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A critical review and meta-ethnography: Developing a birth integrity framework for epidemiological studies

Stephanie Batram-Zantvoort, Lisa Wandschneider, Oliver Razum, Céline Miani

Abstract

With this critical review, we aim to describe and synthesize different conceptual lenses and measurement approaches used to assess maternity care conditions and maternity care provision (MCCP), birth experiences and perceptions of birth (BEP) in epidemiological, quantitative research studies (e.g., disrespect and abuse during in maternity care, obstetric violence, maternal satisfaction, mistreatment during facility-based childbirth, person-centered care, childbirth experiences). On the 82 studies included, we conduct a meta-ethnography (ME) using reciprocal translation, in-line argumentation, and higher-level synthesis to propose the birth integrity concept and multilevel framework. We perform ME steps for the conceptual level and the measurement level. At the conceptual level, and to determine the relationship between studies, we first organize the studies according to the similarity of approaches into conceptual clusters and derive key concepts (definitions) for each cluster. Then, we 'translate' the study clusters into one another by elaborating each approaches' specific angle and pointing out the affinities and differences between the clusters. Finally, we present an in-line argumentation that prepares ground for the synthesis by identifying three components of measures (determinants, and subjective and objective outcome measures). At the measurement level, we first identify themes from the items used to measure MCCP and BEP. Second, we organize the themes into 14 categories and further differentiate in dimension and subdimensions. Finally, we synthesize our result from the analysis at the conceptual and measurement levels by introducing the birth integrity conceptual model and multilevel framework of birth integrity determinants. The macro-to-micro level birth integrity six-field framework is a tool to analytically distinguish between the complex and interwoven contributing factors that can influence the birth situation as such and the integrity of those who give birth. It can guide the development of survey instruments, qualitative interviews, interventional studies, or mixed method studies.

Keyterms: experiences, mistreatment, obstetric violence, birth integrity framework, meta-ethnography

1. Introduction

In the past decade, Public Health research on maternal and newborn health has undergone a transformative process. The former focus on birth outcomes (e.g., mortality, morbidity, cesarean section rate) has now expanded to take into consideration more explicitly the health systems conditions and health care processes that impact maternal and newborn outcomes, now resulting in a more comprehensive set of indicators (Moller et al., 2018). The evolution of maternal health metrics has at the same time shifted attention to how the provision of maternal health care is experienced from the parturients' view (e.g., satisfaction with birth, birth experiences).

This broadening of perspective developed into an entire research stream that deals with a women-centered evaluation of maternity care provision, ranging from studies on maternal satisfaction (Macpherson, Roqué-Sánchez, Legget, Fuertes, & Segarra, 2016) or childbirth experiences (Nilver, Begley, & Berg, 2017) to research approaches taking a more concrete look at substandard or even violent expressions of care, e.g., disrespect and abuse in childbirth (Bowser & Hill, 2010), mistreatment during facility-based childbirth (M. A. Bohren et al., 2016), or obstetric violence (Borges, 2018). The initially few studies concerned with maternity care and birth experiences have generated a response from the World Health Organization (WHO), which first addressed the topic in 2014 with a call for intensified research and action to prevent and eliminate disrespect and abuse toward women in childbirth (World Health Organization, 2014). Since then, WHO supported the enhancement of maternity care provision and the strengthening of maternal rights (World Health Organization, 2018, 2020). In parallel, birthrights organizations have put effort into developing the Respectful Maternity Care Charter (RMC) (The White Ribbon Alliance, 2019), which has been taken up in studies and broadened the research field (Sacks, 2017; Shakibazadeh et al., 2018).

Yet, the beforementioned concepts and frameworks (and related approaches) differ in part significantly from each other when it comes to the operationalization and measurement of the concepts main themes (e.g., consented care, respectful care) (David Sando et al., 2017) and to the definitional outreach of the concept itself (Savage & Castro, 2017). Researchers interested in designing quantitative studies within the research stream of maternity care condition and provision (MCCP), birth experiences and perceptions of birth (BEP) face the challenge of identifying a conceptual model that fits their aims and captures the dimensions of relevance from a multitude of existing (and varying) pool of measures and items.

Through a critical review and meta-ethnography, we aim to contribute to a better understanding of the commonalities and differences in approaches that epidemiological, quantitative research has conceptually taken to examine MCCP and BEP. Our overall research aim is to propose an umbrella concept and framework under which the existing and future research strands can be situated. Therefore, our research objectives are threefold:

- First, to identify and delimit from each other the existing research lenses (frameworks, concepts, terminologies) that are concerned with MCCP and BEP (Explanatory model).
- Second, to assess how these research lenses quantitatively measure MCCP and BEP (Operationalization).
- Third, to synthesize the explanatory models and operationalizations into a new framework that conceptualizes the interwovenness between MCCP and articulates them as determinants of BEP.

2. Methods

2.1 Critical review

We conducted a critical review and followed an iterative, circular and interpretative process (Gough, 2013). Critical reviews step beyond the literature's mere description and seek to include a certain degree of conceptual innovation, often transitioning into a new model (Grant & Booth, 2009). Relevant studies were identified through database searches in PubMed, PsychInfo, CINAHL, and Embase to identify epidemiological studies conducted on MCCP and BEP and using a quantitative methodology. We searched for terms that reflect attitudes or actions that influence MCCP and BEP and are related to the protection and violation of maternal rights by adapting the PICO scheme and using the Boolean operators OR and AND. Setting-wise, we included studies on facility-based childbirth (e.g., hospitals, obstetric clinics, birthing centers) and excluded studies on assisted and non-assisted home birth. Population-wise, we included women and persons with childbearing experience and those involved in childbirth processes (e.g., health care professionals, partners, doulas). Method-wise, we included studies with an exclusively quantitative design (surveys, observations, validation of scales). Terminology-wise, and to specifically capture the studies conducted as a response to the initially mentioned WHO call, we included studies that mentioned frequently used terminologies in this field (e.g., respectful maternity care, disrespect, and abuse, mistreatment in childbirth, human rights in childbirth, obstetric violence, birth experience, maternal satisfaction). Yet, studies not referring to one of these terminologies but still corresponding to the research theme were also eligible for inclusion. Studies exclusively addressing specific childbirth-related procedures or (medical) interventions (e.g., informed consent, episiotomies) were excluded. We limited our scope to studies published between 2010-2020 since the thematic framework proposed by Bowser and Hill in 2010 (Bowser & Hill, 2010) led to a significant increase in research. The full search and eligibility criteria are available in: (Appendix file A).

2.2 Meta-ethnography

By performing a meta-ethnographic analysis as originally outlined by Noblit and Hare (Noblit & Hare, 1988) we aimed to capture the included studies' explanatory models and approaches to measure MCCP and BEP). Meta-ethnography (ME) is used to produce new insights upon a topic by comparing, pooling, and analyzing studies through qualitative meta-synthesis (Atkins et al., 2008; Britten et al., 2002) and suited for analytical (rather than descriptive) findings as the reviewer re-interprets each study's 'conceptual data' (themes, concepts) and transcends them

into ‘higher-order themes’. Unlike the usual meta-ethnographic focus on qualitative studies, we exclusively included epidemiological studies with quantitative designs. We treated the studies’ conceptual definitions and measurement instruments as equivalent to ‘qualitative data’. As our research aims and objectives are oriented towards conceptual contribution, we consider the ME to be the most appropriate (qualitative synthesis) methodology that is applicable upon non-qualitative research when not planning to make outcome-based statements.

The ME analysis consists of three phases and seven steps that are iterating and overlap in a circular way until analytical saturation is reached (Sattar, Lawton, Panagioti, & Johnson, 2021).

The first phase consists of the three steps *Identifying and defining the topic and purpose of the review* (1), *Deciding what is relevant to the initial interest* (2), and *Reading the studies* (3). A crucial element of ME is the familiarization with each study by reading and re-reading several times to identify the main themes, concepts, or metaphors of the studies. We performed this third step by reading the studies multiple times and extracting data into a pre-structured data extraction table. The data extraction form comprised general study information (e.g., country, population, study aim), the definitional scope of the frameworks, concepts or terms (e.g., how did studies on disrespect and abuse during childbirth define these terms?), and the items used for measurement (e.g., how was disrespect and abuse operationalized in these studies?) .

Phase two of the ME comprises another three steps: *Determining how the studies are related* (4), *Translation of the studies into one another* (5), and *Synthesizing translations* (6). For this phase, we distinguished between two levels of analysis: the conceptual and the measurement level. The ‘data’ for the conceptual level refers to the conceptual lens through which the studies approach MCCP and BEP (e.g., definition, concept, framework). At the measurement level, the ‘data’ is constituted of the individual items of each study’s data collection instrument (e.g., validated questionnaire). With ME step 4, we aimed to identify the relationship between the studies at the conceptual level. We first grouped studies that showed similarities in their approaches into conceptual clusters. Then, essential terms, frameworks, or underlying perspectives were derived to create a shared definition for each conceptual cluster. At the measurement level, we listed the items extracted from all studies and tagged the underlying themes, again differentiated by the conceptual clusters. For both the conceptual and measurement level, we created two tables each: one to express the processes of determining the relationship between concepts and items and another to present the results of these processes. We then compared the metaphors and concepts of one article with those in others (ME step 5). At the conceptual level, we first elaborated each clusters’ primary focus, distinguishing from each other the different approaches, while at the same time indicating affinities between the research strands. At the measurement level, we translated the themes into one another by defining categories, dimensions, and subdimensions. Subsequently – and to meet ME step 6 – translations need to be identified as either reciprocal or refutational and brought into a line of argument, when appropriate. In-line argumentations transform the descriptive translations into higher-order interpretations, therefore bearing an analytical but also interpretative character. At the conceptual level, we presented an in-line argumentation through a content-wise and an operationalization-wise argumentation that was supposed to

prepare further conceptual development, including a differentiation between so-called determinants, and a subjective and an objective outcome measure. At the measurement level, we structured the identified categories according to the social context they relate to (e.g., infrastructure, facility-level, care culture).

The third and final phase of ME serves to *Express the synthesis* (7). Syntheses can be expressed by designing a framework, model, hypothesis, or theory if supported by findings from previous ME steps. We merged the findings of the ME analysis on the conceptual and measurement levels into one synthesis. We started by introducing the concept of birth integrity and then presented a six-field framework and allocated all categories identified at the measurement level within this framework. The eMERGE reporting guidance for meta-ethnography can be found in (France et al., 2019): Appendix file B.

3. Results

Our searches yielded 8689 hits in April 2019 and 937 hits in March 2020 (update conducted in PubMed only). After removing duplicates, we screened 9153 records based on the title and abstract. This led to the exclusion 9046 records. We read in full text 107 publications of which 82 studies met the predefined inclusion criteria. All relevant information was extracted in a data extraction table. For the PRISMA flowchart and reporting, data extraction table and a comprehensive overview of the studies' characteristics see: Appendix files A, C, and D.

3.1 Results of ME steps 4-6 on the conceptual level

To meet our first research objective, we identified and delimited from each other the existing frameworks and concepts through which research on MCCP and BEP is conducted.

We compared the theoretical concepts, keywords, definitions, or descriptions each study chose to approach the topic of MCCP and BEP. By doing so, we identified essential terms, underlying perspectives upon the topic (e.g., a rights-based approach), or shared references (e.g., the Respectful Maternity Care Charter) and derived a shared meaning ('key concept') that reflects a common definitional ground for each study cluster. We arrived at 6 main conceptual clusters, namely: Disrespect and Abuse/ Mistreatment during facility-based childbirth (D&A/ MISC), Respectful maternity care (RMC), OV, Person-centered care (PCC), Childbirth experiences (CE), Maternal satisfaction (MS). A few studies used more than one conceptual approach (most often D&A and RMC or D&A and OV). These were allocated to the conceptual cluster they showed greater commonality with, considering both the description and the measurement. We grouped concepts that were marginally used in a separate cluster named "Other". The results are presented in Table 1 where for each conceptual cluster a key concept is given. The process of identifying key concepts for each conceptual cluster included a thematic analysis of the definitions or perspectives each study stated to take upon their phenomenon of interest. The key concepts that were built therefore reflect the 'shared quintessence' of each cluster. An overview of the process of extracting key concepts can be found in: Appendix file E.

Table 1: Key concepts for each cluster of studies

Conceptual cluster	Key concept
D&A, MISC[1]	Disrespect and abuse reflect any form of inhumane treatment or uncaring behavior towards a woman during labor and birth. D&A represents a fundamental violation of women's human rights and undermines the safety and effectiveness of health systems, e.g., through non-dignified care, non-consented care, neglect or abandonment, or lack of privacy. Mistreatment (MISC) in childbirth describes childbirth-related mistreatment at an interpersonal but also at the health-system level and comprises seven domains: 1. physical abuse, 2. sexual abuse, 3. verbal abuse, 4. stigma and discrimination, 5. failure to meet professional standards, 6. poor rapport between women and providers 7. health system conditions and constraints. Drivers of D&A/MISC can include systemic failures, such as overwhelmed health care administration, poor staffing, and inadequate infrastructure.
RMC[2]	RMC is a universal human right due to every childbearing woman in every health system around the world in which maternity care goes beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights. Components of RMC are freedom from harm and ill-treatment; Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice whenever possible; Confidentiality, privacy; Dignity, respect; Equality, freedom from discrimination, equitable care; Right to timely health care and to the highest attainable level of health; and Liberty, autonomy, self-determination, and freedom from coercion.
OV[3]	OV addresses facets of dehumanized care and any action or omission by both health personnel and the health care system that physically or psychologically damaged or denigrated a woman. OV includes medical negligence, improper medication, pathologizing of/inconsideration for natural processes of childbirth, postpartum and female reproductive processes, and forced sterilization. OV links to the concepts of structural and gender violence. Structural violence includes the lack of access to health care services and any kind of health discrimination due to a woman's education, poverty, ethnicity, or other social vulnerabilities.
PCC[4]	Person-centered care is respectful of and responsive to individual patient preferences and needs, ensuring that the patients' values guide all clinical decisions. Elements of PCC are 1. treating the patient with respect, 2. providing care in a non-threatening manner, 3. working in collaboration as equal partners, and 4. giving priority to the patient's preferences over that of the healthcare provider.
CE[5]	Childbirth experiences and especially a woman's relationship with her health care providers in maternity settings significantly impact her health. It has long-term implications for her future emotional, physical, and reproductive health and wellbeing. Negative CE increases the risk for postpartum depression, secondary fear of childbirth, and post-traumatic stress disorder.
MS[6]	Maternal satisfaction refers to a woman's subjective and dynamic evaluation of her birth experience. This multifaceted construct includes elements of perceived quality of care,

	coping efficacy, and reflections of the birth experience as a whole and in context. Low MS can affect the mother's and infant's health. Low levels of MS are associated with greater odds of postnatal depression, post-traumatic stress disorder, requests for future elective cesarean section, sterilization, and abortion.
Others[7]	
Medical ethics **(ME)**	Medical ethics comprises the four ethical principles patient autonomy, nonmaleficence, justice, and beneficence.
Patient's verbal participation **(PVP)**	A patient's verbal participation influences the quality of care, which is, in turn, related to health outcomes. Predisposing factors influence how a person communicates with a health provider. Enabling factors affect communication participation levels. Communication by the health care provider is the final factor that influences the ways and extent to which patients participate.
Informed consent **(IC)**	Informed consent plays a vital role in clinical decision-making. It is a basis of self-determination in health care. In ideal situations, health care professionals inform their patients about all relevant aspects of care and alternative care options, map the value system of the patients, and adjust the information process accordingly. Patients and health care professionals have shared responsibility in the process.
Self-efficacy, control **(SEC)**	Self-efficacy during birth is associated with less anxiety and a greater perception of control during birth. Support from healthcare professionals is more important than the event of birth.
Responsive-ness **(RESP)**	Responsiveness addresses non-clinical aspects of health service quality relevant regardless of provider, country, health system, or health condition. It comprises factors related to health system interactions and health system environments, e.g., respect for human dignity and client orientation.
Support and Control **(SC)**	Caregivers must be supportive and create an atmosphere that allows a woman to gain autonomy over birth. Supportive care helps women obtain their control and enhances dignity during childbirth.
Maternal welfare **(MW)**	Maternal welfare includes six domains: Quality of relationship during care, self-care, and comfort, conditions that allow contact between mother and child, personalized care, continuous participation of the family, and timely and respectful care.
Mothers on Respect **(MOR)**	Mothers on respect captures the mother's sense of disrespect and dismissal, especially when engaging in conversations with providers. This concept is closely related to autonomy and informed consent.

[1] **D&A/MISC**: (22-51), [2] **RMC**: (52-58), [3] **OV:** (59-65), [4] **PCC:** (66-70) , [5] **CE**: (71-77), [6] **MS**: (78-93), [7] Others: **ME:** (94), **PVP**: (95), **IC :** (96), **SEC :** (97), **RESP :** (98, 99), **SC :** (100), **MW :** (101), **MOR** (102)

Considering the definitional outreach and themes found in the conceptual clusters, we identified their relation as 'reciprocal', yet approaching the topic MCCP and BEP from different angles and highlighting varying focal points. Still, we consider a reciprocal synthesis to be useful in terms of gaining a fuller picture of what determines the quality of MCCP and BEP.

The cluster D&A/MISC shows a strong focus on care interactions between healthcare professionals and parturient women. More specifically, it emphasizes negative experiences of poor maternal care. Deficits in care provision range from poor and/or abusive communication (e.g., verbal abuse or emotional threats) over non-dignified treatment to non-consented care, lack of privacy, neglect or abandonment of care, and non-confidential care. The constraints of health systems constituted another focal point of D&A/MISC studies, for example, insufficient staffing, equipment, or infrastructure.

In contrast to the D&A/MISC lens, the study cluster on RMC takes a right-based and ethical perspective in claiming universal and fundamental rights for every woman in childbirth. While many of the rights correspond to the D&A/MISC cluster in building the desirable opposite, it is important to note that RMC goes beyond the mere absence of abusive or disrespectful acts. It highlights specific rights in childbirth such as the rights to dignity and respect, to privacy and confidentiality, to information, informed consent, refusal, and choice, to equality and freedom from discrimination, to self-determination, or the general right to health care in its highest attainable standard.

While the studies clustered in OV showed high similarity to the D&A/MISC approach in pointing out the flaws of maternal care, OV presents violence in obstetric and gynecological care within its wider societal dimensions as a specific expression of gender-based violence and inequality towards marginalized populations (e.g., indigenous peoples). As such, OV addresses structural (e.g., laws on obstetric violence, financing of the health system), cultural (e.g., gender and ethnic inequalities, authoritarian medical habitus, pathologizing of female body processes), and maternal healthcare-related drivers that favor violating conditions and behaviors in obstetric care. OV specifically recognizes non-evidence-based interventions (e.g., routine episiotomies, medically unnecessary cesarean sections) as violent acts arising from an over-medicalized and authoritarian culture that expressed itself in the abusive behavior of health care professionals towards women. Reaching beyond birthing as such, OV addresses all aspects of reproductive health care, including the limited access to and realization of abortions or the performance of forced sterilization.

The PCC approach, in turn, shows affinities with RMC, yet not claiming universal rights but instead laying emphasis upon the parturient's wishes and preferences. PCC's focal point is a successful, cooperative, and engaged interaction between the health professional and the woman, including respect for her autonomy and self-determination. A guiding principle, for instance, is shared decision-making.

The studies clustered in CE link the perceived support during birth and the quality of the relationship between the care provider and the women with postpartum (mental) health and

wellbeing. A similar focus is visible in the studies in the MS cluster: here, the impetus lies within the parturient's expectations towards and feelings during birth, the satisfaction with the care provided, and how this impacts post-partum health.

After bringing the conceptual differences and similarities into one argumentative line, we developed first a content argumentation and second an argumentation for operationalization.

3.1.1 Content-wise argumentation

As outlined before, the key concepts present approaches that can broadly be divided between what is considered as 'good, professional care', leading to positive birth experiences, and 'abusive, non-professional care', leading to negative childbirth experiences. Terms like MISC and D&A imply an (underlying) connotation of intended harmful behavior towards women in childbirth. Although this connotation might apply to some interactions between health care professionals and parturient women, the phenomena and its causes extend beyond the level of interaction. While OV as a term reached beyond the interaction-related implications of abuse and mistreatment, it describes obstetrics as an inherently violent institution. In contrast, the concept of RMC substantiates respectful, maternal rights protecting care not only as a 'nice-to-have-add-on' to low morbidity and mortality rates but as a fundamental right. While the aforementioned concepts approach the topic from a care provision perspective, CE and MS take the individual's evaluation of their birth as their starting point.

A shared key issue identified in all approaches is the quality of the relationship between the care provider and the childbearing women. Moreover, almost all approaches refer (either explicitly or implicitly) to general human rights (e.g., to healthcare) and to topics of medicine ethics (e.g., informed consent, self-determination, autonomy). The conditions of maternity care, the care interactions taking place, and the way maternal rights are protected (or violated) can be interpreted as a reflection of women's (still marginalized) position in societies, and as reflecting an issue of gender equality and violence.

Therefore, we derive from the key concepts the following steps that lay the ground for conceptual synthesis:

1. Propose a concept that includes the care conditions (like D&A/MISC, RMC, OV, and PCC) and the individual's experiences and perception thereof (like MS and CE);
2. Include within this concept the desirable and functionable expressions of 'good' care conditions, not just poor and non-functionable expressions of care;
3. Reflect and contextualize birthing within its gender dimensions, and
4. Justify the concept through a fundamental rights and ethical perspective.

3.1.2 Operationalization-wise argumentation

While each study showed a stringent logic of how to terminologically conceptualize their approach, it is noticeable from an overarching perspective that the approach to the

phenomenon of interest is not always clearly elaborated and delimited within the research field on MCCP and BEP. We considered it relevant to precisely distinguish between the drivers that shape the care conditions, including the societal and medical professions discourses around birth, the actual provision of maternal care within health institutions, and the parturient's subjective expectations towards giving birth. Taken together, these build the *determinants* of how childbirth is *experienced*. The childbirth experience is perceived differently by everyone, which leads to a subjective outcome measure that reflects how the birth experience is *individually perceived*. This individual perception of one's own birth potentially affects postpartum (mental) health and wellbeing. From an analytical perspective, we see three components that need to be reflected in the operationalization of studies on maternity care provision and maternal experiences of birth:

1. Determinants of the birth experience
2. Subjective outcome measure (birth perception)
3. Objective outcome measure (health consequences of the birth perception)

3.2 Results of ME steps 4-6 on the measurement level

With our second objective, we aimed to depict how MCCP and BEP have been operationalized and measured in quantitative studies. To meet this aim, we extracted each item used to measure MCCP or BEP and tagged it with a corresponding theme (e.g., verbal abuse). Table 2 exemplifies the process of creating themes from items in the RMC cluster (the process of identifying themes in items separated by each conceptual cluster can be found in: Appendix file F.)

Table 2: Process of identifying themes in items (examples taken from the RMC cluster)

Study	**Themes**	**Items (as stated in the original studies)**
(Bante et al., 2020)	Empathy	The health worker showed his/her concern and empathy.
	Responsiveness	The healthcare workers responded to my needs whether or not I asked.
	Verbal abuse	Some health workers shouted at me because I haven't done what I was told to do.
(Dynes et al., 2018)	Physical abuse	Did any of the health facility staff ever physically abuse you during your visit? By physical abuse, we mean, did they hit, slap, push, kick you, or use any other type of physical force against you (Absence of physical abuse)?
(Rosen et al., 2015)	Auditory and visual privacy	Delivery in rooms with auditory and visual privacy

Table 3 provides an overview of all themes identified in the study clusters, therefore representing a collection of the aspects that have been considered in research on MCCP and BEP to date. The table also shows which themes were operationalized rather frequently and which

only occurred in fewer conceptual clusters. For example, the theme “Consistency of information” was only found in MS studies, while the theme ‘Non-respectful care’ appeared in all conceptual clusters.

