obstetric protocols, simulation exercises, clinical supervision, referral review, and quality-monitoring processes. Provider education may be more useful when combined with mentoring, feedback, wellbeing support, and organizational mechanisms that address workload, staffing, resource availability, and communication during emergency care. Future studies should evaluate multicomponent interventions directly in obstetric emergency settings and should distinguish educational outcomes from sustained provider-behaviour and service-quality outcomes using validated measures and clearly defined implementation indicators.

This review has several limitations. First, substantial heterogeneity was identified across study designs, populations, settings, interventions, and outcome measures, which limited direct comparison and precluded statistical pooling. Second, several studies were conducted in general maternity-care settings rather than exclusively in obstetric emergency services; consequently, some findings provide indirect evidence for emergency obstetric care. Third, patient-perspective studies were used as contextual evidence to clarify communication, dignity, privacy, autonomy, and referral experiences, but they do not provide direct estimates of provider-level implementation effectiveness. Fourth, although the appraised studies generally demonstrated good methodological quality, researcher reflexivity was incompletely reported in several qualitative studies, and the development-focused studies did not provide controlled estimates of intervention effectiveness. Fifth, much of the empirical evidence originated from low- and middle-income settings, particularly sub-Saharan Africa, which may limit transferability to health systems with substantially different workforce and organizational conditions. Finally, publication bias, selective reporting, and overall certainty of evidence were not formally assessed, and evidence on sustained provider behaviour and long-term quality-of-care outcomes remained limited.

Conclusions

This review identified three main domains of respectful maternity care in obstetric emergency settings. Regarding implementation, RMC was supported by provider training, mentoring, practical competencies, communication skills, and organizational readiness. Regarding barriers and facilitators, implementation was influenced by workload, staffing, provider wellbeing, bias, resource availability, supervision, referral systems, leadership, and institutional support. Regarding provider behaviour and quality of care, respectful communication, dignity, privacy, autonomy, reassurance, and emotional support remained important during urgent maternity care. Overall, the findings indicate that sustainable RMC requires both provider-level capability and supportive organizational systems.

Recommendations

Emergency maternity services should integrate RMC principles into clinical protocols, simulation, supervision, referral procedures, clinical audit, and quality-monitoring indicators. Health-facility leaders should strengthen staffing, provider support, communication procedures, and organizational accountability to enable respectful care during emergencies. Future research should evaluate multicomponent provider-focused interventions directly in obstetric emergency settings using validated measures of RMC, provider behaviour, implementation outcomes, and quality of care.

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