Table 3: Themes in study items (by conceptual clusters)

Themes	**D&A, MISC**	**RMC**	**OV**	**PCC**	**CE**	**MS**	**Other**	**Themes**	**D&A, MISC**	**RMC**	**OV**	**PCC**	**CE**	**MS**	**Other**
Availability of health facility						x		Provision of written information							RESP
Availability of medical services in facility			x				RESP	Admission, service, and information management					x	x	RESP
Accessibility of health facility (from home)						x		Equipment to protect privacy	x	x	x				RESP
Conformity of childbirth expectations and experiences						x		Availability of pain relief medication and comfort measures	x					x	
Staffing capacity	x			x	x	x		Medical assessment	x						
Continuity and choice of the care provider						x	RESP	Comfortability and conditions of amenities						x	MW
Timely care	x	x		x		x	MW	Basic equipment	x			x		x	
Detention in facility	x		x					Provision of translation	x						
Information on individual proceeding and medical	x	x			x	x	MES	General information on labor, birth, postpartum	x	x			x	x	

diagnosis								stage, and newborn care							
Cleanliness and hygienic conditions of facility	x			x		x	RESP	Appropriate length of hospitalization					x		
Hygienic practices	x							Information on choices	x						PVP
Provision of safe medical care					x	x	MES, PVP	Consistency of information						x	
Adherence to medical guidelines and evidence-based care practices			x			x		Explanation of procedures or examinations before proceeding	x	x	x	x			MES
Competency of health provider					x	x		(Non-)Consented care	x		x	x		x	MES, IC, RESP
Encouragement to ask questions	x	x				x	SEC, RESP	Involvement and empowerment				x			
(Non-) Discrimination based upon financial or insurance status	x	x		x			MES, MW, MOR	(Non-)Discrimination based upon individual's attributes	x	x	x	x		x	MW, MOR
(Non-)Effective communication	x			x			PVP, RESP	(Non-) Discrimination based upon disagreement	x	x		x			MW, MOR
Engagement and Empathy		x		x				Internal control					x	x	SEC, RESP, SC
(Non-)Respectful	x		x	x	x	x	MW	Perceived societal	x						

communication								discriminatory practice							
Verbal abuse	x	x	x	x	x		MES	Bodily autonomy	x		x			x	IC
Emotional abuse	x			x	x			Parental rights	x		x			x	
Presence and absence of health professionals	x	x	x		x	x		Provision/ denial of requested care or pain medication	x		x		x		RESP
Physical abuse (force)	x	x	x	x				Bribery	x						MES, RESP
Physical abuse (restraint)	x	x	x	x				(Non-)Respectful care	x	x	x	x	x	x	RESP
External control					x	x	SEC, RESP, SC	Attitudes towards childbirth						x	
Sexual abuse	x						MES	Expectations of control						x	
Visual privacy	x	x	x		x			Preferences and wishes	x		x				
Cooperation between health professionals						x		Perception of violent birth experiences			x				
Visual privacy	x	x	x		x			Coercion	x		x				
Auditory privacy	x							Agentry				x		x	
Stress, anxiety, fear					x	x	SEC, RESP, SC	Pain perception					x	x	SEC, RESP, SC

Satisfaction with self						x		Situational privacy	x				x	x	MES, RESP
(Non-)Confidential handling of sensitive data	x		x	x			MES, RESP	Engagement and Empathy		x		x	x		
Bonding and attachment				x				Depression						x	
Pain management	x			x		x	SEC	Security, safety, trust, feeling of being seen	x	x		x	x	x	SEC, RESP, SC
Posttraumatic stress							SEC	Attitudes towards gender norms				x			

In all, we identified 72 themes. We organized these themes by defining 14 higher-level categories, dimensions, and (where appropriate) more detailed subdimensions. The categories, dimensions, and subdimensions are reciprocal since they all reflect components or determinants of the MCCP or BEP. Building upon the prior operationalization-wise argumentation of distinguishing determinants on the one hand and both subjective and objective outcome measures on the other hand, all categories were allocated accordingly. While each category in the subjective and objective outcomes measure relates to the individual person giving birth, the twelve determining categories stem from different levels and contexts, ranging from policy and infrastructure to culture, the facility, care provision, care approaches, and individual factors.

Boxes 1-12 present the categories that we identified as determinant of birth of integrity, whereas the last two boxes show each one category for the subjective (Box 13) and objective outcome measure (Box 14).

Health service capacity (relates to infrastructure and policy)

In its most basic description, the health service capacity concerns the availability of a health care facility nearby the parturient's residence. Closely linked is the accessibility of the facility depending on the infrastructure (e.g., public transport) and the availability of specific medical services within the facility. Last, this category includes the availability of specialized obstetric services and trained maternal and newborn care staff.

Dimensions, example items:

- Availability of health facilities in region: *'Availability of medical facilities'*
- Accessibility of health facilities (e.g., public transport): *'Access to hospital from residence'*
- Availability of obstetric and maternal care services and trained maternal care and newborn staff in health facilities: *'Did you go to more than one hospital to find a bed for childbirth?'*

Box 1

Societal discriminatory norms (relates to culture)

Societal discourses on gender norms and racism generate, more or less directly/implicitly, inequalities of treatment between women with different social identities and positions. This category encompasses attitudes towards gender norms or the perception about whether racism comes into play in labor room interactions.

Dimensions, example items:

- *Racism:* 'A pregnant white woman is treated with more respect than pregnant African American woman.'
- *Gender norms: 'There are times where a woman deserves to be beaten.', 'Only when a woman has a child, she is a real woman.'*

Box 2

Professional care (relates to care conditions, evidence-based practices)

This category includes the quality of care-provision, including the adherence to medical guidelines, evidence-based care, and hygienic practices to ensure the provision of safe medical care health care.

Dimensions, example items:

- Care quality
    - Medical assessment: *'Checked fetal heart sounds, took obstetric and medical history.'*
    - Adherence to medical guidelines and evidence-based care practices: *'I received a lot of medical intervention, i.e. induction, forceps, section', 'I had a natural labor, i.e. minimal medical intervention.'*
    - Provision of safe medical care: *'I felt that some medical mistakes occurred while providing care to me.'*
    - Competency of health professionals: *'The health-care team was well trained to care for me.'*

Box 3

Facility (relates to care conditions)

A facilities' equipment (beds, rooms, privacy screens, running water and electricity), supplies (medication, postpartum supply, food), hygienic conditions, and comfort (e.g., cleanliness of bathrooms, comfortability, and condition of rooms) are preconditions to ensure safe deliveries.

Dimensions, example items:

- Hygiene and comfort: *'Bed in post-natal ward not clean.', 'How do you rate the quality of the hygiene of the toilets?'*
- Equipment and supplies
    - Basic equipment and supplies: *'Was there electricity in the facility?'*
    - Equipment to protect privacy: *'No screens blocking view during delivery or examination.'*
    - Availability of pain relief medication and comfort measures: *'Supplies of basic drugs and equipment, 'No access to epidural anesthesia.'*

Box 4

Organization of care and management of the facility (relates to care conditions)

A health facility`s workforce planning, the hospitals' service, and information management, room planning, and the duration of hospital stay relate to a facility's ability to organize and manage the maternity care provision.

Dimensions, example items:

- Care capacity
    - Staffing capacity/human resources: *'Thinking about the labor and postnatal wards, did you feel the health facility was crowded?'*
    - Continuity and choice of the care provider: *'I had the same midwife throughout the entire process of labor and delivery.'*
    - Timely care: *'I was kept waiting for a long time before receiving service.'*
- Duration of hospital stay
    - Detention in facility: *'Detention in facility for failure to pay.'*
    - Appropriate length of hospitalization: *'I stayed in hospital as long as I wanted after the birth.'*
- Service and information management: *'Did you find that the services you received during your stay at the delivery ward were well-organized?'*

Box 5

Dignified care (relates to care culture)

Dignified care is shown in the way of communicating and treating the birthing person, e.g., using respectful language, calling the woman by name, or talking calmly, approaching her kindly and in a culturally sensitive manner. Non-dignified care includes verbal, emotional, physical, or sexualized abuse.

Dimensions, example items:

- Communicative approach
    - Respectful communication: '*The staff communicated well with me during labor.'*
    - Verbal abuse: '*Shouted, insulted or threatened the woman during labor or after.'*
    - Emotional abuse: *'Threat of withholding treatment, threatening or negative comments'*
- Handling and treatment
    - Respectful care: *'Did the doctors, nurses, or other staff at the facility treat you with respect?'*
    - Physical abuse: *'Did you feel like you were treated roughly like pushed, beaten, slapped, pinched?', 'Restraining or tying down during labor.', 'Episiotomy sutured without anesthesia.'*
    - Sexual /sexualized abuse: '*Sexual harassment, rape', 'Inappropriate sexual conduct.'*

Box 6

Birth accompaniment (relates to care provision, care culture)

This category refers to an accompanying care culture, including the sufficient presence of the health professionals during labor, e.g., through frequent presence and attention, regular visits, and, if possible, continuous and 1-to-1 care. The opposite of presence at birth is a negligent care culture, including the abandonment of care (e.g., leaving women alone during labor and birth). Birth accompaniment also includes cooperative and effective collaboration between care providers (e.g., respectful communication, respecting professional opinions and decisions). Birth accompaniment also encompasses the responsiveness and adequateness of reactions of health care providers towards the person in birth, including the quick and proper feedback to requests (e.g., requested assistance, support, or administration of pain medication). Non-responsive care is reflected by denial or ignorance of the parturients' requests.

Dimensions, example items:

- Presence of health care professionals*: 'Midwife present in room as much as I wanted during labor and birth', 'Delivery without attendant.',*
- Cooperation between health care professionals: *'Communication between health care providers.',*
- Responsiveness in care interactions
    - Quick Reactions: *'How well did you receive prompt attention at your health service?',*
    - Provision of requested care or pain medication: *'Mother received wished pain relief.', 'Provider ignored me or did not come quickly when I called him/her.'*

Box 7

Supportive care (relates to care provision, care culture)

Supportive care is reflected through a person-centered care approach that prioritizes wellbeing and comfort throughout labor and birth, e.g., allowing for a companion of choice, offering support in managing labor pains, encouragement to choose a comfortable birth position, empathic interaction, involvement in decision-making, supporting autonomy, and empowerment of the birthing person.

Dimensions, example items:

- Supportive practices
    - Assistance and (physical) support: *'Provider did not encourage or assist woman to ambulate and assume different positions during labor at least once.'*
    - Pain management: *'The staff encouraged me to try new ways of coping (such as breathing)', 'The staff encouraged me not to fight against what my body was doing.'*
    - Mobility, Food-and drink-intake, companion of choice: *'Provider encourages client to consume food and fluids during labor.'*
- Supportive attitude:
    - Emotional support, engagement, empathy, encouragement*: 'The health worker responded to my needs whether or not I asked.', 'The health worker showed his/her concern and empathy.'*
    - Involvement, empowerment: *'The delivery room staff encouraged me to make decisions about how I wanted my birth to progress.'*

Box 8

Information, explanation, consent (relates to care conditions, care provision, and care culture)

This category refers to the comprehensibility and accessibility of information, including the provision of multilingual information sheets and, if needed, translators to obtain informed consent. This includes an informative- and consent-seeking care culture that follows the medical ethical principle of obtaining informed consent before conducting examinations, administering medication, or deciding on medical procedures. Non-consented care or coercion to procedures reflect a restriction of self-determination.

Dimensions, example items:

- Hygienic practices: *'Provider used gloves during delivery.'*
- Comprehensibility
    - Provision of (multilingual) written information and consent sheets: *'Was written information provided in such a way you could understand?'*
    - Provision of translation or translator: *'Interpreter not available.'*
- Information and explanation
    - Effective communication: *'Convey information to mothers at a language-level they can understand?'*
    - General information on labor, birth, postpartum stage, and newborn care: *'Satisfaction with: The amount of explanation or information received from the nursing staff in labor and delivery.'*
    - Information on individual proceedings and medical diagnosis: *'During labor, there was always a carer to explain things so that I could understand.'*
    - Explanation of procedures or examinations before proceeding: *'I was informed about all necessary procedures during my labour and childbirth.'*
    - Information on choices: *'Offered choices regarding birth.'*
    - Consistency of information: *'The information received from different caregivers about self-care and baby care was consistent.'*
    - Encouragement to ask questions: *'Did the care providers encourage you to ask questions?'*
- Consent
    - Consented care: *'Provider didn't obtain consent prior to procedure.'*
    - Coercion: *'Coercing into a medical procedure such as a cesarean section.'*

Box 9

Confidential care (relates to care provision, care culture)

This category reflects a culture of confidentiality, trust, and protection of privacy in dealing with the parturient's sensitive information, personal data, and personal space.

Dimensions, example items:

- Protection of privacy
    - Visual privacy: *'Did the health care providers use curtains or other physical barriers so that your privacy was kept during the labor and delivery processes?'*
    - Auditory privacy: *'Women-provider conversation overheard by others (stranger, other patients, or non-medical staff).'*
    - Situational privacy: *'There were people coming in and out of my room unnecessarily during labor.'*
- Confidential handling of sensitive data: *'HIV status shown to others.'*

Box 10

Personal rights, ethics, and equity (relates to individual, interactional)

This category relates to fundamental maternal rights, including wishes and preferences for birth and parental rights. Requests for bribes or informal payment conflict with ethics. Discriminating or privileging parturients based upon personal attributes or identities (e.g., race, sexual or gender, appearance), disagreement (e.g., different views upon health care), socio-economic background (financial status), or health insurance (e.g., denial of needed care) reflects non-equitable care.

Dimensions, example items:

- Maternal rights
    - Preferences and wishes: *'Denied companionship by the husband or close relatives.'*
    - Self-determination, autonomy: *'Freedom of movement during labor'*
- Parental rights
    - Decisions upon newborns' health and nutrition: *'Baby was separated without medical indication.'*
- (Non-) Discrimination, equal care: *'Discrimination based on specific client attributes like race, age, HIV/AIDS status, traditional beliefs and preferences, economic status, or educational background.'*
- Requests for bribery or informal payment: *'Inappropriate demands for money.'*

Box 11

Attitudes and expectations towards birth (individual, subjective)

This category includes the ideas, prior knowledge and wishes for birth, childbirth efficacy (e.g., expectation towards own ability to manage labor pain), and expectations of control.

Dimensions, example items:

- Attitudes towards childbirth: *"I would like a birth that is as natural as possible".*
- Expectations of control: *'There is nothing I can do to make sure my child is born healthy.', 'I could make very few choices that would affect my child's health at birth.'*

Box 12

Childbirth perception and feelings (individual, subjective)

The actual perception of one's birth is measured through different aspects like the conformity of childbirth expectations and experiences, the feelings, emotions, and thoughts experienced during birth with an internal and external reference.

Dimensions, example items:

- Conformity of childbirth expectations and experiences: *'My birth experience was considerably different to what I intended.', 'I had not expected to have some of the medical interventions used at my birth.'*
- Internal and self-reference
    - Internal control: *'I had a sense of not being in control', 'I felt powerless.'*
    - Agentry: *'I experienced a sense of conflict', 'I felt incapable'*
    - Stress, anxiety, fear: *'I coped well during birth.', 'I felt mutilated by my birth experience.', 'I felt very anxious during my labour and birth'*
    - Satisfaction with self: *'Satisfaction with: Your ability to manage your labor contractions.'* Pain: *'Labour was not as painful as I imagined.'*
- External reference
    - External control: *'I could influence which procedures were carried out.', 'I felt I had control over the way my baby was finally born'*
    - Feelings of security, safety, trust, being seen: *'I felt safe in the labor and birth environment.', 'I had confidence and trust in the staff caring for me.'*
- Perception of being violated during birth: *'Do you think you have experienced obstetric violence?'*

Box 13

Health consequences of violated/negative birth experiences (individual, subjective)

The objective outcome measure refers to the potential impacts that violent birth experiences can evoke after birth, including (posttraumatic) stress symptoms, bonding, and attachment, and postpartum depression (e.g., feeling scared, blaming, or harming self).

Dimensions, example items:

- *Bonding and attachment: '*Just seeing my baby makes me feel good.'
- *Postpartum depression: '*I have been anxious or worried for no good reason.', 'I have been so unhappy that I have been crying.'
- *Post-traumatic stress, birth trauma: "*Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.'

Box 14

3.3 Expression of the synthesis (ME step 7): Multilevel birth integrity framework

As elaborated through the conceptual in-line argumentation, our inclusive approach to conceptualize how birth experiences affect individuals needs to consider an ethical- and rights perspective. Furthermore, it should reflect birthing within its societal dimensions, and be terminologically open to determinants that impact either negatively or positively the perception of the birthing situation. Our approach should additionally include the impact of birth experiences and perceptions on postpartum maternal health and wellbeing.

Therefore, we will now propose *birth integrity* as a suitable umbrella term and concept as a synthesis of our meta-ethnographic findings. Then, we continue our synthesis at the measurement level by introducing the multilevel birth integrity framework that may contribute

to a better operationalizing of the different angles that epidemiological (and further research traditions) may take upon birth integrity, its determinants, and the potential consequences of birth integrity violations.

3.3.1 Concept of birth integrity

In recurring to our content- and operationalization-wise in-line argumentation, we suggest the *birth integrity* as an umbrella concept:

Ethical foundation: While giving birth, the parturient strives to preserve their autonomy, self-determination, and dignity as these are reflections of their integrity as human being. Integrity is constituted of one's physical, cognitive, emotional, and social components and can be violated by different means, e.g., through poor care conditions, disrespectful care interactions, or expectations towards birth, that differ strongly from the societally dominant discourses and practices around birth. By placing human integrity terminologically at the center, the concept of BI is ethically founded in fundamental human rights and spans the bridge from breaches to integrity to birthing experiences that are perceived as protective, respecting, or preserving integrity.

Determinants of the birth experience vs. subjective perception of birth vs. objective outcome measure

There is a multitude of determinants that influence birthing experiences. These determinants range from structural (e.g., financing of obstetrics) or cultural drivers (e.g., gender equality) to the actual quality of care provision (respectful or abusive care) and individual expectations towards birth. While birthing experiences and care conditions can be objectively assessed and compared through observational studies or questionnaires (e.g., prevalence studies), it remains highly subjective how birthing is emotionally, bodily, and cognitively perceived and evaluated by the women and individuals of other gender identities themselves. As expectations, practices and cultures around birth differ, a similar birth experiences might lead to varying birth perceptions, leaving one women's integrity violated while another perceived her integrity as being preserved. Nevertheless, it is of high importance to keep both the 'objective' of care provision (as measures that provide information on the quality of maternity care provision) and the 'subjective' birth perception (as subjective outcome measure that provides information on what specifically violated birth integrity) in view. In addition to the measurement of birth integrity determinants and the subjective perception of birth integrity (as being violated or preserved), a third component relates to the potential consequences of birth integrity violations as possibly negatively impacting postpartum (mental) health and wellbeing. Complementary to the subjective outcome measure, the use of a standardized postpartum health instruments as a second – objective – outcome measure serves to reveal the health consequences of disrespectful, abusive, or violent conditions.

We consider it important to carefully distinguish between a subjective and an objective outcome measure as not every violation of birth integrity results in decreased postpartum wellbeing and health (e.g., due to coping mechanism). However, as the protection of a woman's and

childbearing person's integrity is a right in itself, it is important to better understand which conditions and actions exactly violate birth integrity–regardless of whether postpartum health is impacted or not.

Birth integrity as a gender-inclusive term: The social framing and language around childbirth is highly gendered in the sense that thought patterns, institutions, and technical terms imply a predominantly feminine terminology. This stems from the fact that the overwhelming proportion of all parturient identify as women and that obstetrics and assistance to birthing have long been framed as women's health specialties. In considering all people with a uterus and the bodily ability to give birth, we propose birth integrity as a gender-inclusive concept that, in addition to terms like 'women' or 'maternal', acknowledges all bodies and gender identities that give birth.

3.3.2 Multilevel birth integrity framework

To express the synthesis of the ME at the measurement level, we first introduce a framework that has initially been developed by sociologist Ritzer (Ritzer, 1992) for the social analysis of societies, apply it to our topic, extend it by adding a further level and finally place categories identified through the ME within this framework.

This multilevel framework now consists of three levels: the macro-, the meso-, and the micro-level. Additionally, the framework distinguishes between two expressions, namely manifest and latent. As developed theoretically and more detailed elsewhere (Batram-Zantvoort, Razum, & Miani, 2021), we define the six fields as follows:

As for the *macro-manifest* expressions of factors potentially influencing birth integrity, we gather the legislation around birth (e.g., laws addressing obstetric violence (Williams et al., 2018) or health policies programs to ensure maternity care provision. The *macro-latent* field includes norms, values, and collective patterns of interpretation or discourses that are significant for society as a whole, e.g. in relation to (the myths of) birthing, femininity, or motherhood (Cohen Shabot, 2015), risk discourses around birth (Chadwick & Foster, 2013) or birth medicalization (Brubaker & Dillaway, 2009; Clesse, Lighezzolo-Alnot, de Lavergne, Hamlin, & Scheffler, 2018). This field also includes the interrelations between social groups that create superior and inferior positions in power, access, or influence (e.g., positions that are formed along intersecting identities like sex, gender, race, ethnicity, or education) (Carbado, Crenshaw, Mays, & Tomlinson, 2013). In the *meso-manifest* field, we locate the health facilities' infrastructure, and equipment, hygienic conditions, the management and organization of care, and the general quality of medical care provision (e.g., adherence to evidence-based practices). In the *meso-latent* field, we mainly locate the maternity care cultures, which express themselves in the relational approach health care professionals take towards the parturient (Behruzi, Hatem, Goulet, Fraser, & Misago, 2013). In the *micro-manifest* field, we arrange the health

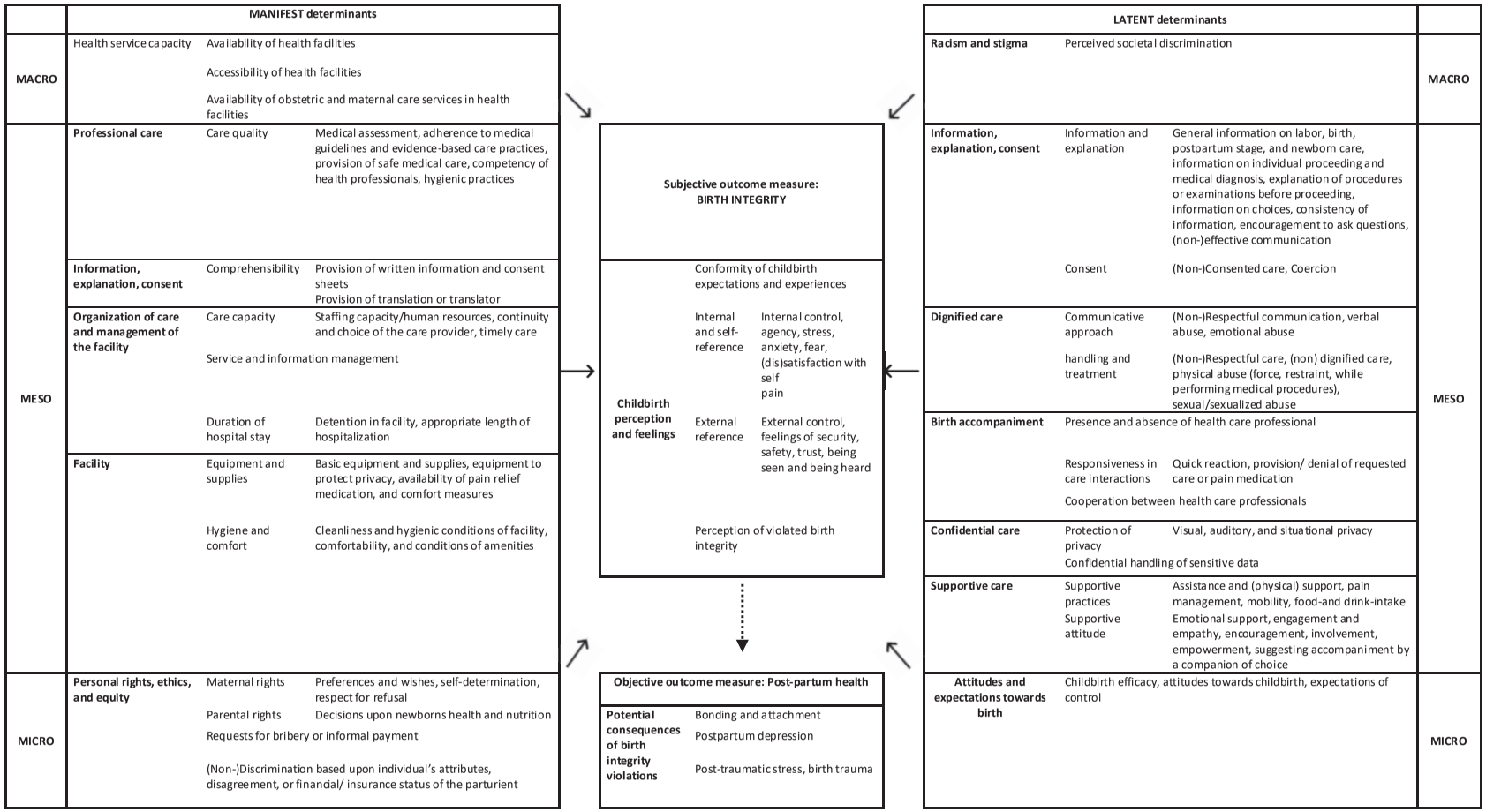
professionals' direct reactions to a person's attributes, requests, and actions. While this field also reflects the care culture (as in the meso-latent field), it shifts the perspective from the culture itself to the individual with its specific characteristics and how this can lead to ethnic or socioeconomic discrimination in the labor room (Santiago, Monreal, Rojas Carmona, & Dominguez, 2018). Last, in the micro-latent field, we place the subjective attitudes and expectations towards childbirth (Davis-Floyd, 2001).

Placing categories within the multilevel birth integrity framework

In each of the fields, we can place at least one category that was built through the ME process. On the macro-level, we assign in the manifest expression the category '*Health service capacity*' and in the latent expression the category '*Societal discriminatory norms'.* As expectable, we have matched most categories on the meso-level. On the meso-manifest side, we locate the categories: '*Facility', 'Organization of care and management of the facility', 'Professional care'* and certain aspects of *'Information, explanation, consent'* (e.g., availability of multilingual consent sheets, availability of translator). On the latent side, we assign the categories*, 'Dignified care', 'Birth accompaniment', 'Confidential care', 'Supportive care'* and *'Information, explanation, consent'* (e.g., consent-seeking care approach). On the macro-manifest side, we place the categories '*Personal rights, ethics and equity'* and on the macro-latent side category '*Attitudes and expectations towards birth*'.

Besides these categories identified as determinants, we characterized one category each for the subjective outcome of birth integrity (*Childbirth perception and feelings*) and the objective outcome (*Health-consequence of violative birth experiences*). Figure 1 gives an overview of the multilevel birth integrity framework including the category, dimensions, and subdimensions on the macro-to-micro level in manifest and latent expression:

Figure 1: The multilevel birth integrity framework



4. Discussion

In this critical literature review applying a ME approach, we first aimed to identify and delimit from each other recent research lenses on maternity care conditions and provision, birthing experiences, and maternal perception of birth. We met this aim by creating study clusters, providing shared definitions for each cluster, and elaborating each clusters' specific focus upon the phenomenon. Based upon the reciprocal translation of the clustered studies, we deduced an in-line-argumentation resulting in key considerations that prepared ground for the pending conceptual synthesis.

Our second aim was to assess the operationalization and quantitative measurement of maternity care conditions, care provision, and maternal birth experiences. From all studies, we extracted items, labeled each item with a theme, and merged these themes into categories, dimensions, and subdimensions. In all, we identified 14 categories that arise from and are related in different contexts: While the majority of categories (12) corresponds to being a driver of maternity care provision or a determinant of how maternity care is experienced, one category refers to the subjective perception of birth (subjective outcome measure) and one category to the potential health consequences of unfavorable birth experiences and/ or a negative birth perception (objective outcome measure, subordinated in time).

The findings presented at the conceptual and measurement level prepared ground for a higher-level synthesis, the third aim of this review. We underpinned the terminology of birth integrity by expounding its gender-inclusiveness and referred to human rights by claiming that to every parturient is the right that their integrity remains unaffected during birth. By distinguishing from one another the determinants of birth integrity and subjective and objective outcome measures, the concept of birth integrity is suitable to integrate determinants that result in positive perceptions of birth ('preserved' or 'protected' birth integrity) and negative perceptions of perceptions ('violated' birth integrity) and conceptually envisage the (potential) negative health effects of violated birth integrity.

Recurring to the findings at the measurement level, we considered it useful to introduce a macro-to microlevel framework that distinguishes between a manifest and a latent expression. Into the six fields, we allocated all categories (including dimensions and subdimensions) that we identified as determinants of birth integrity. Hence, the underlying (social) context of each dimension is obvious at first sights, e.g., staffing capacity of the facility at the meso-manifest level, a maternity care institution's care culture at the meso-latent level, or one's individual predispositions (e.g., attitudes towards birth, birth-related locus of control) at the micro-latent level. We linked the category on birth perceptions (subjective outcome measure) with our concept of birth integrity and outlined the potential (negative) health effects of violated birth integrity as an objective outcome measure.

4.1 Determinants of birth integrity: Expanding the field

Current epidemiological research reflects and integrates a multitude of birth integrity determinants into their quantitative study designs. Most measures refer to the meso- and microlevel as they put the institution and the individuals involved in childbirth in focus (health facility, health care professionals, person who gives birth). We propose to consider to a greater extent the macro-level driver(s) that potentially determine how maternal care is executed. This implies, for instance, a stronger focus on structural forms of disrespect towards women that have manifested in a lack of resources (human, equipment, infrastructure) in maternity care settings (Betron, McClair, Currie, & Banerjee, 2018). Thereby we have in mind the financing of obstetrics (e.g., remuneration system, insurance coverage), policies and laws concerning obstetric and midwifery care (e.g., on staff sub-limits, ensuring sufficient staff and bed availability to prevent overcrowding and, as a consequence, rejection of parturient from the clinic, laws addressing obstetrical violence), the availability of maternity clinics close to residence (in remote areas), free choice of birth location (e.g., midwifery-led clinics or labor rooms for low-risk-pregnancies, specified resourced facilities for high-risk pregnancies), the existence of routes to report experiences or observations of violations against fundamental rights in childbirth (e.g., informed consent) and abusive events during obstetric or midwifery care (e.g. verbal abuse, threats) (Quattrocchi, 2019). We also consider it relevant to integrate macro-level indices of discrimination as potential determinants of birth integrity, e.g., gender equality indices or racial equity indices (Nagle & Samari, 2021).

A society's gender relations, practices, and norms have cultivated dominant narratives that are mirrored in expectations, ideas, semantics, and actions around childbirth (e.g., on femininity and motherhood, power relations). Research on birth integrity should include measures on a society's dominant gender roles, on narratives of childbirth medicalization, or reflect on how childbirth is negotiated as 'risky' at the macro-latent level. By considering medicalization and risk discourses, light is shed on different knowledge and normative pattern that highly determine how practices around birth are organized (e.g. 'biomedical'/'technocratic' vs. 'women-centered'/'humanized' paradigm of birth (van Teijlingen, 2017)).

Additional to the manifold determinants identified at the meso-manifest level, we propose to examine in more detail how a facilities' amenities impact options for coping with labor progress or pains, e.g., availability of warm-watered tubs or space for motion to find relaxing poses or favor the progress of birth (Ondeck, 2014; Shilling, Romano, & Difranco, 2007). Technical equipment (e.g., wireless electronic fetal monitor) can enable movement. Similarly, posters that illustrate body postures beneficial to labor progress may positively affect the course of birth. One of the most discussed and obvious support while birthing is the continuous, 1-to-1 support, usually provided by a midwife or doula (M. A. Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017; Sosa, Crozier, & Stockl, 2018). (Epidemiological) research on birth integrity should in more detail evaluate how continuous support (according to our expectation: positively) impacts birth integrity.

At the meso-latent level, we identified a strong emphasis on how the person in labor and birth is approached in terms of communicative skills (e.g., effective communication, respectful tone). An aspect that might be worth deepening and examining as a potential determinant of birth integrity relates to the semantics used in communicating with the parturient. As language matters, a rather passive/ passivating or active/activating wording implicitly creates certain expectations and perceptions about one´s birthing capabilities and a reflection of (dis)respecting a childbearing individual's autonomy. For example, while the phrase 'a baby is delivered by the doctor' terminologically puts the parturient into a waiting and passive position, the term 'giving birth' connotates the actively involved childbearing person (Mobbs, Williams, & Weeks, 2018).

At the micro-manifest level, more emphasis could be directed to birth-related discrimination. In addition to the determinants identified through the ME study, we think it is useful to integrate intersectional theory (Carbado et al., 2013) into measurement endeavors, as it highlights how intersecting lines of difference along race, gender, sexuality, ability, religion or class create privileged and marginalized positions that result in advantages and disadvantages. Taking an intersectional lens on care provision (e.g., upon frequency and duration of care attendance during birth) or more birth-related outcomes (e.g. scrutinizing racial disparities in maternal and newborn mortality (National Center for Health Statistics, 2018)) might be fruitful for research on the determinants of birth integrity.

4.2 Subjective outcome measure: Violated and preserved birth integrity

For the subjective outcome measure of (violated and preserved) birth integrity, we found in the studies validated scales that capture different aspects of birth perception, e.g., on agentry and control (Hodnett & Simmons-Tropea, 1987) or satisfaction (Hollins Martin & Martin, 2014; Lomas, Dore, Enkin, & Mitchell, 1987). Yet, we consider it highly relevant to develop and validate a specific scale that measures whether a person's birth integrity felt violated or protected during birth. Components of this measure could range from feeling embarrassed, scared, anxious, sad, out of control, ignored, vulnerable, dissociated, dehumanized, or traumatized to feeling seen, supported, and respected, deemed important, taken seriously, braced, empowered, confident, energetic, comfortable and sheltered.

4.3 Objective outcome measure: Potential (mental) health effects of violated birth integrity

Supposing that preserved birth integrity builds a vital resilience for maternal health, simultaneously implicates that a violation of birth integrity may entail poor health outcomes in the short- or long run. As mentioned earlier, we did not integrate all the possible adverse health effects of birth integrity violations explicitly. Nevertheless, we identified a few measures linking negative childbirth experiences to postpartum mental health conditions.

These initial linkages between birth integrity violations and existing knowledge on traumatic birth experiences need to be systematically deepened. Research on traumatic birth experiences has mainly focused on medically complicated deliveries or undesired health outcomes. We consider birth integrity violations as a critical vulnerability factor for developing birth-related post-traumatic stress disorders, postpartum depressions, or challenges in bonding and attachment of mother and child (Ayers, Bond, Bertullies, & Wijma, 2016). Mental or physical distress, a highly interventionist birth, or an unexpected course of childbirth can similarly cause trauma. Additionally, we see the necessity to research the physical and social consequences possibly deriving from birth integrity violations, like avoidance of subsequent pregnancies or impairments of sexual functions. Recently, a specific scale on postpartum, birth-related PTSD has been developed (Ayers, Wright, & Thornton, 2018). While there exist studies that demonstrate a significant association between birth experiences and postpartum depression (Bell & Andersson, 2016), there is, to our knowledge, no scale that has operationalized a linkage between one's individual birth perception (birth integrity) and postpartum depression. Understanding better if a violation of birth integrity can cause postpartum or birth-experience-related depression marks an important step towards recognizing, addressing, and improving mental postpartum health. Similarly, future research needs to better understand if and how violated birth integrity affects the bonding and attachment between the mother/parent and the child, the partnership (e.g., impairments in sexuality, withdrawal), or negatively impacts the body functions (e.g., body sensation, pains).

4.4 Strengths and limitations

This review constitutes a critical appraisal of quantitative epidemiological research conducted in the field of maternal care conditions, maternal care provision, childbirth experiences, and perceptions of birth. We have synthesized our findings and developed a new multilevel birth integrity framework that not only presents an overview on what is currently included in the studies' concepts and measurement (determinants, birth perception, consequence of negative birth experiences) but additionally identifies gaps that may be addressed in future studies. By choosing a meta-ethnographic methodology, we entered an iterative process. Thereby, we considered each studies' terminological embedding and developed more apparent conceptual profiles illuminating the differences and similarities between the research lenses. At the level of the instruments, we extracted the smallest unit of measurement, namely items. Our rationale for comparing at the item level is that, at first glance, items may appear equivalent. Still, these alleged similarities dissolve on precise consideration of item wording, as the same care experience (e.g., neglected care) can arise from different causes. To give an example: A category often found in D&A/ MISC studies was the abandonment of care, which at first glance triggers the idea of a shared underlying construct. However, by comparing all items, we identified different causes for absent care. A lack of care can be traced back to a facility's care capacity (e.g., deficits in staffing), it can reflect a care culture of neglect, or occur as an explicit act of discrimination against the

parturient when their request for birth accompaniment is denied. Gaining a fuller picture of the reasons that evoke suboptimal treatment and birth integrity violations becomes relevant when planning interventions.

Despite a thoughtful and transparent review process, some measures might have been missed. Also, we did not appraise the studies' quality since we were not focused on the study findings. After reading all the full texts, we decided to exclude research on quality of care, since these studies mainly assessed how maternity care was rated through rating scales (e.g., "How would you rate the care you received? – "Excellent", "good", etc.). First, to identify determinants of birth integrity, we found these kinds of survey questions less insightful. Second, considering the high volume of quality-of-care studies, we decided to focus on the remaining 82 studies more relevant to our review aims.

5. Conclusion

The protection of birth integrity is an essential step towards respecting human rights in maternal health services globally. To achieve health equality in childbirth, additional interdisciplinary research, and various actors' (practitioners, policymakers, legislation) collaborative engagement is needed. The multilevel birth integrity framework is a tool to analytically separate the complex and interwoven factors that can influence the birth situation as such and birth integrity. It can guide the development of survey instruments, qualitative interviews, interventional studies, or mixed method studies.

We consider this framework as dynamic and under development. Current epidemiological research on birth integrity measures many determinants related to the health system, the care culture, and rights in childbirth, mainly located on both meso-fields and the micro-manifest field. In this respect, the remaining macro-level fields seem under-studied and not sufficiently incorporated into quantitative health research. The inclusion of both macro-level measures and theoretical contributions and qualitative insights from multidisciplinary perspectives (e.g., medical ethics, medical anthropology, psychology, sociology, gender studies, philosophy, or health economics) are necessary to expand and enhance the multilevel birth integrity framework.

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Appendix

APPENDIX file A: Search strategy, inclusion and exclusion criteria, and data extraction

Search strategy

We developed the search strategy according to a modified PICO scheme (population, intervention, comparison and outcome). For P (Population), we subdivide the search terms into birth (e.g. “birth”, “delivery”, “labour”) and setting (e.g. “maternity ward”, “obstetric care”, “birth clinic”) and connected them by OR. We connected I (Intervention) and C (Comparison) by OR as well, containing search terms for the violations of maternal rights or deficient care (e.g. “birth violence”, “discrimination”, “disrespect”) and the protection of maternal rights or respectful maternal care provision (e.g. respectful maternity care, self-determination, autonomy, informed consent). Electronic searches were conducted in PubMed, PsychInfo, CINAHL and Embase. Studies we considered eligible for inclusion researched aspects directly relevant to the measurement of maternal care conditions, maternal care provision, birth experiences and perception of birthWe excluded studies assessing maternity care’s general quality, access to and utilization of maternity health care services or pregnancy care, and studies on violence outside the context of labour and birth (e.g. sexual abuse, domestic violence). Setting-wise, we included studies on facility-based childbirth (e.g. hospitals, obstetric clinics, birthing centres) and excluded studies on assisted and non-assisted home birth.

Concerning the population, we included people during childbirth and early postpartum phase and attendees of the birthing context (e.g. health care professionals, doulas, partners). We excluded studies on people using reproductive health services other than childbirth (e.g. fertility treatment, abortion). Primary quantitative studies of different types were included (e.g. cross-sectional, cohort-studies). In contrast, we excluded qualitative and mixed-methods studies and secondary research, reviews, editorials, commentaries or conceptual articles. The focus on quantitative studies serves the purpose to comprehend how maternal care provision, birth experiences the perception of birth has been operationalized and measured. We included studies aiming to validate instruments since these study types contain a new set of items. We excluded interventional studies since they build upon a prior research study using an equivalent set of items. We limited our scope on studies published between 2010-2020 since the thematic framework proposed by Bowser and Hill in 2010[19] led to a significant increase in research.

Connector	**Category**	**Connector**	**Sub-category**	**Terms**
	Population		Birth	“birth” OR “childbirth” OR “delivery” OR “labor” OR “labor”
		AND	Setting	“facility” OR “facilities” OR “clinic” OR “hospital” OR “maternity ward” OR “maternity care” OR “assisted delivery” OR “birthing center” OR “birth center” OR “birthing centre” OR “birth centre” OR “gynaecology” OR “gynecology” OR “obstetrics ward” OR “obstetric ward” “obstetric” OR “labor ward” OR “labor ward” OR “delivery room” OR “obstetric care” OR “obstetric delivery”
AND	Intervention / Comparison			
			Violation of maternal rights	(“violence” OR “violation” OR “violate” OR “violating” OR “physical constraint” OR “moral constraint” OR “psychological constraint” OR “physical pressure” OR “moral pressure” OR “psychological pressure” OR “medicalization” OR “medicalisation” OR “discrimination” OR “disrespect” OR “disrespectful” OR “lack of respect” OR “marginalisation” OR “marginalization” OR “defamation” OR “abuse” OR “degrade” OR “harass” OR “harassment” OR “lack of privacy” OR “sexism” OR “racism” OR “classism” OR “bodism” OR “ageism” OR “stigmatization” OR “stigmatisation” OR “lack of privacy” OR “abandon” OR “over-use” OR “under-use” OR “instrumentalization” OR “instrumentalisation”

				OR “mistreatment” OR “dehumanisation” OR “dehumanization” OR “over-medicalization” OR “over-medicalisation” OR “under-medicalization” OR “under-medicalisation” OR “violence against woman” OR “obstetric violence”
		OR	Maintainence of maternal rights	“informed consent” OR “respectful maternity care” OR “reproductive rights” OR “maternal rights” OR “bioethics” OR “human rights” OR “maternal treatment” OR “self-determination” OR “autonomy” OR “integrity” OR “dignity” OR “attentiveness” OR “empathy” OR “person-centered” OR “patient-oriented” OR “decision-making” OR “respectful” OR “quality of care” OR “maternal health”

Exemplary search strategy for pubmed.

	Inclusion	**Exclusion**
Terms and concepts	Epidemiological, quantitative studies on maternal care conditions, maternal care provision, birth experiences and perception of birth (common terms and concepts for this phenomenon are: Obstetric violence, mistreatment, disrespect or abuse during childbirth, dehumanized childbirth, autonomy Respectful maternity care, humanized childbirth, human rights in childbirth	Studies on violence, mistreatment or similar terms non-related to childbirth (e.g. domestic violence, sexual abuse, genital mutilation). Studies on quality of care Studies on particular interventions (e.g. epidural) or procedures (episiotomy),
Setting	Studies on facility-based childbirth in obstetric clinics or midwifery-guided birthing centers.	Studies on assisted or non-assisted homebirth.
Range of coverage	global	
Population	People/ women during childbirth and postpartum phase	Woman using reproductive health services other than childbirth
Study types	Primary observational quantitative research studies (cross-sectional studies, cohort-studies, case-control-studies, ecological/correlation studies)	Primary research studies consisting of qualitative data or mixed method data. Secondary research, reviews, commentaries, editorials, conceptual articles, interventional studies, non-scientific literature-
Date	2010-2020	

Inclusion and exclusion criteria

Data extraction

Pilot screening and pilot data extraction was conducted independently by three researchers on a sample of 10% of the included studies. CM and LW extracted 15 studies each for the final data extraction, SBZ extracted all studies. We extracted a variety of general information and information specifically relevant to the review's aim, e.g., terminology or concepts, definitional scope, theoretical reference, operationalization and measurement tools (including items) on

maternal care provision, birth experiences and perceptions of birth. When the items were not reported, we contacted the authors and asked to send us the instruments they used (full data extraction format: example study).

Reference	Banks et al. (2018)
Title	Jeopardizing quality at the frontline of healthcare: prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia.
Study type	Cross-sectional study (survey and observation)
Study Region	Ethiopia, Africa
Duration of study	2013 (Jul-Sep)
Study objective	To "quantify and the frequency and categories of D&A experienced by women in four health centres in two rural regions of Ethiopia".
Data type and collection	**Interviewer-administered questionnaire** and **structured observations** by trained researchers. Client-provider interactions were captured through one-to-one direct observation from a woman's time of entry at the health centre, throughout the labour and delivery period, until her time of entry to the post-natal ward. The data collector used a structured observation tool to capture specific manifestations of D&A. The exit interview was conducted at the time of discharge, approximately three to 6 h post-par- tum; the questionnaire focused on the woman's perceived experiences of D&A during her labour and delivery at the health centre.
Strategy and methods used for data analysis	**Logistic regression model** to assess the associations between reported D&A and client characteristics and specific health facility.
Sample size	193 observations 204 interviews
Units of information (from sample size)	397
Study population	All women who gave birth in one of the four health care centres.
Women with birth experiences	Y
Health professionals involved in childbirth	Y
Non-health professionals involved in childbirth	N
Type of health care setting (e.g. hospital, midwifery-led unit, birthing center)	Four rural health centres in Amhara and Southern Nations, Nationalities, and Peoples.
Context of health care setting (LIC, MIC, HIC)	LIC
Theory	NA
Framework or programme reference	WHO quality of care framework for maternal and newborn health and preventable maternal mortality (EPMM)
Terminology/ concept	Disrespect and Abuse (D&A)
Definition or description of concept/term	(D&A) experienced by women during facility-based childbirth is gaining recognition as violation of women's rights'. D&A has been acknowledged as a deficiency in the delivery of high quality maternal health services, threatening the ability of health systems to achieve good maternal health outcomes.D&A manifests as physical violence, harsh language, stigma and neglect suffered by women at the hands of health care providers. Drivers of D&A can include systemic failures, such as overwhelmed health care administration, poor staffing and supervisory structures and inadequate physical infrastructure. Women who experience D&A are more likely to report lower satisfaction with their birth experience and are less likely to seek facility-based delivery for future pregnancies.
Items to measure birth integrity	**Observations of disrespect and abuse:** **Physical abuse (3rd)**: fundal pressure applied (1st) **Non-consented care(3rd)**: Lack of consent for first vaginal examination (1st) **Non-confidential care (3rd):** Mother's history taking findings shared when others could hear (1st),auditory privacy not respected during post-natal examination (1st) **Lack of privacy(3rd)**: No partitions separating beds for first examination (1st), Partitions do not give privacy in prenatal ward (1st), Mother not covered during examination in prenatal ward (1st), Mother not covered while being moved from prenatal ward to delivery room (1st) Mother not covered during delivery (1st), Partitions not closed during delivery (1st), Mother not well covered after third stage of labour (1st), No partitions/curtains between beds in post-natal ward (1st), Mother's physical privacy not respected during post-natal examination(1st). **Non-dignified care(3rd)**: mother not welcomed in a kind and gentle maner(1st); provider did not introduce herself to mother (antenatal ward) (1st), use of non-dignified language during history taking(1st); delivery midwife did not introduce herself by name(1st); delivering service provider did not congratulate mother after birth(1st); mother not cleaned after birth and third stage of labour(1st); no pad provided to mother(1st); mother not allocated her own bed inpost-natal ward(1st), bed in post-natal ward not clean(1st); mother not called by her name throughout interactions(1st); mother not asked about preferred birth position (1st); mother not allowed to practice religious/cultural custom, if requested(1st); Items for reported experiences of D&A not reported.
Outcome variable	D&A
Control-variables, mediators, confounders, demographic variables	Age, education, marital status, occupation, wealth tercile, place of residence, travel time to the facility, referred to the facility, any complications, delivery time, birth attendant, numbe of anc visits, previously delivered at facility, previously used the facility.
Main results	Reported experiences of D&A: 21,1%, Non-consented care: 17,8%, lack of privacy: 15,2%, lack of confidential care: 13,7%). Birth-complications increased the odds of reporting D&A. Observed D&A was high, especially non-dignified care (89%). Examinations of predictors show that most client characteristics in the unadjusted models were not significantly assosiated with reporting D&A. However, reporting birth complications were most strongly associated with the increased odds of reporting D&A and the magnitude nearly doubled when adjusted.

Table 1: Full data extraction format: Example study.

Appendix file B: eMERGE meta-ethnography reporting guidance

The eMERGe meta-ethnography reporting guidance (France et al., 2019) (where applicable)			
	Criteria Headings	Reporting criteria	Where to find:
Phase 1—Selecting meta-ethnography and getting started			
Introduction			
1	Rationale and context for the meta-ethnography	Describe the gap in research or knowledge to be filled by the meta-ethnography, and the wider context of the meta-ethnography.	Page 3
2	Aim(s) of the meta-ethnography	Describe the meta-ethnography aim(s).	Pages 4-5
3	Focus of the meta-ethnography	Describe the meta-ethnography review question(s) (or objectives)	Page 2-3
4	Rationale for using meta-ethnography	Explain why meta-ethnography was considered the most appropriate qualitative synthesis methodology	Page 3
Phase 2 – Deciding what is relevant			
Methods			
5	Search strategy	Describe the rationale for the literature search strategy	Page 3
6	Search process	Describe how the literature searching was carried out and by whom	Page 3, Appendix file A
7	Selecting primary studies	Describe the process of study screening and selection, and who was involved	Page 3-4, Appendix file A
Findings			
8	Outcome of study selection	Describe the results of study searches and screening	Page 5, Appendix file A + C
Phase 3- Reading included studies			
Methods			
9	Reading and data extraction approach	Describe the reading and data extraction method and processes	Appendix file A
Findings			
10	Presenting characteristics of included studies	Describe the characteristics of the included studies	Appendix file D
Phase 4 – determining how studies are related			

Methods			
11	Process for determining how studies are related	Describe the methods and processes for determining how the included studies are related: -Which aspects of studies were compared **AND** -How the studies were compared	Page 7, Table 1
Findings			
12	Outcome of relating studies	Describe how studies relate to each other	Pages 7-13, Table 2, Table 3
Phase 5 – Translating studies into one another			
Methods			
13	Process of translating studies	Describe the methods of translation: - describe the steps taken to preserve the context and meaning of the relationship between concepts within and across studies - describe how the reciprocal and refutional translations were conducted - Describe how potential alternative interpretations or explanations were consideres in the translations.	Table 1, Page 5-24
Findings			
14	Outcome of translation	Describe the interpretative findings of the translation	Page 5-24
Phase 6 – Synthesizing translations			
Methods			
15	Synthesis process	Describe the methods used to develop overarching concepts (“synthesised translations”). Describe how potential alternative interpretations or explanations were considered in the synthesis	Page 24-25
Findings			

16	Outcome of synthesis process	Describe the new theory, conceptual framework, model, configuration, or interpretation of data developed from the synthesis	Page 24-26, Fig 1
Phase 7 – Expressing the synthesis			
Discussion			
17	Summary of findings	Summarize the main interpretative findings of the translation and the synthesis and compare them to existing literature.	Pages 27
18	Strengths, limitations and reflexivity	Reflect on and describe the strengths and limitations of the synthesis: - Methodological aspects— for example, describe how the synthesis findings were influenced by the nature of the included studies and how the meta-ethnography was conducted. - Reflexivity- for example, the impact of the research team on the synthesis findings	Page 30
19	Recommendations and conclusions	Describe the implications of the synthesis.	Page 28-31

France, E.F., Cunningham, M., Ring, N., Uny, I., Duncan, E.A., Jepson, R.G., et al. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *J Adv Nurs,* 75, 1126-1139.

Appendix file C: PRISMA 2020 flow diagram and adapted PRISMA for reporting systematic reviews reporting of qualitative and quantitative evidence

Available upon request.

Appendix file D: Overview in included studies' characteristics

Available upon request.

Appendix file E: Process of identifying key concepts in conceptual clusters

Table 2: Disrespect and abuse (D&A), Mistreatment during facility-based childbirth (MisC)

Key concept derived from conceptual ideas: Disrespect and abuse reflect any form of inhumane treatment or uncaring behavior towards a woman during labor and birth. D&A represents a fundamental violation of women's human rights and undermines the safety and effectiveness of health systems, e.g., through non-dignified care, non-consented care, neglect or abandonment, or lack of privacy. Mistreatment (MisC) in childbirth describes childbirth-related mistreatment at an interpersonal but also at the health-system level and comprises seven domains: 1. physical abuse, 2. sexual abuse, 3. verbal abuse, 4. stigma and discrimination, 5. failure to meet professional standards, 6. poor rapport between women and providers 7. health system conditions and constraints. Drivers of D&A/MisC can include systemic failures, such as overwhelmed health care administration, poor staffing, and inadequate infrastructure.	
Study	**Conceptual idea (individual studies in D&A and MisC cluster)**
(Azhar et al., 2018, 2)	Women experience ill treatment not only in violation of their autonomy and dignity but also as verbal insults, humiliation, discrimination, abandonment of care and physical assault during childbirth. (…) formally called these maltreatments Disrespect and Abuse (D&A) during childbirth and highlighted this as a main factor in the underutilization of health care facilities. Although an objective assessor reviewing statements about a woman's experience during labor and birth may see that she has been a victim of D & A "experienced D & A", the woman herself may not recognize that this was D & A "reported D & A.
(Bekele et al., 2020)	N/A
(Bhattacharya & Sundari Ravindran, 2018, 2)	"Bowser and Hill conducted a land- scape analysis identifying seven categories of disrespect and abuse: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities due to failure to pay (…)".
(Gebremichael et al., 2018, 1)	"Disrespectful and abusive care includes impoliteness of care providers, inappropriate reprimands, shouting at the client, lack of empathy, refusal to assist, threatening clients for their non-compliance, and denying clients opportunities to choose or give an opinion on the care they are receiving".
(Kruk et al., 2018, 27)	"These include physical abuse (beating, slapping and pinching), lack of consent for care (e.g. for Caesarean section or tubal ligation), non- confidential care (e.g. lack of physical privacy or sharing of confidential information), undignified care (e.g. shouting, scolding and demeaning comments), abandonment (e.g. being left alone during delivery), discrimination on the basis of ethnicity, age, or wealth, or detention in facilities for failure to pay user fees" following the Browser and Hill categorization (…)".
(Kujawski et al., 2015, 2243)	"Disrespectful and abusive treatment during childbirth, such as physical abuse, abandonment, threatening and negative language, shouting and scolding, physical privacy violations, and non-consented care, has been observed in several resource-constrained contexts, including Tanzania (…)".
(Sando et al., 2016, 2)	"D&A is also a fundamental violation of women's human rights and undermines the safety and effectiveness of health systems. (…) seven categories of disrespect and abuse (D&A) during childbirth emerged from qualitative and anecdotal reports: physical abuse, non-consented care, non-confidential care, non- dignified care, discrimination, abandonment, and detention in health care facilities (…)".
(Wassihun et al., 2018, 1)	"Disrespect and abuse are defined as any form of inhumane treatment or uncaring behavior toward a woman during labor and delivery (…). Laboring mothers may face various forms of disrespectful and abusive treatment during childbirth at a facility, including physical abuse, lack of consent for care, non-confidential care, undignified care, abandonment, discrimination, and detention in facilities for failure to pay user fees" (…).
(Banks et al., 2018, 318)	"D&A has been acknowledged as a deficiency in the delivery of high quality maternal health services, threatening the ability of health systems to achieve good maternal health outcomes (…). D&A manifests as physical violence, harsh language, stigma and neglect suffered by women at the hands of health care providers (…). Drivers of D&A can include systemic failures, such as overwhelmed health care administration, poor staffing and supervisory structures and inadequate physical infrastructure (…). Women who experience D&A are more likely to report lower

	satisfaction with their birth experience and are less likely to seek facility-based delivery for future pregnancies (…)".
(Montesinos-Segura et al., 2018, 185)	"Disrespect and abuse during childbirth care is considered a form of violence that directly violates women's rights as defined by the United Nations—i.e., the right to respect, timely care, autonomy, self-determination, and information during childbirth (…)".
(Asefa & Bekele, 2015, 2)	" (…) 7 categories of disrespect and abuse during childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities (…)".
(Galle et al., 2019, 2)	"(…) physical abuse; non-consented care; non-confidential care; non-dignified care; discrimination; abandonment of care; and detention in facilities (…).The mistreatment of women during childbirth often occurs at the level of the interaction between women and healthcare providers but deficiencies in the health care system (e.g. lack of adequate personal and poor infrastructure) also contribute to its occurrence (…)".
(Ukke et al., 2019, 3)	"Disrespect and abuse during childbirth is common throughout the world (…). It can occur at the level of contact between the client and the care provider, as well as through systemic failures at the health facility and health system level (…)".
(Sethi et al., 2017, 2)	„While disrespect and abuse during delivery does not necessarily mean that respectful care was provided, it does mean that the fundamental human right of women to receive the highest attainable standard of care was violated (…)".
(Morton et al., 2018, 264)	"Three typologies of disrespectful care: 1. verbal abuse including threats of poor outcome, racially demeaning comments; sexually degreeding remarks. 2.stigma and discrimination: extra procedures because of race/ethnicity. 3. failure to meet professional standards of care: failure to secure fully informed consent or performing procedures explicitly against a women´s wishes (…)".
(Diamond-Smith et al., 2017)	„(…) domains of mistreatment, including physical, sexual, and verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health care-related conditions and constraints".
(Hameed & Avan, 2018, 2)	„This mistreatment can have immediate and long-term consequences: for example, denial of pain relief medication, episiotomy (without anaesthesia) and physical abuse can cause extreme pain and suffering (…) It may also lead to adverse psychological effects such as re-traumatisation (…) post-traumatic stress symptoms, sleeping problems, poor self-rated health (…) and feelings of dehumanisation (…) that could result in a distorted body perception and fear of childbirth (…).These categories were reworked as follows: physical abuse, verbal abuse, right to information, non-consented care, non-confidential care, discrimination and abandonment of care."
(Diamond-Smith et al., 2016, 114)	"Mistreatment can encompass a number of factors, including verbal and physical abuse, disrespect, and neglect of various forms (…)".
(Vedam et al., 2019, 3)	"(…) 'mistreatment' and delineated the phenomena across seven dimensions: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and poor conditions and constraints presented by the health system (…)".
(Bohren et al., 2019, 1751)	"Evidence suggests that women across the world experience mistreatment during childbirth, including physical abuse, verbal abuse, discrimination, non-consented procedures, and non-supportive care (…). Bowser and Hill's landscape analysis (…) brought this issue to global attention and our mixed-methods systematic review developed a typology of what constitutes mistreatment".
(Sheferaw et al., 2019, 3)	"Physical abuse included hitting, slapping or pinching. Verbal abuse included shouting, scolding, threatening to take women into the operating theatre or addressing women using insulting names. Failure to meet standards of care included neglecting women when they needed care at some point during labor and childbirth, ignoring women's requests for pain relief, providing treatment without consent and providing care that violated privacy of women. Poor rapport between women and providers included not greeting women, not explaining the labor progress, not responding to women's questions in a polite manner, not encouraging women to move around freely, not allowing women to bring a companion, not allowing women to give birth in their preferred birth position and not offering hot drinks or food after childbirth"(…)".

(Dey et al., 2017, 2)	„A growing body of literature suggests that fear of such mistreatment is a key impediment to timely acquisition of care and use of institutional facilities for childbirth, particularly among less educated and poor women, and is associated with poor birth outcomes for both mother and child (…) Such mistreatment can include a broad array of provide behaviors, from neglectful or non-consensual care to verbal or physical abuse against a woman during childbirth (…)".
(Siraj et al., 2019, 2)	"Seven categories of disrespect and abuse during child- birth are physical abuse, non-dignified care, discrimination based on specific patient attributes, non-consented care, non-confidential care, abandonment of care and detention in facilities. However, Numerous factors (individual and community-level) may contribute to the experiences of disrespect and abuse. Lack of legal and ethical foundations to address D&A, normalizing D&A, lack of standards and accountability, lack of leadership commitment, and provider prejudice due to training and lack of resources are some among many factors (…)".
(Okafor et al., 2015, 110)	"(…) seven categories of attributes that effectively defined disrespectful and abusive care in facility-based skilled childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment/ neglect of care, and detention in facilities until hospital bills are paid (…)".
(Silveira et al., 2019, 442)	"Women´s experiences of disrespect and abuse often results from the nature of patient-provider interactions in the context of obstetric care and can be expressed as verbal, physical or sexual abuse, stigma and discrimination, neglect, and failure to meet standards of care and attention – such as privacy and confidentiality breaches, limiting access to information and medical procedures con- ducted without consent (…). They have also been linked to the institutional structures and processes that frame the practice of obstetric care in health systems and the persistence of structural gender inequalities in society being considered by some authors as a dimension of violence against women (…)".
(Tekle Bobo et al., 2019, 4)	"(…) Types of D&A were then categorized as physical abuse, non-dignified care, abandonment, non-consented care, non-confidential care, detention and discrimination."
(Abuya et al., 2018, 48)	„Measures of mistreatment for this assessment were collected during the birthing process and categorised using the WHO typology at the analysis (…) stage. For example, three second order themes were assessed during admission: harsh language, lack of informed consent and lack of privacy. During delivery, four second order themes were examined: harsh language, use of force, unhygienic conditions (these were defined as the basic requirement a provider must adhere to as part of broader infection control practices regard- less of level of care), and lack of privacy. During immediate postpartum care, three second order themes were assessed: unhygienic conditions, lack of privacy and lack of informed consent".
(Bakker et al., 2020, 2)	"Mistreatment comprises (…) seven domains: 1. physical abuse, such as slapping, 2. sexual abuse, such as rape, 3. verbal abuse, such as shouting, 4. stigma and discrimination, such as providing poor treatment due to HIV status, 5. failure to meet professional standards, such as neglect, 6. poor rapport between women and providers, such as dis- missal of women's concerns, and 7. health system conditions and constraints, such as lack of privacy. Mistreatment is often justified as a means of punishment for patients' misbehavior (…)".
(Baranowska et al., 2019, 2)	"A systematic review in the area of negligence and violations of childbirth led by Bohren et al. allowed a widening to the typology of these abuses (…). The review presented a detailed typology that was evidence based and comprehensively illustrated how women in perinatal care facilities can be mistreated on multiple levels: inter- actions between women and healthcare providers as well as system and organizational failures (…)".
(Asefa et al., 2018, 2)	"(…) interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified (…)"

Table 3: Respectful maternity care (RMC)

Key concept derived from conceptual ideas: A universal human right that is due to every childbearing woman in every health system around the world in which the maternity care is expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights. Components of RMC are: Freedom from harm and ill treatment; Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice whenever possible; Confidentiality, privacy; Dignity, respect; Equality, freedom from discrimination, equitable care; Right to timely health care and to the highest attainable level of health; and Liberty, autonomy, self-determination, and freedom from coercion.	
Study	**Conceptual idea (individual studies in RMC cluster)**
(Rosen et al., 2015, 2)	„Seven rights of childbearing women from Respectful Maternity Care Charter (…) Article 1. Every woman has the right to be free from harm and ill treatment., Article 2. Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care. Article 3. Every woman has the right to privacy and confidentiality. Article 4. Every woman has the right to be treated with dignity and respect. Article 5. Every woman has the right to equality, freedom from discrimination, and equitable care. Article 6. Every woman has the right to healthcare and to the highest attainable level of health. Article 7. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion".
(Wassihun & Zeleke, 2018, 2)	"A universal human right that is due to every childbearing woman in every health system around the world in which the maternity care is expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, such as having a companion wherever possible (…)".
(Dynes et al., 2018, 2)	"Respectful Maternity Care Charter defined seven rights of childbearing women(…): Freedom from harm and ill treatment; Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice whenever possible; Confidentiality, privacy; Dignity, respect; Equality, freedom from discrimination, equitable care; Right to timely health care and to the highest attainable level of health; and Liberty, autonomy, self-determination, and freedom from coercion.".
(Bante et al., 2020, 2)	"Respectful maternity care (RMC) during childbirth is an interaction between the client and the healthcare providers (HCPs) or facility conditions. It has a significant role in maternal mortality ratio reduction by enhancing clients' inclination to deliver in health facilities. Furthermore, RMC is the standard of care for all women that encompasses women's basic human rights".
(Begley et al., 2018, 2)	"Respectful maternity care encompasses physical and psychological care, communication and interactions, is influenced by structural, organisational and cultural systems, and financial issues and implies 'doing no harm'. The terms used to describe respectful care include both positive descriptions, such as 'respectful' and 'humanised', and negative descriptions, such as 'disrespectful', 'obstetric violence', 'mistreatment' and 'abuse'".
(Sheferaw et al., 2017, 2)	"The White Ribbon Alliance defines RMC as an approach that emphasizes the positive inter-personal interactions of women with health care providers and staff during labor, delivery, and the postpartum period. Absence of D&A by health care providers and other staff alone is not sufficient for provision of RMC; the RMC definition calls for fostering positive staff attitudes and behaviors that are conducive to improved satisfaction of women with their birth experience".
(Taavoni et al., 2018, 335)	"Over recent years, promotion of the usage of Respectful Maternity Care (RMC) has been developed gradually, emphasizing the importance of underlying professional ethics and considering psychological, social and cultural aspects of health care delivery as essential elements of care (…). While medical treatment is only one aspect of RMC, failure to focus on the well-being of women and newborns by imposing unnecessary or harmful practices can be considered abusive and disrespectful (…)".

Table 4: Childbirth experiences (CE)

Key concept derived from conceptual ideas: Childbirth experiences and especially a woman's relationship with her health care providers in maternity settings significantly impact her health. It has long-term implications for her future emotional, physical, and reproductive health and wellbeing. Negative CE increases the risk for postpartum depression, secondary fear of childbirth, and post-traumatic stress disorder.	
Study	**Conceptual idea (individual studies in CE cluster)**
(Mukamurigo et al., 2017, 2)	"A positive childbirth experience is important for the woman's wellbeing, facilitates the mother-child bonding and may have implications for the future health for both the mother and baby. On the contrary, a negative experience increases the risk for postpartum depression, secondary fear of childbirth and post-traumatic stress disorder".
(Okumus, 2017, 3)	"A woman's experience of labour and birth may have long-lasting and profound effects on her wellbeing and that of her baby and husband.2 Further, the childbirth experiences of primiparous women are especially important because of their impact on future births, most especially if the first birth is a caesarean section. There is also an impact on the nature of the birth stories that are told to subsequent generations. Negative childbirth experiences often lead women to prefer caesarean sections to vaginal birth (…)".
(Alzyoud et al., 2018, 71)	"Women's relationship with health care providers in maternity settings during childbirth significantly impacts their physical, psychological, and emotional health during childbirth. (…) An important, but little understood component of the poor quality of care experienced by women during childbirth in facilities is disrespectful and abusive behavior by health care professionals and other facility staff".
(Thies-Lagergren & Johansson, 2019, 2)	"Childbirth is a highly significant event for the mother, her family and the community (…) The experience of giving birth has long-term implications for mothers' future emotional, physical and reproductive health and wellbeing.3,4 It has been shown that the experience of childbirth also has an impact on the birth partner's future emotional, physical and reproductive health and wellbeing. Parents' birth experiences affect bonding with their child which in turn may influence the child's future health. (…) Quality of intrapartum care is understood as a resource structure of the care organisation in combination with parents' preferences and therefore it is important to not only measure satisfaction but also to simultaneously measure the subjective importance accorded the care given".
(Overgaard et al., 2012, 973)	"While positive birth experiences contribute to women's feeling of accomplishment and self-esteem and lead to psychological growth, empowerment, and easier adaptation to motherhood (…), negative experiences are associated with a number of complications such as postpartum anxiety, depression, post- traumatic stress syndrome (…) fear of childbirth (…), reduced future reproduction (…),and request for caesarean section (…) Four key dimensions of patient-centred care (…)have been identified as prominent aspects of the childbirth experience: the woman's perceptions of intrapartum support, participation in decision-making, information, and control".
(Redshaw et al., 2019, 2)	"Positive experiences during this time can be looked back upon fondly, empowering the woman in her role as a mother, and strengthening her emotionally during her transition to motherhood (…) Conversely, a negative maternity experience may significantly increase the risk of negative health outcomes for the mother such as postnatal mental health disorders with possible long-lasting effects on the mother, the child, and the family system as a whole. The care a woman receives during the perinatal period can have a profound impact on her overall maternity experience, with potentially significant implications for her health and wellbeing both at the time and subsequently (…) In turn, this can impact on the mother-baby relationship and also on the health and wellbeing of the baby (…).A woman's experiences and memories of maternity care might also influence her decision-making regarding future pregnancies, requests for medical intervention during future childbirth, as well as having an im- pact on future reproduction in general. Thus, it is necessary to monitor, evaluate and optimise the care that women and their families receive during this important time".
(Sjetne et al., 2015, 1)	"Collection of patient-reported outcomes, including patient experiences, is an important aspect of evaluations of health services. (…) These surveys call for descriptions of mainly non- technical aspects of the health-care services and may in- volve different target populations, such as the general population, broad groups of service users, or patients with specific conditions (…)".

Table 5: Maternal satisfaction (MS)

Key concept derived from conceptual ideas: Maternal satisfaction refers to a woman's subjective and dynamic evaluation of her birth experience. This multifaceted construct includes elements of perceived quality of care, coping efficacy, and reflections of the birth experience as a whole and in context. Low MS can affect the mother's and infant's health. Low levels of MS are associated with greater odds of postnatal depression, post-traumatic stress disorder, requests for future elective cesarean section, sterilization, and abortion.	
Study	**Conceptual idea (individual studies in MS cluster)**
(Monazea & Al-Attar, 2015, 64)	"An important predictor of satisfaction is quality of care (contributors to poor quality of care (…): provider incompetency, lack of drugs and supplies, delay in referral, non cleanliness, and poor interaction between clients and healthcare providers (…). Women are more vocal about patient–provider communication and value good interaction with their provider (…). Mothers who are treated with respect, courtesy, and dignity are more likely to be satisfied with the obstetric care (…). The influences of the attitudes and behaviors of the caregivers are more powerful and obvious on subsequent satisfaction than the influences of pain relief, and intrapartum medical interventions (…) even with the evidence that the majority of women would want pain relief in labor (…). Moreover, it was concluded that poor sanitary condition of the health facilities and lack of basic amenities were the major cause of dissatisfaction (…)".
(Kabakian-Khasholian et al., 2017, 17)	"A woman's satisfaction with the birth experience has been shown to influence her relationship with her infant, to affect her self-esteem and self-image, and influence her future childbirth expectations. Perceptions of being in control during childbirth have been recognised as the strongest component of women's birth experiences, of their own behaviour during labour and their inter- action with care providers, contributing largely to women's feelings of fulfilment and postpartum well-being. Satisfaction is also related to the caregiver's attitude, good communication with care providers, and the responsiveness of staff to women's needs. One report indicates that dissatisfaction with care and perceptions of diminished control over the process of childbirth have led to a preference for caesarean sections for future births".
(Jha et al., 2017, 1)	"Studies show that women who are satisfied with child- birth services tend to have better self-esteem and confidence, are faster in establishing a maternal–neonatal bond, and are more likely to breastfeed compared with women who are dissatisfied (…). Women who are dis- satisfied with their childbirth experiences are more prone to develop a fear of childbirth and postnatal depressive symptoms, and to face difficulties in breastfeeding and in performing baby and self-care (…)".
(Gungor & Beji, 2012, 348)	"Women's satisfaction with their childbirth experience also has implications for the health and well-being of a woman and her newborn. A woman's satisfaction with her childbirth experience may have immediate and long-term effects on her health and her relationship with her infant, including: postpartum depression, post-traumatic stress disorder, future abortions, a lack of ability to resume sexual intercourse, preference for a caesarean section, negative feelings towards her infant, poor adaptation to the mothering role and breast-feeding problems (…)".
(Hollins Martin & Martin, 2014, 1)	"Every woman's perceptions of birth are important, which within this study is conceptualised as 'birth satisfaction'. In terms of quantitative research, a woman's satisfaction with intrapartum care can only be considered high quality when gratification over what she received is measured as high (…)."
(Gitobu et al., 2018, 2)	"Patients' satisfaction with healthcare services is one of the measures for quality of care that has been shown to influence confidence in a health facility and the subsequent utilization of services from the facility (…). Patients' satisfaction with quality of healthcare is the degree to which the patients' desired expectations, goals, and preferences are provided by the healthcare service providers (…). Patients' satisfaction and dissatisfaction with healthcare services indicate their perception about the strengths and weaknesses in the service delivery (…)".
(Caballero et al., 2016, 1)	"The outcomes of health care delivery are measured in terms of effectiveness and efficiency but also in terms of the individual's experience as a patient. This experience involves pain, autonomy, a feeling of physical and mental well-being and satisfaction with the favorable results achieved (…) and provides a unique opportunity to better understand satisfaction with the quality of the health care provided (…). Satisfaction with health care delivery is significantly associated with patients' adherence to medical treatment (…), their quality of life) (…) or simply improvements in their health status (…). Therefore, patients' experiences are increasingly being used inter- nationally as an indicator of the quality and performance of health systems (…), and thousands of surveys are used by health care providers, administrators or policymakers to assess the quality of care, make

	decisions about pro- visions and organization of health care services, avoid malpractice and support a competitive edge in the health care area (…)".
(Bitew et al., 2015, 2)	"Patient satisfaction is a subjective and dynamic perception of the extent to which the expected health care is received (...). It is not important whether the patient is right or wrong, but what is important is how the patient feels".
(Haines et al., 2013, 429)	"Satisfaction, patient perceptions, and actual experiences of the care received are not synonymous concepts, although the terms are often used inter- changeably within one study and between studies (…) Most women report high satisfaction with maternity care, but when asked to consider particular aspects of that care they are more critical. During the intrapartum period, women are consistently dissatisfied with three dimensions of care: their perceived sense of control (…), support received from caregivers (…), and their experiences of managing pain (…). Dissatisfaction has been reported to be associated with operative delivery (especially emergency caesarean) and admission of the infant to neonatal intensive care (…)".
(Mehata et al., 2017, 1)	"Satisfaction with maternity care is a multidimensional construct embracing satisfaction with self (personal control), and with the physical environment of delivery room and quality of care. Aspects of care that may influence client satisfaction include provider attitude, provider competence, outcome, physical environment, continuity of care, access, information, cost, bureaucracy and attention to psychosocial problems. Quality of care may not al- ways be linearly associated with the level of satisfaction as perceived by the clients; however client satisfaction an important determinant of utilization of health services and the choice of health facility (…). Women who are treated with respect, courtesy and dignity, and have trusting relationships with their care providers are more likely to be satisfied (…). Lack of involvement in decision making and inadequate information about their care are associated with dissatisfaction (…)".
(Conesa Ferrer et al., 2016, 1)	"Satisfaction with childbirth is the most important qualitative outcome in assessing childbirth experiences, given the fact that this experience affects their health and tehri relationship with their infant. (…) Five dimensions: the delivery experience (pain intensity, complications and length of labour), medical care, nursing care, information received and participation in the decision-making process, and physical aspects of the labour and delivery rooms. (…) identified the following features of obstetric care as influencing satisfaction with childbirth: explanation of procedures and involvement of mothers in administering or choosing them; support from the presence of a partner and qualified hospital staff; and physical comfort of the postnatal ward. (…) described factors contributing to a satisfying birth experience as follows: support, information, intervention, decision-making, control, pain relief and trial participation (…)".
(Fair & Morrison, 2012, 39)	"Birth satisfaction refers to a woman's satisfaction with her birth experience throughout labour, birth, and the immediate postpartum period (…). It is assessed by measuring the mother's perceptions of care received, maternal control, personal support, medical interventions, and overall health (…) Birth satisfaction is an important construct, as unsatisfying birth experiences are associated with the occurrence of postpartum depression and even posttraumatic stress disorder (…). Research has consistently identified control as one of these factors that greatly affects a woman's assessment of the quality of her birth Issues of control during pregnancy and childbirth manifest themselves in three ways. These include prenatal control of fetal health during the pregnancy, expectations of control for labour and birth, and actual control experienced during childbirth (…)".
(Vardavaki et al., 2015, 488)	"Birth satisfaction represents a woman's subjective and uniquely personal evaluation of her birth experience. This complex, multifaceted construct includes elements of perceived quality of care, coping efficacy and reflections of the birth experience as a whole and in context. Birth satisfaction is thus a retrospective reconstruction related directly to the salient events surrounding the experience of birth (…). The woman's individual evaluation of her own birth experience is important, as this may be a potent indicator of perinatal mental health outcome; for example, birth trauma, which would be anticipated to be experienced as a negative event, may be

	associated with the experience and manifestation of postpartum post-traumatic stress disorder (…)".
(Johansson & Hildingsson, 2013, 196)	"(…) Parents' satisfaction with given care has been described as an indicator of care quality,14 and may be used to improve healthcare. Dissatisfaction with given care has been related to professionals lacking skills, giving inadequate information, and professionals restricted in number. To increase satisfaction with given care, the care should be individualized. The most important determinants for patient satisfaction, in general, have been related to respect for patient preferences, and giving emotional and physical support. (…)".
(Goncu Serhatlioglu et al., 2018, 236)	"Birth satisfaction: "tells how a woman feels about her birth experience, which requires the midwife to take into consideration her personal wants and needs within confines of safety and cost (…). Markers of 'birth satisfaction' include, for example (…): considering person-centred preparation for childbirth, providing respect and support throughout the birth process, maintaining open and honest communication, affording a comfortable environment in which the woman is less likely to lose control, offering acceptable methods of pain relief, minimising obstetric injury, and helping the woman to give birth in her desired position (…). Levels of 'birth satisfaction' can affect the mental health of both mother and infant, with a negative experience having the potential to reduce mother–infant attachment, reduce willingness to breast-feed, instigate sexual dysfunction, instigate infant neglect/abuse, result in postnatal depression (PND), post-traumatic stress disorder (PTSD) and request for future elective cesarean section (CS), and lead to requests for sterilisation and/or abortion (…)".
(Gashaye et al., 2019, 1)	"Studies show that women accessing modern institutional health care still face many challenges including disrespectful, abusive, and inhumane ways of treatment, especially during labor and delivery processes. Such treatment violates the right of women to respectful care, and can also threaten their rights to life, health, bodily integrity, and freedom from dis- crimination (…). Evidence has shown that dissatisfied mothers, especially in the developing world like Ethiopia, tend to prefer utilizing traditional means of health care, using modern health care services as a last resort (…)".

Table 6: Obstetric violence

Key concept derived from conceptual ideas: OV addresses facets of dehumanized care and any action or omission by both health personnel and the health care system that physically or psychologically damaged or denigrated a woman. OV includes medical negligence, improper medication, pathologizing of/inconsideration for natural processes of childbirth, postpartum and female reproductive processes, and forced sterilization. OV links to the concepts of structural and gender violence. Structural violence includes the lack of access to health care services and any kind of health discrimination due to a woman's education, poverty, ethnicity, or other social vulnerabilities.	
Study	**Conceptual idea (individual studies in OV cluster)**
(Da Silva et al., 2018, 2408)	„The term obstetric violence is used to describe the various forms of violence that occur in the care of pregnancy, childbirth, postpartum and abortion. It is understood by the appropriation of the body and the reproductive processes of women by health professionals who express themselves through dehumanizing relations, abuse of medicalization and pathologization of natural processes resulting in loss of autonomy and ability to freely decide on their body and sexuality and negatively impacting the quality of life of women (…)"
(Brandao et al., 2018, 2)	„The definition of obstetric violence is, "the acts of dehumanizing treatment, abuse of procedures, and loss of autonomy that affect the quality of life of women." It is important to realize that obstetric violence is considered another form of gender violence against women (…)".

(Castro & Frias, 2020, 3-4)	"Obstetric violence as a specific type of gender violence affecting women, rather than as a problem of poor- quality health care service or mistreatment and abuse in health care services that might affect any patient (…) This perspective, which is adopted in our study, allows mistreatment and abuse to be studied in the broader context of the various types of violence suffered by women. (…) this phenomenon was legally defined in Venezuela as: the appropriation of a woman's body and reproductive processes by personnel, expressed as dehumanizing treatment, an abuse of medication, and the pathologization of natural processes, bringing about a loss of autonomy and the capacity to freely decide about their bodies and sexuality, negatively impacting the quality of life of women (…) ".
(Mihret, 2019, 1)	"Obstetric violence (OV) is a specific type of violation of women's rights in medical practice during health care related to the childbirth processes. Laboring mothers may be subjected to different forms of OV during facility child birth.. Such ill-treatments and abuses create a psychological distance between the women and care providers and then drive women away from formal health care systems in fear of being subjected to such violence and sometimes are a more prominent hindrance than geographical or financial barriers to maternal health service utilization".
(Souza et al., 2017, 2)	"(…) Among the problems related to the health of pregnant women, concerns have been raised more recently regarding certain practices adopted in medical assistance, referred to by specialists as 'institutional violence in childbirth' or 'obstetric violence' (…) institutional violence is defined as the failure to act or any type of omission in health care services. This ranges from the broad level of lack of access to these services to their bad quality. (…) Some epidemiological studies have associated the occurrence of psychiatric disorders in the puerperal period, among them postpartum depression, with elements related to obstetrical care (…) such as feeling of abandonment during delivery, inadequate pain management, frustration for having delivered via cesarean section when natural childbirth was possible, and the pregnant woman's perception of the team who provided the care".
(Meijer et al., 2020, 355)	„Obstetric violence, a specific type of violation of women's rights, includes the right to equality, freedom, information, integrity, health, and reproductive autonomy (…). In Ecuador, the latest definition of obstetric violence has been extended to include the concept of 'gynecological-obstetric violence'. It includes: abuse; imposing cultural practices and non- consented scientific procedures; violation of professional secrecy; improper medicalization; inconsideration for natural processes of pregnancy, childbirth, and postpartum; forced sterilization; loss of autonomy and women's incapacity to freely decide over their body and their sexuality; all of which can have a negative impact on women's quality of life, especially in regards to their sexual and reproductive health".
(Montoya et al., 2020, 2)	"The law defines obstetric violence as 'any action or omission of action by health personnel that damages, injures, denigrates or causes the death of a woman during pregnancy, birth and the puerperal period' (…). More specifically, the law penalises medical negligence, which is expressed as '(1) dehumanised care; (2) abuse of medication and pathologisation of natural processes; (3) use of a caesarean section even when the conditions for a natural birth exist; (4) use of contraceptive methods or sterilisation without voluntary consent, and (5) interference in the early attachment between the newborn and his or her mother without medical justification, denying the mother the possibility of carrying and nursing the newborn immediately after birth (…)".

Table 7: Person-centered care (PCC)

Key concept derived from conceptual ideas: Person-centered care is respectful of and responsive to individual patient preferences and needs, ensuring that the patients' values guide all clinical decisions. Elements of PCC are 1. treating the patient with respect, 2. providing care in a non-threatening manner, 3. working in collaboration as equal partners, and 4. giving priority to the patient's preferences over that of the healthcare provider.	
Study	**Conceptual idea (individual studies in PCC cluster)**

(Afulani et al., 2018, 2)	"Person-centered maternity care (PCMC) refers to "maternity care that is respectful of and responsive to individual women and their families' preferences, needs, and values" (…). The WHO recommendations highlight respectful maternity care, effective communication, and companionship during labor and childbirth as key dimensions of PCMC that should be provided to every women throughout labor and birth (…). These recommendations are based on a human rights-based approach, as well as on evidence of the potential impacts of these interventions to reducing maternal morbidity and mortality (…)."
(Afulani et al., 2019, 81)	"Person-centered maternity care is "respectful of and responsive to individual women and their families' preferences, needs, and values"—in accordance with the Institute of Medicine's definition of person-centered care, (…). The concepts of respectful maternity care (RMC) are incorporated in PCMC as part of the broader interest in person-centered care, (…) and capture the experience dimensions in the WHO vision for quality of maternal and newborn health (…)."
(Attanasio & Kozhimannil, 2015, 863)	"PCC, defined as 'care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions' (…)Aspects of patient-centered care such as patient-provider communication and patient involvement in decision making are associated with higher levels of patient satisfaction, more trust in the provider, and better treatment adherence (…); in some studies patient-centered care is also associated with better health outcomes (…)".
(Attanasio & Hardeman, 2019, 270)	„ (…) patient-centered care has been held up as the ideal model of patient-provider interaction in all types of health- care; the implementation of patient-centered care is now recognized as an integral component of care quality (…). In an approach consistent with patient-centered care, clinicians respect and take into account individual patients' preferences and values, and involve patients in decision-making (…). Along with this shift toward patient-centered care, patients are increasingly viewed as consumers (...). In this model, healthcare providers are charged with providing adequate information to patients to enable them to make decisions that best fit their preferences, while patients are charged with active involvement in making decisions about their treatment and following through to implement treatment plans (…)"
(Iida et al., 2012, 459)	"From the evidence, care provided at birth centres can be called women-centred care (WCC).The four elements of WCC were respect, safety, holism, and partnership and its goal is the general well-being of women, potentially leading to the woman's empowerment (…). (…) basic attitudes to be important in providing WCC: (1) treating women with respect, (2) providing care in a non-threatening manner, (3) working in collaboration as equal partners, and (4) giving priority to the woman's preferences over that of the health-care provider (…)".

Appendix file F: Process of identifying themes in items

Table 8: Childbirth experiences (CE)

Theme	Items	Studies
Staffing capacity	• Did the health-care personnel have time for you when you needed it?	(Sjetne et al., 2015)
Appropriate length of	• I stayed in hospital as long as I wanted after the birth.	(Redshaw et al.,

hospitalization		2019)
Service and information management	• Were you received well when you arrived at the delivery ward? • Did you receive sufficient information during your stay at the delivery ward? • Did you find that the services you received during your stay at the delivery ward were well-organized? • Did you receive information about who had the main responsibility for you? • Resources and organization during your postnatal stay. • Were things arranged so that you could get enough peace and rest.	(Sjetne et al., 2015)
Provision of safe medical care	• I received a safe care for me and my child. • I felt that some medical mistakes occurred while providing care to me. • While still in the labor room and after I gave birth, I received a medical checkup or health care assessment.	(Alzyoud et al., 2018)
	• I had the best possible care during labour and birth.	(Redshaw et al., 2019)
	• Mother received best possible medical care	(Thies-Lagergren & Johansson, 2018)
	• Did you find that the health-care personnel cared about you?	(Sjetne et al., 2015)
Competency of health professionals	• Did you have confidence in the health-care personnel's competence?	(Sjetne et al., 2015)
	• The health-care team was well trained to care for me.	(Alzyoud et al., 2018)
General information on labor, birth, partum stage and newborn care	• There were times that no one described what was happening to me.	(Alzyoud et al., 2018)
	• Level of information.	(Overgaard et al., 2012)
	• Everything was explained to me well during labour and birth. • I had enough information from health professionals about how to care for my baby. • I was not given the advice and information I needed by health professionals after my baby was born.	(Redshaw et al., 2019)
	Did you receive sufficient information about the following? • Any possible mood changes after giving birth. • Breastfeeding and other ways of feeding the child, childcare. • Information and guidance about your child during your postnatal stay	(Sjetne et al., 2015)
Information on individual proceeding and medical diagnosis	• There were times that no one described what was happening to me. • I was provided with all new information about the development of my childbirth. • Has any one of the health care team gave you incorrect or withhold information about your medical condition during childbirth?	(Alzyoud et al., 2018)
	• Midwife gave information about labour progress.	(Thies-Lagergren & Johansson, 2018)
	• Did you receive sufficient information about the following? • Your physical health after giving birth.	(Sjetne et al., 2015)
(Non-)	• Staff communicated well with me during labour and birth.	(Redshaw et al.,

Respectful communication		2019)
Verbal abuse	• Has any one of the health care team shouted at you while in labor? • Did any one of the health care team use an aggressive tone of voice with you during childbirth? • Has any one of the health care team used swearing or harsh words while you were in labor such as (You are stupid; You know nothing about labor). • Has any one of the health care team ridiculed you while were in labor such as (stop pretending you are in pain; I am not the one that made you pregnant). • Has any one of the health care team called you names during childbirth?	(Alzyoud et al., 2018)
Emotional abuse	• Has any one of the health care team used verbal threats such as (if you do not push, I will give you a C- section, if you do not push good, I will make you a vaginal cut).	(Alzyoud et al., 2018)
(Non-)Respectful care	• Were you treated politely and with respect by the health-care personnel at the delivery ward?	(Sjetne et al., 2015)
	• Has any one of the health care team treated you roughly (rude/unkind) while you were in labor?	(Alzyoud et al., 2018)
Presence and absence of health care professionals	• The health-care team stayed with me all the time and when I needed them. • I was able to see the doctor any time I needed him/her.	(Alzyoud et al., 2018)
	• Midwife's presence in the labour room.	(Thies-Lagergren & Johansson, 2018)
	• Midwife present when I wanted.	(Overgaard et al., 2012)
	• Health professionals left me alone more than I would have liked.	(Redshaw et al., 2019)
Cooperation between health care professionals	• Did you find that the health-care personnel cooperated well during the birth?	(Sjetne et al., 2015)
Visual privacy	• Protection of the privacy.	(Okumus, 2017)
	• The health-care team protected my privacy during childbirth. • I have been well covered by sheets while in labor process especially during vaginal examination.	(Alzyoud et al., 2018)
Situational privacy	• Undisturbed contact with newborn.	(Overgaard et al., 2012)
Encouragement	• Mother encouraged by midwife during second stage birth position. • Mother encouraged by midwife for birth position at birth.	(Thies-Lagergren & Johansson, 2018)
Assistance and physical support	• Position and mobility, maintaining oral intake, skin to skin contact, midwife support, gynecologist support.	(Okumus, 2017)
Engagement and empathy	• I needed more staff support during labour and birth. • The staff could have done more to help me to feel in control of my labour and birth.	(Redshaw et al., 2019)
Pain	• I received pain killers during stitching	(Alzyoud et al.,

management	• The health-care team did what they could to mediate my labor pain.	2018)
	• Suggestions for pain-relief.	(Overgaard et al., 2012)
	• I felt that my pain relief needs were not managed well.	(Redshaw et al., 2019)
Engagement and empathy	• The health team gave me all possible care and attention. • The health-care team took into consideration my feelings and circumstances. • The health-care team took very good care of me and gave me all the attention I need during childbirth. • I was asked how I have been doing after childbirth by the health care providers in labor room. • I received psychological and emotional support from the health-care team during labor.	(Alzyoud et al., 2018)
	• Attention to psychological needs	(Overgaard et al., 2012)
	• I was treated as an individual by staff. • I was treated as an individual by midwives/doctors after the birth. • I received enough care and attention from staff on the postnatal ward. • After I had given birth, health professionals treated me as though I was no longer important.	(Redshaw et al., 2019)
Involvement and empowerment	• I felt involved in decision making.	(Thies-Lagergren & Johansson, 2018)
Provision/denial of requested care	• Did you find that the health-care personnel were open to your questions?	(Sjetne et al., 2015)
	• Consideration for birth wishes.	(Overgaard et al., 2012)
	• The health care provider refused to assist me during or after giving birth.	(Alzyoud et al., 2018)
Provision/denial of requested pain medication	• Mother received wished pain relief.	(Thies-Lagergren & Johansson, 2018)
	• The health-care team refused to give me pain killer.	(Alzyoud et al., 2018)
(Non) Kindness	• Some health care providers answered my questions angrily while in labor	(Alzyoud et al., 2018)
Control (internal)	• I felt in control	(Thies-Lagergren & Johansson, 2018)
	• Loss of control over labour/ reactions (internal control)	(Overgaard et al., 2012)
Pain	• I still could feel pain during stitching even though I was given pain killers / anesthesia	(Alzyoud et al., 2018)

	• Perception of pain during labour and birth.	(Okumus, 2017)
Anxiety, fear	• I felt scared during the childbirth process	(Alzyoud et al., 2018)
	• Perception of anxiety during labour and birth. • Perception of fear during labour and birth	(Okumus, 2017)
Control (external)	• Loss of control over staff actions (external control)	(Overgaard et al., 2012)
Security, safety, trust, being seen	• Feeling of being listened to.	(Overgaard et al., 2012)
	• I felt safe in the labour and birth environment. • I had confidence and trust in the staff caring for me.	(Redshaw et al., 2019)

Table 9: Disrespect and abuse (D&A), Mistreatment in childbirth (MisC)

Perceived societal discriminatory practice	• (e.g.) • A pregnant white woman is treated with more respect than • pregnant African American woman. • Racial discrimination in a doctor's office is common. • In most hospitals, African American women and white women get the same kind of care. • If an African American pregnant woman comes to a doctor's office, it's assumed that she is on welfare. • African Americans have the same opportunities as whites to live a middle-class life	(Saraswathi Vedam et al., 2019)
Attitudes towards gender norms and equity	GEM scale, e.g.: • There are times where a woman deserves to be beaten. • It is a woman's responsibility to avoid getting pregnant. • Only when a woman has a child she is a real woman.	(N. Diamond-Smith et al., 2017)
Staffing capacity **Timely care**	• Is it easy for service providers to respond to mothers' calls for help?	(Anteneh Asefa et al., 2018)
	• Waiting time to be seen by health worker, scheduled time (for cesarean section), delay of service provision due to health facilities internal problems.	(P. A. Afulani et al., 2018b; Alvares et al., 2018; Bitew et al., 2015; Gungor & Beji, 2012; Jha et al., 2017; Mehata et al., 2017; Wassihun et al., 2018a; Wassihun & Zeleke, 2018b)
Detention in facility	• Kept in health facility without her will.	(Workineh Bekele et al., 2020b)
	• Detention in facility for failure to pay.	(Bhattacharya & Sundari

		Ravindran, 2018)
	• Inappropriate demands for payment. • Detention in facility for failure to pay.	(Kruk et al., 2018; Kujawski et al., 2015)
	• Discharge was postponed until hospital bills were paid. • I was detained in a health facility against my will.	(Wassihun et al., 2018a)
	• The health personnel told her that if she did not cancel for childbirth services she or her baby would stay at the health facility until the payments were made.	(Montesinos-Segura et al., 2018)
	• I was detained in health facility against my will.	(A. Asefa & Bekele, 2015)
	• Detainment: Unpaid bills mother, unpaid bills baby.	(Galle et al., 2019)
	• Did the health care providers detain you in the health facility because of payment of because you have pose damage to the property of the health institution?	(Ukke et al., 2019)
	• Discharge postponed until her hospital bills are paid. • Detained in the hospital until infant's bills are paid.	(Okafor et al., 2015)
	• Detention in health facility for failure to pay.	(Tekle Bobo et al., 2019)
	• Mothers have been detained at the facility, against their will.	(Anteneh Asefa et al., 2018)
	• Detention or confinement in facilities: mother was delayed in health facility against her will.	(Siraj et al., 2019)
Medical assessment	• Medical history taking (e.g.): • Asked about personal history. • Took obstetric and medical history. • Physical assessment (e.g.): • Took blood pressure. • Examined legs. • Checked fetal heart sounds. • Immediate postpartum (e.g.): • Confirmed uterine contracting • Provider took blood pressure. • Checked amount of vaginal bleeding. • Examined fundal height.	(Abuya et al., 2018)
Hygienic practices	• Physical examinations and procedures-unhygienic practices (e.g.): • Provider used gloves during delivery. • Provider swabbed perineum with antiseptic solution. • Providers wore sterile gown.	(Abuya et al., 2018)
Basis equipment	• Woman did not have her own bed.	(Sethi et al., 2017)
Equipment to protect privacy	• Delivery without any physical barriers.	(Bhattacharya & Sundari Ravindran, 2018)
	• Lack of physical privacy	(Kruk et al., 2018;

		Kujawski et al., 2015)
	• No screens blocking view during delivery or examination. • No partitions separating beds in antenatal ward. • Partitions do not give privacy in antenatal ward. • No partitions/curtains between beds in post-natal ward. • Mother not given a bed to herself in post-natal ward.	(Sando et al., 2014; Sando et al., 2016)
	• No partitions separating beds for first examination • No partitions/curtains between beds in post-natal ward. • Partitions do not give privacy in prenatal ward	(Banks et al., 2018)
	• Absence of private room	(Cruz da Silva et al., 2018)
	• Woman did not have audio and visual privacy.	(Sethi et al., 2017)
	• No partitions between beds.	(Abuya et al., 2018)
	• Curtains, partitions, or other measures available to provide privacy for the women throughout labour, childbirth and post-partum period.	(Bohren et al., 2019)
Availability of pain relief medication and comfort measures	• No access to epidural anesthesia.	(Baranowska et al., 2019)
Cleanliness and hygienic conditions	• Delivery coach on which I gave birth was not clean.	(Workineh Bekele et al., 2020b)
	• Woman instructed to clean up blood, urine, faeces, or amniotic fluid.	(Bohren et al., 2019)
	• Bed in post-natal ward not clean. • Bed in post-natal ward not covered with a bed sheet.	(Sando et al., 2016)
	• Bed in post-natal ward not clean.	(Banks et al., 2018)
Translation	• Language interpretation needed: Interpreter not available.	(Bohren et al., 2019)
General information on labor, birth, partum stage and newborn care	• The provider did not explain to me what was being done and what to expect throughout labor and birth.	(A. Asefa & Bekele, 2015; Wassihun et al., 2018a)
	• Did the care providers(s) explain to you what is being done and what to expect throughout the labor and birth process?	(Ukke et al., 2019)
	• Did not explain what will happen in labor to woman (support person) at least once.	(Sethi et al., 2017)
	• Client not provided with information on problem you might face after delivery. • Provider did not advice client on avoiding illness after delivery.	(Dey et al., 2017)

	• The health personnel did not explain to her what to expect throughout labour.	(Montesinos-Segura et al., 2018)
	• Explain to mothers what is being done and what to expect throughout labor and birth?	(Anteneh Asefa et al., 2018)
Information on individual proceeding and medical diagnosis	• Provider didn't give the periodic updates on status and progress.	(Azhar et al., 2018; W. Bekele et al., 2020a)
	• Not told information before/during a procedure.	(Gebremichael et al., 2018)
	• The provider did not give me periodic updates on status and progress of my labor.	(Montesinos-Segura et al., 2018; Wassihun et al., 2018a)
	• Did the care providers share the findings of your initial assessment with you and or your families?	(Ukke et al., 2019)
	• Did not inform pregnant woman of findings. • Provider did not give at least one update on status and progress of labor	(Sethi et al., 2017)
	• Right to information: share results/diagnosis of medical reports, regularly share progress of childbirth.	(Hameed & Avan, 2018)
	• Provider did not tell client about her health, • Provider did not tell client about her baby's health	(Dey et al., 2017)
	• Service provider did not explain what is being done and expected outcome during labor and birth, periodic updates on status and progress of labor not given.	(Siraj et al., 2019)
	• On a busy day, the admission room of a district hospital is overcrowded with many emergency cases. During the admission of one of the cases – a woman in advanced labor who has vaginal bleeding and is very anxious – the midwife does not offer explanations about what he/she is doing or any findings on the procedures to the woman and her sister who accompanied her.	(Bakker et al., 2020)
	• Providing information in an incomprehensible way. • Not giving all the information needed.	(Bitew et al., 2015)
	• Not explaining the labor progress.	(Sheferaw et al., 2019)
	• Provide periodic updates on status and progress of labor to laboring mothers?	(Anteneh Asefa et al., 2018)
	• Have you witnessed a care provider engage in procedures without giving the woman a choice or time to consider the procedure?	(Morton et al., 2018)
	• Provider didn't explain procedure and explain expectations.	(Azhar et al., 2018; W. Bekele et al., 2020a)
	• Did not explain procedures to woman (support person) before proceeding. • Did not inform the woman what will happen before conducting the vaginal examination.	(Sethi et al., 2017)

	• Lack of information about care provided.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• Explain about the procedure to be used for delivery.	(Hameed & Avan, 2018)
	• Client was not provided with complete information on the delivery procedures	(Dey et al., 2017)
	• An episiotomy (surgical cut at opening of vagina) is performed at an obstetric health facility due to fetal distress. The woman is illiterate and comes from a rural area. The midwife believes that the woman will not understand the medical procedure and that offering explanations would be a waste of time. In order to quicken childbirth, the midwife carries out the episiotomy without any explanation and getting the woman's permission.	(Bakker et al., 2020)
	• The health personnel did not explain to her what is being done.	(Montesinos-Segura et al., 2018)
Information on choices	• Offer choices regarding births.	(Hameed & Avan, 2018)
	• Physical examinations and procedures: "My doctor or midwife explained different options for care during my labour and birth". • My _____ asked me how involved in decision making I wanted to be. • My _____ told me that there are different options for my maternity care. • My _____ explained the advantages and disadvantages of the maternity care options. • I was given enough time to thoroughly consider the different maternity care options. • My _____ helped me understand all the information • I was able to choose what I considered to be the best care options. • My _____ respected that choice. • My doctor or midwife asked me what I wanted to do before the following procedures were done: (episiotomy, continuous fetal monitoring, screening tests etc)	(Saraswathi Vedam et al., 2019)
Encouragement to ask questions	• Provider did not encourage to ask questions	(Azhar et al., 2018; W. Bekele et al., 2020a; Wassihun et al., 2018a)
	• Did the care providers encourage you to ask questions?	(Ukke et al., 2019)
	• Did not ask woman (and support person) if she has any questions. • Did not ask client if there are any other problems the client is concerned about.	(Sethi et al., 2017)
	• Right to information: Encouragement to ask questions.	(Hameed & Avan, 2018)
	• Encourage mothers to ask questions during labor?	(Anteneh Asefa et al., 2018)
(Non-)Effective communication	• Convey information to mothers at a language-level they can understand?	(Anteneh Asefa et al., 2018)
	• The provider spoke to me in a language and at a language-level that I cannot understand.	(A. Asefa &

		Bekele, 2015)
	• Provider used language difficult to understand.	(Azhar et al., 2018)
(Non-)Consented care	• Procedure/s done without being adequately informed	(Gebremichael et al., 2018)
	• Provider didn't obtain consent prior to procedure	(A. Asefa & Bekele, 2015; W. Bekele et al., 2020a; Wassihun et al., 2018a)
	• Non-consent for tubal ligation/c-section/hysterectomy	(Kruk et al., 2018; Kujawski et al., 2015)
	• Lack of consent for first examination in antenatal ward. • Lack of consent for vaginal examination in antenatal ward. • Lack of consent for: Tubal ligation, hysterectomy, abdominal palpation, vaginal examination, episiotomy, other.	(Sando et al., 2016)
	• Lack of consent for first vaginal examination	(Banks et al., 2018)
	• Health personnel did not obtain her consent or permission prior to: • Vaginal examinations, being examined by other health personnel or a student, labour induction, Pubic hair shaving, episiotomy, Caesarean section, Blood transfusions, tubal ligation, if she had a caesarean section, hysterectomy, if she had a caesarean section	(Montesinos-Segura et al., 2018)
	• Imposition of non-consensual interventions: • C-section due to circular cord. • C-section due to post-maturity.	(Cruz da Silva et al., 2018)
	• Caesarean section, Episiotomy, Stitching, Blood transfusion, Sterilization, Injection, Shaving.	(Galle et al., 2019)
	• Have you undergone an episiotomy? If Yes, did the birth attendant explain the indication and asked your permission/consent before she/he cut? • Have you undergone a cesarean section? If Yes, did the care providers explain the indication and asked you to sign consent/ permission? • Was your labor augmented? If Yes, did the care providers explain the indication and asked your permission before putting you on the medication/oxytocin? Did you receive blood during the course of labor and delivery? • If you were given blood, were you informed about the indication and was your/your families/ permission asked before the procedure is started? Did the care providers coerce you to undergo C/S?	(Ukke et al., 2019)
	• Perform procedure without consent.	(Hameed & Avan, 2018)
	• Informed consent and confidentiality (C-section non-consented, episiotomy non-consented), Vaginal examinations (first vaginal examination, across all vaginal examinations) (e.g. permissions optained, total number),	(Bohren et al., 2019)
	• Providing treatment without consent.	(Sheferaw et al., 2019)
	• Consent or permission prior to any procedure not obtained.	(Siraj et al., 2019)
	• Episiotomy, augmentation of labour, shaving of pubic hair, sterilization, Cesarean delivery, blood transfusion,	(Okafor et al.,

		2015)
	• Non-consented episiotomy, C-section, tubal ligation	(Tekle Bobo et al., 2019)
	• Failure to meet professional standards of care: Lack of informed consent: Provider did not obtain permission before examination, Provider did not explain what would be done.	(Abuya et al., 2018)
	• An episiotomy (surgical cut at opening of vagina) is performed at an obstetric health facility due to fetal distress. The woman is illiterate and comes from a rural area. The midwife believes that the woman will not understand the medical procedure and that offering explanations would be a waste of time. In order to quicken childbirth, the midwife carries out the episiotomy without any explanation and getting the woman's permission.	(Bakker et al., 2020)
	• Abuse doing things without asking women for permission (lack of consent): Enema, Newborn vaccination, shaving of pubic hair, wewborn examination, Induction of delivery, Administration of an oxytocin drip, Episiotomy, vaginal examination, newborn drug administration, insertion of intravenous cannula, feeding a newborn baby with modified milk, presence of students during delivery, newborn bath	(Baranowska et al., 2019)
	• Has any professional ever con- ducted any procedure against your will, without explaining the need to conduct it, such as episiotomy or medication to induce labor?	(Silveira et al., 2019)
	• Obtain consent or permission of mothers prior to any procedure?	(Anteneh Asefa et al., 2018)
	• Have you witnessed a care provider engage in procedures explicitly against the wishes of the woman?	(Morton et al., 2018)
Coercion	• Coercion to undergo caesarean section	(Hameed & Avan, 2018)
	• The provider coerced me.	(A. Asefa & Bekele, 2015)
(Non-)Respectful communication	• Do service providers at this facility: • Introduce themselves to laboring mothers? • Respond to mothers' questions with promptness, politeness, and truthfulness?	(Anteneh Asefa et al., 2018)
	• Provider did not introduce herself. •	(Azhar et al., 2018)
	• The provider did not introduce himself/herself to me and my companion. • The provider did not speak to me politely.	(A. Asefa & Bekele, 2015; Wassihun et al., 2018a)
	• Did the care provider introduce him/herself to you and your companion?	(Ukke et al., 2019)
	• Service provider did not introduce him/herself to the mother, mother was not encouraged to ask questions • Service provider did not speak politely.	(Siraj et al., 2019)
	• Conversation in a rude and uncultured manner	(Baranowska et al., 2019)
	• Mother not welcomed in a kind and gentle manner • Use of non-dignified language during history taking.	(Sando et al., 2016)

	• Use of non-dignified language during history taking. • Mother not called by her name throughout interactions. • Mother not welcomed in a kind and gentle manner. • Provider did not introduce herself to mother (antenatal ward). • Delivery midwife did not introduce herself by name. • Delivering service provider did not congratulate mother after birth.	(Banks et al., 2018)
	• The health personnel who attended her most of the time did not introduce himself/herself to her.	(Montesinos-Segura et al., 2018)
	• Did not respectfully greet pregnant woman.	(Sethi et al., 2017)
	• Did the care provider speak to you politely throughout the course of the labor)	(Ukke et al., 2019)
	• Not greeting women	(Sheferaw et al., 2019)
Verbal abuse	• Support staff insulted me and my companion. • Providers shouted at or scolded me during labor. • Providers made negative comments during labor. • The provider verbally insulted me during labor.	(Wassihun et al., 2018a)
	• Provider made insults, threats etc. • Provider used abusive language	(Azhar et al., 2018)
	• Health provider shouted at me, • Health providers made negative comments about me.	(W. Bekele et al., 2020a)
	• Shouting/ scolding.	(Bhattacharya & Sundari Ravindran, 2018)
	• Shouted at; scolded/insulted; discouraging/became negative to me	(Gebremichael et al., 2018)
	• Shouting/scolding.	(Kruk et al., 2018; Kujawski et al., 2015)
	• Shouted at, scolded, laughed at or scorned. • Use of harsh tone or shouting during history taking.	(Sando et al., 2016)
	• The provider made insults, intimidation.	(A. Asefa & Bekele, 2015)
	• Did the care provider intimidate/ humiliate you at least one times? • Did the care provider balm you for getting pregnant or shouting/crying due to the pain of the labor? • Did the care provider shout at you to calm you down?	(Ukke et al., 2019)
	• Shouted, insulted or threatened the woman during labor or after.	(Sethi et al., 2017)
	• Insult and shouting.	(Nadia Diamond-Smith et al., 2016; N.

		Diamond-Smith et al., 2017)
	• Have you witnessed a care provider use sexually degrading language with a laboring woman?	(Morton et al., 2018)
	• Insulting or degrading comments, harsh tone or shouting, abusive language.	(Hameed & Avan, 2018)
	• Scolded, shouted at slanderous remarks or intimidated.	(Galle et al., 2019)
	• Shouted at, scolded, mocked, insulted, hissed at,	(Bohren et al., 2019)
	• Verbal abuse: included shouting, scolding, or addressing women using insulting names.	(Sheferaw et al., 2019)
	• Provider used bad/abusive language.	(Dey et al., 2017)
	• Mother was insulted, intimidated, threaten, or coerced.	(Siraj et al., 2019)
	• Received slanderous remarks (aspersions) from birth attendant; Scolded, shouted at, or called stupid;	(Okafor et al., 2015)
	• Has any professional been rude to you, cursed you or yelled at you, humiliated you?	(Silveira et al., 2019)
	• Shouted at.	(Tekle Bobo et al., 2019)
	• Verbal abuse: Harsh language: Provider did not use dignified language, Provider used harsh tone/shouted	(Abuya et al., 2018)
	• A midwife attends to a woman that came for delivery services to a district hospital. Other women are also being attended to in the same room. The woman is shouting and crying and others feel disturbed. The healthcare personnel are finding it hard to concentrate when carrying out routine tasks. A midwife tells the woman to be quiet, yet the woman continues to make a lot of noise. Eventually, the midwife yells at the woman to be quiet using very harsh language.	(Bakker et al., 2020)
	• Inappropriate comments • Nonchalant treatment • Not answering questions/ignoring • Raising your voice, shouting, disrespectful expressions • Mocking, Insulting	(Baranowska et al., 2019)
	• Service providers have used coercion to mothers or their companion.	(Anteneh Asefa et al., 2018)
Emotional abuse	• Did the birth attendant(s) threaten you with beating to let you obey their order?	(Ukke et al., 2019)
	• Threatening to withhold treatment • Threatening or negative comments	(Bhattacharya & Sundari Ravindran, 2018)
	• Threat of withholding treatment, threatening or negative comments	(Kruk et al., 2018;

		Kujawski et al., 2015)
	• Threatened to withhold services.	(Sando et al., 2016)
	• The provider made threats.	(A. Asefa & Bekele, 2015)
	• Threatened with C-section, Blamed.	(Galle et al., 2019)
	• Threatening for poor outcomes.	(Hameed & Avan, 2018)
	• Threatened the woman during labor or after.	(Sethi et al., 2017)
	• The health personnel made her feel guilty for getting pregnant ("you should have used condoms"). • The health personnel mocked, laughed about her person or behaviour, or insulted her.	(Montesinos-Segura et al., 2018)
	• Health care providers threatened to withhold treatment or to force you to accept treatment you did not want • Health care providers threatened you in any other way.	(Saraswathi Vedam et al., 2019)
	• Threatened to withhold care, • Threatened with poor outcome for baby. • Threatened with medical procedure. • Threatened with physical violence. • Blamed woman for poor outcome.	(Bohren et al., 2019)
	• Threatening to take women into the operating theatre.	(Sheferaw et al., 2019)
	• Provider threatened to slap client.	(Dey et al., 2017)
	• Mother was threatened or coerced.	(Siraj et al., 2019)
	• Blamed or intimidated during childbirth. • Threatened with cesarean delivery to discourage patient from shouting	(Okafor et al., 2015)
	• Has any professional threatened not to assist you?	(Silveira et al., 2019)
	• Threat of withholding treatment, blamed or intimidated.	(Tekle Bobo et al., 2019)
	• Blackmailing with child's health / woman's health	(Baranowska et al., 2019)
	• Threatening to withhold treatment.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)

	• Service providers have used coercion to mothers or their companion.	(Anteneh Asefa et al., 2018)
(Non-) Respectful care	• The providers did not demonstrate caring in a culturally appropriate way.	(Wassihun et al., 2018a)
	• Mother was not cared for in a culturally appropriate way.	(Siraj et al., 2019)
Physical abuse (force)	• Provider used physical force, slapped or hit the woman.	(Azhar et al., 2018)
	• Health provider hit or slapped. • Forcing leg apart during labor.	(W. Bekele et al., 2020a)
	• Physical abuse (slapping/ pinching etc.). • Use of excessive force during delivery.	(Bhattacharya & Sundari Ravindran, 2018)
	• Hit, slapped, pushed by provider.	(Gebremichael et al., 2018)
	• Physical abuse (slapping, pinching, etc.).	(Kruk et al., 2018; Kujawski et al., 2015)
	• Kicked, pinched, slapped, pushed.	(Sando et al., 2016)
	• The provider used physical force/slapped me/hit me.	(Wassihun et al., 2018a)
	• Provider slapped, hit or pinched the woman during labor or after	(Sethi et al., 2017)
	• Slapping or hitting	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• Beating, slapping, push badly to change position, pinch irritably.	(Hameed & Avan, 2018)
	• Slap, held down to the bed forcefully, punch, hit, kick, pinch, gag, other physical abuse.	(Bohren et al., 2019)
	• Hitting, slapping or pinching.	(Sheferaw et al., 2019)
	• Beaten / slapped by health care provider.	(Dey et al., 2017)
	• Physical force was used (e.g. slapping/hitting the mother).	(Siraj et al., 2019)
	• Aggressive physical contact	(Saraswathi Vedam et al.,

		2019)
	• beaten, slapped, or pinched.	(Okafor et al., 2015)
	• "Has any professional ever pushed, hurt, beat, or held yourself strongly or conducted any examinations rudely or disrespectfully?"	(Silveira et al., 2019)
	• The staff would force their legs apart when pushing. • The staff poked her.	(Baranowska et al., 2019)
	• Physical force or abrasive behavior with laboring mothers (for example slapping or hitting them).	(Anteneh Asefa et al., 2018)
	• The health personnel assaulted her physically at some point. Example: Pinching /Slapping/Pushing/Beating Stitching.	(Montesinos-Segura et al., 2018)
	• Did the birth attendants/the care providers use physical forces (slapping, pinching, beating /hitting) against you while you were in a labor pain?	(Ukke et al., 2019)
	• Beaten, slapped or pinched.	(Galle et al., 2019)
	• Hitting (slapped, beaten or pinched), harshly forcing legs apart.	(Tekle Bobo et al., 2019)
	• A woman is constantly closing her legs during the second stage of labor. A midwife tells her that she should not do that, as he/she believes that the baby will not deliver, yet the woman continues to move her legs together. Each time the woman closes her legs, the midwife slaps her legs and forces them apart again. • A woman wants to give birth in a kneeling position, however a midwife believes that the bed is not suited for that position. Hence, the midwife forces the woman to give birth in a lying position.	(Bakker et al., 2020)
	• Provider slapped, pinched, /inappropriately handled client.	(Abuya et al., 2018)
Physical abuse (restraint)	• Woman was physically restrained.	(Azhar et al., 2018)
	• Tied down or restrained.	(Galle et al., 2019)
	• Have you been tied down on a delivery bed when you were in labor? •	(Ukke et al., 2019)
	• Mother was physically confined.	(Siraj et al., 2019)
	• Restrained or tied down during labour	(Okafor et al., 2015)
	• Tied down during labor.	(Tekle Bobo et al., 2019)
	• The staff tied their legs to the delivery bed.	(Baranowska et

		al., 2019)
	• Tied to the bed.	(Bohren et al., 2019)
	• The health personnel tied her up sometime during labour.	(Montesinos-Segura et al., 2018)
Physical abuse while performing (medical) procedures	• Episiotomy without anesthesia.	(Sando et al., 2016)
	• Episiotomy, cesarean section. • Touching during labor, average of touching.	(Cruz da Silva et al., 2018)
	• Episiotomy sutured without anesthesia.	(Galle et al., 2019)
	• Did the health care provider(s) suture your perineum? If so, did they use local anesthesia so that it was pain-free? • Did the birth attendants push your tummy down to deliver the baby (used fundal pressure)?	(Ukke et al., 2019)
	• Episiotomy given or sutured without anesthesia.	(Okafor et al., 2015)
	• Forceful downward pressure on abdomen.	(Bohren et al., 2019)
	• Provider forcefully pushed abdomen during delivery. • Provider applied force to pull baby.	(Dey et al., 2017)
	• Fundal pressure applied	(Banks et al., 2018)
	• The health personnel performed the Kristeller manoeuvre. • The health personnel stitched the episiotomy without anaesthesia.	(Montesinos-Segura et al., 2018)
	• Refusal to provide anesthesia for an episiotomy, etc.).	(Saraswathi Vedam et al., 2019)
	• Manual exploration of uterus after delivery when unindicated. • Used episiotomy (without indication).	(Sethi et al., 2017)
Sexual abuse	• Sexual harassment, rape	(Kruk et al., 2018; Kujawski et al., 2015)
	• Rape	(Sando et al., 2016)
	• The health personnel rape her or inappropriate touched her during exam (genital/ thighs).	(Montesinos-Segura et al., 2018)
	• Sexually abused by health worker.	(Galle et al.,

		2019; Okafor et al., 2015)
	• Inappropriate sexual conduct.	(Saraswathi Vedam et al., 2019)
Presence and absence of health care professionals	• Provider left me alone, or unattended. • Provider didn't encourage to call if needed.	(Azhar et al., 2018)
	• Delivery without attendant.	(Bhattacharya & Sundari Ravindran, 2018)
	• Left alone unattended.	(Gebremichael et al., 2018)
	• Delivery without attendant.	(Kruk et al., 2018; Kujawski et al., 2015)
	• Lack of care: While in labor, while delivering, while experiencing a complication, after delivery, other.	(Sando et al., 2016)
	• The provider left me alone or unattened.	(Wassihun et al., 2018a)
	• The health personnel left her alone or unattended. • The health personnel did not attend her, so she gave birth alone.	(Montesinos-Segura et al., 2018)
	• The provider did not encourage me to call if needed • The provider left me alone or unattended	(A. Asefa & Bekele, 2015)
	• Have you ever been left alone without the care provider nearby you while you were in labor and needed help? • Did you give birth in the health institution by yourself because the care providers were not around you?	(Ukke et al., 2019)
	• Delivering alone.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• Abandon women during childbirth or afterward. • Delay birthing after deciding for operative procedure.	(Hameed & Avan, 2018)
	• Neglect: (no staff member present when baby came out).	(Bohren et al., 2019)
	• Client faced problem due to unavailability of provider during delivery.	(Dey et al., 2017)
	• Mother was not encouraged to call provider if needed. • Mother was left alone or unattended.	(Siraj et al., 2019)
	• Being left unattended in second stage of labor. • Birth attendant failed to intervene in a life-threatening situation.	(Okafor et al., 2015)

	• Gave birth outside delivery room (corridor, waiting room or floor). • Delivered without skilled attendant.	(Tekle Bobo et al., 2019)
	• Are mothers encouraged to call for help if they are in need? • Mothers have been left alone or unattended •	(Anteneh Asefa et al., 2018)
	• Mother not cleaned after birth and third stage of labour. • No pad provided to mother.	(Banks et al., 2018)
Visual privacy	• Providing care that violated privacy of women.	(Sheferaw et al., 2019)
	• Mother not covered while being moved from antenatal ward to delivery room. • Mother not covered during delivery. • Partitions not closed during delivery. • Mother not well covered after third stage of labor • No partition/curtain during post-natal examination, if done/ Mother not covered during post-natal examination, if done.Curtains and physical barriers were not used. • Drape or body covering was not used.	(Azhar et al., 2018)
	• Did not us drapes or cover to keep privacy.	(W. Bekele et al., 2020a)
	• Mother not covered during examination in antenatal ward.	(Sando et al., 2016)
	• Mother not covered during examination in prenatal ward. • Mother not covered while being moved from prenatal ward to delivery room. • Mother not covered during delivery. • Partitions not closed during delivery. • Mother not well covered after third stage of labour. • Mother's physical privacy not respected during post-natal examination.	(Banks et al., 2018)
	• The health personnel did not use curtains or other visual barriers to protect her.	(Montesinos-Segura et al., 2018)
	• The provider did not use curtains or other visual barriers to protect me.	(A. Asefa & Bekele, 2015)
	• Did the health care providers use curtains or other physical barriers so that your privacy was kept during the labor and delivery processes?	(Ukke et al., 2019)
	• Provider did not drape woman (one drape under buttocks, one over abdomen). • Provider did not use curtains or other visual barriers to protect woman during exams, births, procedures.	(Sethi et al., 2017)
	• Curtains or other visual barriers not used.	(Siraj et al., 2019)
	• Conducted examinations without privacy. • Provider did not cover mother during examination. • Mother was not covered when being moved to delivery room. • Mother not covered except perineal area during delivery.	(Abuya et al., 2018)
	• Privacy during examination. • Cover woman while taking to and from labour room.	(Hameed & Avan, 2018)
	• Your physical privacy was violated (i.e., being uncovered or having people in the delivery room without your consent).	(Saraswathi Vedam et al.,

		2019)
	• Use curtains or other visual barriers to protect mothers during exams, births and procedures? • Mothers' privacy during labor and delivery has not been protected.	(Anteneh Asefa et al., 2018)
	• Provision of care without privacy.	(Okafor et al., 2015; Tekle Bobo et al., 2019)
	• Were other persons apart from the care providers allowed to the room you were giving birth who could observe you while you are naked on the bed?	(Hameed & Avan, 2018)
Situational privacy	• Personal issues discussed in earshot of others.	(Sando et al., 2016)
Auditory privacy	• Mother's history taking findings shared when others could hear • Auditory privacy not respected during post-natal examination	(Banks et al., 2018)
	• Women-provider conversation over- heard by others (stranger, other patients, or non-medical staff)	(Hameed & Avan, 2018)
	• Were other persons apart from the care providers allowed to the room you were giving birth who could observe you while you are naked on the bed?	(Ukke et al., 2019)
Confidential handling of sensitive data	• Health provides discussed your private health information in a way that others could hear	(W. Bekele et al., 2020a)
	• Disclosing private health information to others	(Bhattacharya & Sundari Ravindran, 2018)
	• Providers discussed my private health information in public • Shared my health information with others;	(Gebremichael et al., 2018)
	• HIV status shown to others, other health information shown to others. • HIV status shown to non-health staff, health information discussed with non-health staff. • Mother's history taking findings shared when others could hear.	(Sando et al., 2016)
	• The health personnel commented that she was a single mother publicly. • The health personnel commented that she had a sexually transmitted disease publicly. • The health personnel commented that she was a teenager publicly.	(Montesinos-Segura et al., 2018)
	• Disease (HIV), Age, medical history.	(Galle et al., 2019)
	• Did the birth attendants share your secret information with other non-concerned persons? Or don't you trust them that your secret is likely to be shared with others?	(Ukke et al., 2019)
	• Age disclosure without consent. • Medical history disclosure without consent. • Disclosure of HIV status without consent.	(Okafor et al., 2015)
	• Medical history disclosed without consent	(Tekle Bobo et al., 2019)
	• Assure woman for confidentiality of information	(Hameed & Avan,

		2018)
	• A midwife is caring for a woman in labor who is HIV positive. In order to limit the risk of infection, the midwife believes she needs to tell the woman's HIV status to a colleague, who works at the outpatient department and who is not directly involved in the care of that woman during lunch break in the cafeteria.	(Bakker et al., 2020)
	• Your private or personal information was shared without your consent.	(Saraswathi Vedam et al., 2019)
	• Health provides discussed your private health information in a way that others could hear	(W. Bekele et al., 2020a)
	• Disclosing private health information to others	(Bhattacharya & Sundari Ravindran, 2018)
	• Providers discussed my private health information in public; • Shared my health information with others;	(Gebremichael et al., 2018)
	• HIV status shown to others, other health information shown to others. • HIV status shown to non-health staff, health information discussed with non-health staff. • Mother's history taking findings shared when others could hear.	(Sando et al., 2016)
	• The health personnel commented that she was a single mother publicly. • The health personnel commented that she had a sexually transmitted disease publicly. • The health personnel commented that she was a teenager publicly.	(Montesinos-Segura et al., 2018)
	• Disease (HIV), Age, medical history.	(Galle et al., 2019)
	• Did the birth attendants share your secret information with other non-concerned persons? Or don't you trust them that your secret is likely to be shared with others?	(Ukke et al., 2019)
	• Age disclosure without consent. • Medical history disclosure without consent. • Disclosure of HIV status without consent.	(Okafor et al., 2015)
	• Medical history disclosed without consent	(Tekle Bobo et al., 2019)
	• (Hameed & Avan, 2018)	(Hameed & Avan, 2018)
	• A midwife is caring for a woman in labor who is HIV positive. In order to limit the risk of infection, the midwife believes she needs to tell the woman's HIV status to a colleague, who works at the outpatient department and who is not directly involved in the care of that woman during lunch break in the cafeteria.	(Bakker et al., 2020)
	• Your private or personal information was shared without your consent.	(Saraswathi Vedam et al., 2019)
Assistance and physical support	• Woman not offered to have a labour companion during labour and birth. • Companion not present at any time during labour and birth. • Companion not present at the time of birth.	(Bohren et al., 2019)
	• Provider did not encourage the woman to have a support person present during labor and delivery • Provider did not encourage or assist woman to ambulate and assume different positions during labor at least once.	(Sethi et al., 2017)

	• Provider did not ask woman which position she would like to deliver in.	
	• Not offering hot drinks or food after childbirth. • Not encouraging women to move around freely	(Sheferaw et al., 2019)
	• No access to lactation consultant. • No support in breastfeeding. • No support in dealing with depressed mood.	(Baranowska et al., 2019)
Pain management	• Did not receive a comfortable/pain-relief treatment.	(A. Asefa & Bekele, 2015)
	• Didn't receive comfort, pain relief as necessary.	(Azhar et al., 2018)
	• Received unnecessary pain-relief treatment	(Wassihun et al., 2018a)
	• Did care providers in this facility: Provide appropriate pain relief or comfort measures for laboring mothers.	(Anteneh Asefa et al., 2018)
(Non-)Discrimination based upon attributes	• Healthcare providers discriminated by race, ethnicity, or economic status. • Healthcare providers discriminated because of being a teenager.	(Wassihun et al., 2018a)
	• Women felt that health personnel discriminated: • For her socioeconomic status, for being teenager, for being single, for her religion, for having a sexually transmitted disease	(Montesinos-Segura et al., 2018)
	• The provider showed disrespect to me based on any specific attribute.	(A. Asefa & Bekele, 2015)
	• Ethnicity, young and unexperienced, single motherhood, status HIV seropositive status, low socio-economic status	(Galle et al., 2019)
	• Did the care provider discriminate you because of your traditional belief? • Did the care provider discriminate you because of your religion? • Did the care provider discriminate you because of your educational status? • Did the care provider discriminate you because you are from rural area/ from a very far distance? • Did the care provider discriminate you because you are RVI patient? • Did the care providers discriminate you because of your age?	(Ukke et al., 2019)
	• Have you observed a laboring woman receive more procedures because of her racial or ethnic background?	(Morton et al., 2018)
	When I had my baby, I felt that I was treated poorly by my (midwife, doctor): • Because of my race, ethnicity, cultural background or language. • Because of my sexual orientation and/or gender identity.	(Saraswathi Vedam et al., 2019)
	Discrimination based on race, ethnicity, or ability to pay.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	Denial of service due to ethnicity.	(Hameed & Avan, 2018)

	• Stigma or discrimination: Race/ethnicity, economic circumstances, age, marital status, level of education/literacy, religion, HIV-status; other stigma/discrimination • Negative comments on her sexual activity. • Negative comments on her appearance. Negative comments on baby's appearance.	(Bohren et al., 2019)
	• Client was treated differently based on her caste.	(Dey et al., 2017)
(Non-)Discrimination based upon disagreement	• Because of a difference in opinion with your caregivers about the right care for yourself or your baby.	(Saraswathi Vedam et al., 2019)
(Non-)Discrimination based upon financial or insurance status	• Providers discriminated by economic status	(Workineh Bekele et al., 2020b)
	• Because of my health insurance.	(Saraswathi Vedam et al., 2019)
	• Denial of service due to lack of money.	(Hameed & Avan, 2018)
Preferences and wishes	• Birth companion(s) not allowed	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• A midwife believes that if companions are allowed in the delivery room, the cleanliness of the room will be compromised, which poses a risk to the health of newborns. Moreover, the midwife thinks that companions reduce patients' privacy, given the fact that multiple women give birth in the same room. A woman asks if her mother can be present during her delivery, but the midwife denies this request for the above-mentioned reasons.	(Bakker et al., 2020)
	• Did the care providers allow your companion to enter the delivery room?	(Ukke et al., 2019)
	• Not allowing women to bring a companion.	(Sheferaw et al., 2019)
	• The health personnel did not accept when she requested for having a companion during the delivery.	(Montesinos-Segura et al., 2018)
	• If support person was not present at birth: Support person was restricted from being present.	(Sethi et al., 2017)
	• Denied companionship by the husband or close relatives.	(Okafor et al., 2015)
Maternal rights	• The health personnel did not allow her to move around during labour, even if the amniotic sac was not broken. • The health personnel did not allow her to assume position of choice during birth.	(Montesinos-Segura et al., 2018)
	• Provider didn't allow to move during delivery. • Provider didn't allow to assume position of choice.	(Anteneh Asefa et al., 2018; Azhar et

		al., 2018; Workineh Bekele et al., 2020b; Wassihun et al., 2018a)
	• Movement restricted for a long time.	(Gebremichael et al., 2018)
	• Did the care providers allow you to assume the position of your choice during the current childbirth? Did the birth attendants(s) allow you to move around? (Ambulate) during the course of the labor? If No, have they told you that you have a medical condition or you are in advanced labor or any other reason why they have not allowed you to do so?	(Ukke et al., 2019)
	• Denying choice of position during delivery	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• Mother not allowed to move about during labor, mother not allowed to take position of choice during childbirth • Mother denied food/fluid without medical indication.	(Siraj et al., 2019)
	• Mother not asked about preferred birth position.	(Banks et al., 2018)
	• Not allowing women to give birth in their preferred birth position and.	(Sheferaw et al., 2019)
	• Woman was not allowed to deliver in her preferred birthing position (if she had a preferred position).	(Sethi et al., 2017)
	Do service providers at this facility: • Allow mothers to move around during labor? • Allow mothers to assume the position of her choice during birth? • Mothers have been denied foods or fluids unnecessarily.	(Anteneh Asefa et al., 2018)
	• Provider allowed her to move. • Client was allowed to drink. • Client was allowed to eat.	(Abuya et al., 2018)
	• Denied from food or fluid in labor unless medically necessitated.	(Azhar et al., 2018; Bhattacharya & Sundari Ravindran, 2018)
	• The health personnel refused to give her food or fluids when she asked for them.	(Montesinos-Segura et al., 2018)
Maternal/ parental rights	• I was separated from my baby without medical indication.	(Wassihun et al., 2018a)
	• Baby was separated without medical indication.	(Azhar et al., 2018; Workineh Bekele et al., 2020b)

	• Mother and newborn were separated without medical indication.	(Siraj et al., 2019)
	• Unnecessary separation from baby after birth.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
Provision/denial of requested care	• Provider didn't come quickly when needed.	(Azhar et al., 2018)
	• Provider ignored me or did not come quickly when I called him/her.	(Workineh Bekele et al., 2020b)
	• Request for assistance/help ignored.	(Gebremichael et al., 2018)
	• Ignored when needed help.	(Bhattacharya & Sundari Ravindran, 2018; Kruk et al., 2018; Kujawski et al., 2015; Tekle Bobo et al., 2019)
	• The provider did not come quickly when I called him/her.	(Anteneh Asefa et al., 2018; Wassihun et al., 2018a)
	• Have you encountered a life-threatening condition for which you have shouted for help but could not get anyone reached you in time?	(Ukke et al., 2019)
	• Ignoring or abandoning patient when in need.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• Health care providers ignored you, refused your requests for help, or failed to respond to requests for help in a reasonable amount of time.	(Saraswathi Vedam et al., 2019)
	• Provider did not answer client's questions.	(Dey et al., 2017)
	• Provider did not arrive quickly when called.	(Siraj et al., 2019)
	• Not granted requested attention because staff was exhausted	(Okafor et al., 2015)
	• A mother with postpartum bleeding arrives at a health facility following a home birth. She has lost about 400 ml of blood within the first 24 hours following childbirth and is unwell. She waits two hours for a midwife that works alone to finish attending to two births. After the deliveries, the midwife is exhausted and wants to go home as the scheduled shift is over. Therefore, the midwife decides to refer the woman to another health facility, which is one hour away.	(Bakker et al., 2020)
	• Woman felt that health workers or staff did not listen and respond to her concerns.	(Bohren et al.,

		2019)
Provision/denial of requested pain medication	• The health personnel denied administration of pain medication when she asked for it.	(Montesinos-Segura et al., 2018)
	• I did not receive comfort/pain-relief as necessary.	(Anteneh Asefa et al., 2018)
	• Ignoring women's requests for pain relief.	(Sheferaw et al., 2019)
	• Woman requested some pain relief for her pain but was not given anything.	(Sethi et al., 2017)
	• Ignore while asking pain relief/medication.	(Hameed & Avan, 2018)
	• Neglect: Pain relief (request for pain relief, receive of pain relief).	(Bohren et al., 2019)
	• Has any professional refused to give you anything that you asked for, such as water or painkillers?	(Silveira et al., 2019)
Kindness	• Provider didn't respond politely, truthfully and promptly	(Azhar et al., 2018)
	• The provider did not respond to my questions with promptness, politeness, and truthfulness.	(A. Asefa & Bekele, 2015; Wassihun et al., 2018a)
	• Service provider did not answer questions promptly, politely and truthfully.	(Siraj et al., 2019)
	• Not responding to women's questions in a polite manner.	(Sheferaw et al., 2019)
Bribes	• Request for bribe. • Inappropriate demands for money.	(Bhattacharya & Sundari Ravindran, 2018; Kruk et al., 2018; Kujawski et al., 2015; Tekle Bobo et al., 2019)
	• Request or suggestion for informal payments or bribes for better care.	(Nadia Diamond-Smith et al., 2016; N. Diamond-Smith et al., 2017)
	• Staff suggested or asked the woman or companion for a bribe, informal payment, or gift.	(Bohren et al., 2019)
Security, safety, trust, being seen	• Provider made patient feel alone or unattended.	(Azhar et al., 2018)

Post-partum depression	e.g., Edinburgh Postnatal Depression Scale (EPDS): • I have been able to laugh and see the funny side of things • I have looked forward with enjoyment to things • I have blamed myself unnecessarily when things went wrong • I have been anxious or worried for no good reason • I have felt scared or panicky for no very good reason. • Things have been getting on top of me	(Silveira et al., 2019)

Table 10: Obstetric violence (OV)

Availability of medical services in facility	• Did you go to more than one hospital to find a bed for childbirth? • Did your delivery not happen in the hospital originally recommended?	(Souza et al., 2017)
Adherence to medical guidelines and evidence-based care practices	(e.g.) • Fetal Heart Rate monitored at least 15 min prior to birth • Administration of a uterotonic soon after birth • Birth of the placenta by controlled cord traction • Uterine massage • Placenta examination after birth • Breastfeeding prior to leaving the birth room (60 min) • Non-insertion of IV cannula during labour • No: labour induction, Kristeller manoeuvre, episiotomy, manual uterine exploration	(Montoya et al., 2020)
Detention in facility	• Detention in facilities: Detaining of mothers in health facility because of bills or damage to the property of the health care facility.	(Mihret, 2019)
Equipment to protect privacy	• Privacy (gowns, curtains or doors) during labour.	(Montoya et al., 2020)
	• Giving birth in a public view without privacy barriers such as curtains.	(Mihret, 2019)
Explanation of procedures or exams before proceeding	• Lack of information	(Brandao et al., 2018; Meijer et al., 2020)
	• Did any health care professional not explain the procedures he or she was doing to you?	(Souza et al., 2017)
	• Provider explains medications • Provider explains procedures • Providers not giving women or her relatives proper information about medical procedures	(Mihret, 2019)
	• Were you informed in such a way for you to understand why a C-section was necessary?	(Castro & Frías, 2019)
(Non-)Consented care	• Execution of procedures without information and/or without consent.	(Brandao et al., 2018; Meijer et al., 2020)
	• Did you give permission or authorization for the C-section? • Were you sterilized, given a contraceptive, or had an IUD (intrauterine device) inserted, or had surgery to prevent you from having more children without being asked or letting	(Castro & Frías, 2019)

	you know?	
	• Not asking for women's permission to conduct medical procedures such as cesarean sections, episiotomies, hysterectomies, blood transfusions, tubal ligation, augmentation of labor.	(Mihret, 2019)
	• Women signs informed consent.	(Montoya et al., 2020)
Coercion	• Were you pressured to accept the insertion of an IUD or an operation to prevent further pregnancies? • Were you obliged or threatened to sign a piece of paper without being told what it was or what it was for?	(Castro & Frías, 2019)
	• Coercing into a medical procedure such as a cesarean section.	(Mihret, 2019)
(Non-)Respectful communication	• Provider communicates with the woman by name. • Provider verbal communication is positive. • Provider nonverbal communication is positive.	(Montoya et al., 2020)
Verbal abuse	• Inappropriate comments, intimidating language.	(Brandao et al., 2018; Meijer et al., 2020)
	• Did they yell at you or scold you? • Did they say offensive or humiliating things (e.g., "Is that how you screamed when he did that to you?" or "When he did it, you opened your legs all right, didn't you?").	(Castro & Frías, 2019)
	• intentional humiliation, blaming, rough treatment, scolding, shouting at, and ordering to stop crying while they are in labor pain.	(Mihret, 2019)
	During delivery, did any of the health professionals: • yell at you? • or said something similar like • Don't cry! Next year you will be here again • "When you were making the baby, you didn't cry, or called your mommy. Why are you crying now? "If you keep screaming, I will stop what I'm doing and I won't come back again;" • "If you keep screaming, you will harm your baby. It will be born deaf."	(Souza et al., 2017)
(Non-)Respectful care	• Lack of respect for cultural customs.	(Brandao et al., 2018; Meijer et al., 2020)
Physical abuse (force)	• beating, threatening with beating, slapping, pinching,	(Mihret, 2019)
	• During childbirth, did any of the health care professionals: hit you?; push you?; tie you?	(Souza et al., 2017)
Physical abuse (restraint)	• Restraining or tying down during labor.	(Mihret, 2019)
	• During childbirth, did any of the health care professionals: tie you?	(Souza et al., 2017)
Physical abuse while performing (medical)	• Physical violence, including the Kristeller maneuver; routine episiotomy; routine oxytocin; repeated vaginal examinations; vaginal examinations by several individuals outside the recommended time frame; and shaving.	(Brandao et al., 2018; Meijer et al., 2020; Souza et al., 2017)

procedures	• Cutting or suturing of episiotomy cuts or perineal tears without the use of anesthesia and the use of fundal pressure to fasten the delivery of the baby.	(Mihret, 2019)
	• During childbirth, did any of the health care professionals hurt you during the vaginal exam?	(Castro & Frías, 2019)
Presence and absence of health care professionals	• Negligent care, including lack of breastfeeding help and absence of a professional during delivery	(Brandao et al., 2018; Meijer et al., 2020)
	• Leaving laboring woman alone, women giving birth by themselves at health facilities, failure of care givers to monitor women in labor and intervene in life threatening conditions.	(Mihret, 2019)
Visual privacy	• Privacy	(Brandao et al., 2018; Meijer et al., 2020)
Confidential handling of sensitive data	• Confidentiality	(Brandao et al., 2018; Meijer et al., 2020)
	• Having healthcare providers share sensitive clients' information, such as HIV status, age, marital status, and medical history, in a way that other people who are not involved in their care can hear.	(Mihret, 2019)
(Non-)Discrimination based upon attributes	• Discrimination.	(Brandao et al., 2018; Meijer et al., 2020)
	• Discrimination: Discrimination based on specific client attributes like race, age, HIV/AIDS status, traditional beliefs and preferences, economic status, or educational background.	(Mihret, 2019)
Preferences and wishes	• Women not allowed to bring companion to the labor ward	(Mihret, 2019)
	• Were you not allowed a companion of your own choice during labor?(during childbirth?; and, c) after childbirth?)	(Souza et al., 2017)
	• A companion is allowed during labour and birth	(Montoya et al., 2020)
Bodily autonomy	• freedom of movement during childbirth; • freedom of movement during labor;	(Brandao et al., 2018)
Maternal/ parental rights	• Were you prevented from seeing, holding, or breastfeeding your baby for more than 5 hours for no reason or without being told of a reason for the delay?	(Castro & Frías, 2019)
	• Immediate attachment and permanence of skin-to-skin contact with the mother immediately after delivery	(Brandao et al., 2018)
Provision/denial of requested care	• Provider gives the woman all of the information she requests. • Provider addressed the woman's questions or concerns during labour.	(Montoya et al., 2020)
	• Were you ignored when you asked things about your delivery or about your baby? • Did they take a long time to assist you, saying that you were screaming or complaining a lot?	(Castro & Frías, 2019)
	• Did the health care professionals deny you pain relief; b) Did any health care professional deny assistance?	(Souza et al.,

		2017)
	• Did they refuse to anesthetize you or apply a pain blocker without providing any explanation?	(Castro & Frías, 2019)
Perception of violent birth experiences	• Perception of obstetric violence, including patient perception about their experience in relation to obstetric violence via the following questions, "Do you know what obstetric violence is?" and, "Do you think you have experienced obstetric violence?"	(Brandao et al., 2018)
(Postpartum) depression	• Edinburgh Postnatal Depression Scale (EPDS):	(Souza et al., 2017)

Table 11: Person-centered care (PCC)

Staffing capacity	• Do you think there was enough health staff in the facility to care for you?	(P. A. Afulani et al., 2018b)
Timely care	• How did you feel about the amount of time you waited? • Thinking about the labor and postnatal wards, did you feel the health facility was crowded?	(P. A. Afulani et al., 2018b)
Basis equipment	• Was there water in the facility? • Was there electricity in the facility?	(P. A. Afulani et al., 2018b)
Cleanliness and hygienic conditions of the facility	• Thinking about the wards, washrooms and the general environment of the health facility, will you say the facility was very clean, clean, dirty, or very dirty	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
Explanation of procedures or exams before proceeding	• Did the doctors and nurses explain to you why they were carrying out examinations or procedures? • Did the doctors and nurses explain to you why they were giving you any medicine?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
(Non-)Effective communication	• Did the doctors, nurses or other staff at the facility speak to you in a language you could understand?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
	• Noneffective communication	(Iida et al., 2012)
(Non-)Consented care	• Did the doctors, nurses or other staff at the facility ask your permission/consent before doing procedures on you?	(P. A. Afulani et al., 2018b)
(Non-)Respectful communication	• Did the doctors, nurses or other healthcare providers call you by your name? • During your time in the health facility did the doctors, nurses, or other health care providers introduce themselves to you when they first came to see you?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)

Verbal abuse	• Did you feel the doctors, nurses, or other health providers shouted at you, scolded, insulted, or talked to you rudely?	(P. A. Afulani et al., 2018b)
Emotional abuse	• Did you feel the doctors, nurses, or other health providers threatened (…) you)	(P. A. Afulani et al., 2018b)
(Non-)Respectful care	• Did the doctors, nurses or other staff at the facility treat you with respect? • Did the doctors, nurses or other staff at the facility treat you in a friendly manner?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
	• being respected	(Iida et al., 2012)
Physical abuse (force)	• Did you feel like you were treated roughly like pushed, beaten, slapped, pinched?	(P. A. Afulani et al., 2018b)
Physical abuse (restraint)	• Did you feel like you were (…) physically restrained, or gagged?	(P. A. Afulani et al., 2018b)
Visual privacy	• During examinations in the labor room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
Confidential handling of sensitive data	• Do you feel like your health information was or will be kept confidential at this facility?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
Encouragement, assistance and support	• Were you allowed to have someone you wanted (outside of staff at the facility, such as family or friends) to stay with you during labor? • Were you allowed to have someone you wanted to stay with you during delivery?	(P. A. Afulani et al., 2018b)
Pain management	• Do you feel the doctors or nurses did everything they could to help control your pain?	(P. A. Afulani et al., 2018b)
Involvement and empowerment	• Did you feel like the doctors, nurses or other staff at the facility involved you in decisions about your care?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
	• Help in decision-making	(Iida et al., 2012)
Engagement and empathy	• Did the doctors and nurses at the facility talk to you about how you were feeling? • When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention? • Did the doctors, nurses or other staff at the facility try to understand your anxieties? • Did the doctors and nurses at the facility talk to you about how you were feeling?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
(Non-)Discrimination based upon attributes	• During your hospital stay when you had your baby, how often were you treated poorly because of: • Your race, ethnicity, cultural background or language?	(L. Attanasio & Kozhimannil, 2015; L. B. Attanasio &

		Hardeman, 2019)
(Non-)Discrimination based upon disagreement	• A difference of opinion with your caregivers about the right care for yourself or your baby?	(L. Attanasio & Kozhimannil, 2015; L. B. Attanasio & Hardeman, 2019)
(Non-)Discrimination based upon financial or insurance status	• Your health insurance situation?	(L. Attanasio & Kozhimannil, 2015; L. B. Attanasio & Hardeman, 2019)
Agentry	(e.g.): • I felt incomplete and like I was going to pieces • Everything seemed wrong • Everything seemed unclear and unreal	(Iida et al., 2012)
Security, safety, trust, being seen	• Trusting the caregiver	(Iida et al., 2012)
	• Did you feel you could ask the doctors, nurses or other staff at the facility any questions you had? • Did you feel you could completely trust the doctors, nurses or other staff at the facility with regards to your care? • In general, did you feel safe in the health facility?	(Patience A. Afulani et al., 2019; P. A. Afulani et al., 2018b)
Maternal attachment	(e.g.: maternal attachment inventory): • I feel love for my baby • I think my baby is cute • Just seeing my baby makes me feel good • I feel warm and happy with my baby • I want to spend special time with my baby	(Iida et al., 2012)

Table 12: Maternal satisfaction (MS)

Availability of medical facilities	• Availability of medical facilities	(Mehata et al., 2017; Monazea & Al-Attar, 2015)
Accessibility to facility from home	• Access to hospital from residence	(Monazea & Al-Attar, 2015)
Staffing capacity	• Availability of staff in the delivery rooms • Availability of Staff in the wards	(Gitobu et al., 2018)
	• The number of doctors, midwives and nurses involved in my care was enough during my hospital stay.	(Gungor & Beji, 2012; Jha et al., 2017)

Continuity and choice of the care provider	• I had the same midwife throughout the entire process of labour and delivery.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
Timely care	• How satisfied were you about the waiting time?	(Mehata et al., 2017)
	• I was taken in the operating room for cesarean birth without delay at the scheduled time.	(Gungor & Beji, 2012; Jha et al., 2017)
	• Waiting time to be seen by health worker.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Service and information management	• We could easily find everything we needed in hospital	(Gungor & Beji, 2012; Jha et al., 2017)
Provision of safe medical care	• I could not get any better care in this hospital.	(Gungor & Beji, 2012; Jha et al., 2017)
	• Satisfaction with medical care during labor and birth • I got the best possible medical care during labor and birth	(Haines et al., 2013)
	• During labour I received outstanding medical care.. • My baby was avoidably hurt during birth. • The staff provided me with insufficient medical care during my birth.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• I would have liked the management of labor and delivery to have been done differently. • If the staff had been more capable during labor and delivery, I would have been happier with • the care received. • I felt that some mistakes were made in the care received from the staff during labor and delivery. • Sufficient attention was paid to the safety of mother and baby during labor and delivery. • I was very satisfied with the care we received during labor and delivery.	(Fair & Morrison, 2012)
	• Satisfaction with: The physical care you received from the nursing staff during labor and delivery, • Satisfaction with: The physical care you received from the medical staff during labor and delivery.	(Caballero et al., 2016)
	• Satisfaction with: • the way the nurses treated them. • the way the workers treated them. • The way the doctor treated them.	(Monazea & Al-Attar, 2015)
Competency of health professionals	• Satisfaction with: The technical knowledge, ability, and competence of the nursing staff in labor and delivery, • Satisfaction with: The technical knowledge, ability, and competence of the medical staff in labor and delivery.	(Caballero et al., 2016; Kabakian-Khasholian et al., 2017)
	• How satisfied are you with the level of skill the provider had to deliver your baby?	(Mehata et al., 2017)

	• Competency of care provider. • Health advices	(Monazea & Al-Attar, 2015)
Adherence to medical guidelines and evidence-based care practices	• I received a lot of medical intervention, i.e. induction, forceps, section, etc. • I had a natural labour, i.e. minimal medical intervention.	(Hollins Martin & Martin, 2014)
	• There were too many vaginal examinations. • They tried to deliver the placenta too quickly. • The appropriate amount of equipment was used to monitor the labor and delivery. • There was too much equipment used during labor and delivery. • Some unnecessary interventions were carried out on mother or baby during labor and delivery.	(Fair & Morrison, 2012)
	• I believe that doctors have done necessary medical interventions during childbirth	(Gungor & Beji, 2012; Jha et al., 2017)
Basis equipment	• Availability of beds	(Monazea & Al-Attar, 2015)
Availability of pain relief medication and comfort measures	• Availability of drugs and supplies	(Gitobu et al., 2018)
	• Supplies of basic drugs and equipment	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Cleanliness and hygienic conditions	• The delivery room was clean and hygienic.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• How satisfied are you with the cleanliness of the facility?	(Mehata et al., 2017)
	• Examination area cleanliness and comfort • Overall cleanness of the facility, • Accessibility and cleanness of toilets and/or shower,	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
	• Cleanliness in the health facilities	(Gitobu et al., 2018)
	• The room in which I stayed during labour was clean and adequate to meet my needs. • The room in which I gave birth was a comfortable and clean place. • The room in which I stayed after birth was comfortable and adequate to meet my needs. • The room in which I stayed after birth was suitable for the visits of my family and friends.	(Gungor & Beji, 2012; Jha et al., 2017)
	• cleanliness, sanitary facilities,	(Monazea & Al-Attar, 2015)
Comfortability	• I felt that the delivery room was unthreatening and comfortable	(Hollins Martin & Martin, 2014)
	• My birth room was a little impersonal and clinical.	(Gitobu et al.,

	• The area where I gave birth was very pleasant and relaxing.	2018)
	• Examination area cleanliness and comfort • Restfulness of the rooms of the facility	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
	• My family had a proper and comfortable place in the hospital to rest and wait during birth. • The food service was good at hospital.	(Gungor & Beji, 2012; Jha et al., 2017)
	• I felt that the delivery room was unthreatening and comfortable	(Gitobu et al., 2018)
General information on labor, birth, partum stage and newborn care	• I received information about the process of labour.	(Johansson & Hildingsson, 2013)
	• How satisfied are you with the information you received from the providers?	(Mehata et al., 2017)
	• I received information about the progress of labor.	(Haines et al., 2013)
	• Satisfaction with: The amount of explanation or information received from the nursing staff in labor and delivery. • Satisfaction with: The amount of explanation or information received from the medical staff in labor and delivery.	(Caballero et al., 2016; Kabakian-Khasholian et al., 2017)
	• Nurses spent enough time to give information about my own care after birth. • Nurses spent enough time to give information about the care of my baby.	(Gungor & Beji, 2012; Jha et al., 2017)
Information on individual proceeding and medical diagnosis	• Explanation about the treatment given. • Explanation about the drugs prescribed, • Explanation about the side effects of drugs,	(Bitew et al., 2015)
	• There were occasions when no one explained to me what was going on. • I was given all the information needed about progress in labor	(Fair & Morrison, 2012)
	• During labour, there was always a carer to explain things so that I could understand.	(Conesa Ferrer et al., 2016)
	• Doctors and nurses explained me every new situation occurred during birth. • Doctors and nurses explained my partner/family every new situation occurred during birth. • I was informed about all necessary procedures during my labour and childbirth. • My partner/family was informed about all necessary procedures during my labour and childbirth.	(Gungor & Beji, 2012; Jha et al., 2017)
Consistency of information	• The information received from different caregivers about self-care and baby care was consistent.	(Gungor & Beji, 2012; Jha et al., 2017)
Encouragement to ask questions	• Opportunity to discuss the birth afterward with the assisting midwife.	(Johansson & Hildingsson, 2013)
(Non-)Consented care	• My consent was asked before performing the procedures related with my care during birth. • Consent of my partner / family was asked before performing the procedures	(Gungor & Beji, 2012; Jha et al.,

	related with my care during birth when necessary.	2017)
(Non-)Respectful communication	• The staff communicated well with me during labour.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• Satisfaction with: Communication by the health care workers	(Gitobu et al., 2018)
(Non-)Respectful care	• All my carers treated me in the most friendly and courteous manner possible.	(Gitobu et al., 2018)
	• How satisfied are you with the politeness of the staff with whom you consulted?	(Mehata et al., 2017)
	• The doctors, midwives and nurses involved in my birth treated me/behaved well.	(Gungor & Beji, 2012; Jha et al., 2017)
	• Respect of social norms and values	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
	• The staff were sometimes rude to me during labor and delivery. • I would be feeling better now if the staff had been more considerate during labor and delivery. • Staff treated me as if this was just one more delivery.	(Fair & Morrison, 2012)
Presence and absence of health care professionals	• Midwife was present in the room as much as I wanted.	(Johansson & Hildingsson, 2013)
	• I saw the doctor as often as I wanted. • The nurse was with me as much as I wanted.	(Fair & Morrison, 2012)
	• Midwife present in room as much as I wanted during labor and birth.	(Haines et al., 2013)
	• How satisfied are you with: The amount of time the nurses spent with you during labor. • How satisfied are you with: The amount of time the doctors spent with you during labor.	(Caballero et al., 2016; Kabakian-Khasholian et al., 2017)
	• The nurses spent enough time to meet my needs during labour and delivery. • Midwives and nurses spent enough time help me to cope with pain during labour. • Nurses spent enough time to prepare me for cesarean birth. • The nurses spent enough time to meet my needs before cesarean birth.	(Gungor & Beji, 2012; Jha et al., 2017)
	• Satisfaction with consultation time.	(Gitobu et al., 2018)
Cooperation between health care professionals	• Communication between health care providers.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Situational privacy (e.g. intimate	• There were too many staff or students involved in the labor and delivery.	(Fair & Morrison, 2012)

moments)	• There were people coming in and out of my room unnecessarily during labor. • There were people coming in and out of my room unnecessarily after birth. • Health-care personnel showed respect to my privacy during their practices. • Special moments I lived with my family during and after birth were interrupted by medical staff because of routine interventions that could be delayed easily. • Special moments I lived with my family before and after cesarean birth were interrupted by medical staff because of routine interventions that could be delayed easily.	(Gungor & Beji, 2012; Jha et al., 2017)
	• Respect and assurance of privacy.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
	• Satisfaction with: Privacy maintained during care.	(Monazea & Al-Attar, 2015)
	• How satisfied are you with the level of privacy you received?	(Mehata et al., 2017)
Encouragement, assistance and support	• I felt well supported by staff during my labour and birth. • I was encouraged to hold my baby for a substantial amount of time after birth. • I was separated from my baby for a considerable period of time after my birth.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• I got to see my baby at exactly the right time after she/he was born. • After my baby was born, I was not given him/her quite as soon as I wanted. • I needed to hold my baby a little earlier than I did.	(Gitobu et al., 2018)
	• Satisfaction with: The amount of time which passed before you first held your baby. • Satisfaction with: The amount of time which passed before you first fed your baby.	(Caballero et al., 2016)
	• Delivery position of patient choice.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
	• Best possible help when I was breastfeeding the first time.	(Haines et al., 2013)
Pain management	• I should have been offered something more to relieve my labour pains. • I got excellent pain relief in labour. • More pain relief would have made my labour easier. • I should have been offered something more to relieve the pains I had after my baby was born.	(Gitobu et al., 2018)
	• I got the pain relief I wanted during labor and birth.	(Haines et al., 2013)
	• Some more things (medication, massage, etc.) could have been done for relieving my pain during labour. • Some more things could have been done to reduce my pain and discomfort after birth.	(Gungor & Beji, 2012; Jha et al., 2017)
	• Satisfaction with: The help and support with breathing and relaxation which you received from the nursing staff in labor and delivery. • Satisfaction with: The help and support with breathing and relaxation which you received from the medical staff in labor and delivery.	(Caballero et al., 2016; Kabakian-Khasholian et al., 2017)
Involvement and empowerment	• The delivery room staff encouraged me to make decisions about how I wanted my birth to progress.	(Hollins Martin & Martin, 2014; Vardavaki et al.,

		2015)
	• Midwife involved me in care. • I was involved in decision-making during labour and birth.	(Johansson & Hildingsson, 2013)
	• How satisfied are you regarding your involvement in decision making during the care at the facility?	(Mehata et al., 2017)
	• I was involved in decision making during labor and birth.	(Haines et al., 2013)
	• Involvement of patient in decision making.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Companion of choice	• The doctors, midwives and nurses involved in my birth treated my family well. • My family should have received more attention to reduce their stress during birth. • My family should have received more attention to reduce their stress before cesarean birth.	(Gungor & Beji, 2012; Jha et al., 2017)
	• The midwife I met most of the time involved my partner in the care.	(Haines et al., 2013)
(Non-)Discrimination based upon attributes	• Equal treatment of people	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Bodily autonomy	• There were unnecessary restrictions on mother walking around during labor. • The most comfortable position was used for the actual delivery.	(Fair & Morrison, 2012)
Provision/denial of requested care	• Responsiveness: The doctors and midwives & nurses took into account everything I said at birth.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Parental rights	• I got to see my baby at exactly the right time after she/he was born. • After my baby was born, I was not given him/her quite as soon as I wanted. • I needed to hold my baby a little earlier than I did.	(Gitobu et al., 2018)
	• I held the baby as soon as I wanted.	(Fair & Morrison, 2012)
	• I was separated from my baby for a considerable period of time after my birth.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• Satisfaction with: The amount of time which passed before you first held your baby • Satisfaction with: The amount of time which passed before you first fed your baby.	(Caballero et al., 2016)
Provision/denial of requested care	• Responsiveness: The doctors and midwives & nurses took into account everything I said at birth.	(Bitew et al., 2015; Monazea & Al-Attar, 2015)
Attitudes towards childbirth	(e.g.): I would like a birth that • is as natural as possible	(Haines et al., 2013)

	• is the safest option for my baby • is the least stressful option for my baby • is as pain free as possible.	
Expectations of control	(e.g.): • There is nothing I can do to make sure my child is born healthy. • I could make very few choices that would affect my child's health at birth.	(Fair & Morrison, 2012)
Conformity of childbirth expectations and experiences	• My birth experience was considerably different to what I intended. • My birth proceeded as I planned it. • I felt it was better not to know in advance about the processes of giving birth. • I was well prepared for my labour, i.e. read a lot of literature and/or attended parenthood education classes. • My birth experience was completely as I had expected and hoped.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• The labour was longer than I had expected. • I had not expected to have some of the medical interventions used at my birth. • This birth was one of the most beautiful experiences in my life. • The cesarean birth took longer than I had expected	(Gungor & Beji, 2012; Jha et al., 2017)
	• My labour went totally normally. • The labour went nearly exactly as I had hoped that it would. • The delivery went almost completely as I had hoped that it would. • My labour was just about the right length.	(Conesa Ferrer et al., 2016)
Internal control	• I felt in control of what happened during labor and delivery.	(Fair & Morrison, 2012)
	• I felt out of control during my birth experience.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
	• I was in control of my body during labor and birth	(Haines et al., 2013)
	• Someone or something else was in charge of my labor • I had a sense of not being in control • I behaved extremely badly – I did not behave badly at all. • I dared to totally surrender control to my body – I did not dare surrender control to my body at all. • I lost total control of myself – I did not lose control of myself at all. • I felt powerless.	(Jha et al., 2017)
Agentry	• I experienced a sense of conflict. • I felt incapable. • I felt incomplete and like I was going to pieces. • Everything seemed wrong. • Everything seemed unclear and unreal.	(Kabakian-Khasholian et al., 2017)
Anxiety, fear, security	• I felt fearful. • I experienced a sense of great anxiety. • Extremely afraid - not at all afraid. • I felt secure.	(Jha et al., 2017; Kabakian-Khasholian et al., 2017)
Stress	• I found giving birth a distressing experience. • I coped well during birth. • I had a swift and speedy labour. • I was not distressed at all during labour. • I thought my labour was excessively long. • I felt very anxious during my labour and birth. • I came through childbirth virtually unscathed. • I felt mutilated by my birth experience. • I gave birth to a healthy normal baby.	(Goncu Serhatlioglu et al., 2018; Hollins Martin & Martin, 2014)

Pain	• I was in a fair bit of pain immediately after the birth. • I didn't need a lot of pain relief after the birth.	(Conesa Ferrer et al., 2016; Mehata et al., 2017)
	• Labour was not as painful as I imagined. • Giving birth was incredibly painful.	(Hollins Martin & Martin, 2014; Vardavaki et al., 2015)
Satisfaction with self	• Satisfaction with: Your level of participation in decision-making during labor. • Satisfaction with: Your level of participating in decision-making during delivery. • Satisfaction with: Your ability to manage your labor contractions. • Satisfaction with: The control you had over your emotions during labor • Satisfaction with: The control you had over your emotions during delivery • Satisfaction with: The control you had over your actions during labor • Satisfaction with: The control you had over your actions during delivery	(Caballero et al., 2016; Kabakian-Khasholian et al., 2017)
	• How satisfied are you regarding your involvement in decision making during the care at the facility?	(Jha et al., 2017; Mehata et al., 2017)
	• I feel happy about this labor and delivery experience.	(Fair & Morrison, 2012)
External control	• Everyone seemed to tell me what to do in labour. • Labour was just a matter of doing what I was told by my carers.	(Gitobu et al., 2018)

Table 13: Respectful maternity care (RMC)

Timely care	• I was kept waiting for a long time before receiving service. • Service provision was delayed due to the health facilities internal problem.	(Wassihun & Zeleke, 2018b)
Equipment to protect privacy	• Delivery in rooms with auditory and visual privacy.	(Rosen et al., 2015)
General information on labor, birth, partum stage and newborn care	• Provider explains what will happen during labor to client.	(Rosen et al., 2015)
	• Did the staff explain what will happen during your labor and delivery? (Explain what will happen)	(Dynes et al., 2018)
	• RMC explains what will happen in labor to woman.	(Sheferaw et al., 2017)
Information on individual proceeding and medical diagnosis	• Informs client of findings.	(Rosen et al., 2015)
	• Did the staff inform you of the findings from procedures and exams? (Inform about findings from procedures/exams). • Did you feel the information given to you during your visit was too little, just about right, or too much? (Right amount of information).	(Dynes et al., 2018)
Explanation of procedures or exams	• Did the staff explain procedures or exams before proceeding? (Explain procedures/exam beforehand)	(Dynes et al., 2018)

before proceeding	• RMC explains each step of the examination to the woman.	(Sheferaw et al., 2017)
	• Explains procedures before proceeding.	(Rosen et al., 2015)
Encouragement to ask questions	• Asks client if she has any questions.	(Rosen et al., 2015)
	• RMC encourages the woman to ask questions	(Sheferaw et al., 2017)
	• Did the staff ask if you have questions? (Provider asked if any questions)	(Dynes et al., 2018)
Verbal abuse	• The health workers shouted at me because I haven't done what I was told to do.	(Wassihun & Zeleke, 2018b)
	• Verbal abuse.	(Sheferaw et al., 2017)
(Non-)Respectful care	• Greets client in a respectful manner. • Provider supports client in friendly way during labor.	(Rosen et al., 2015)
	• The HWs was talking positively about pain and relief. • All HWs treated me with respect as an individual. • The health provider called me by my name. • The HWs speak to me in a language that I can understand. • I felt that health workers cared for me with a kind approach. • The health workers treated me in a friendly manner.	(Wassihun & Zeleke, 2018b)
	• RMC receives and greets the pregnant woman.	(Sheferaw et al., 2017)
Physical abuse (force)	• The health provider slapped me during delivery for different reasons.	(Wassihun & Zeleke, 2018b)
	• Did any of the health facility staff ever physically abuse you during your visit? By physical abuse, we mean, did they hit, slap, push, kick you, or use any other type of physical force against you (Absence of physical abuse)	(Dynes et al., 2018)
	• Physical abuse	(Sheferaw et al., 2017)
Presence and absence of health care professionals	• Abandonment: or being left alone	(Sheferaw et al., 2017)
Visual privacy	• Provider drapes client before delivery.	(Rosen et al., 2015)
	• Privacy violated.	(Sheferaw et al., 2017)
Encouragement, assistance and	• Did the staff encourage you to have a support person with you throughout labor and delivery? (Provider encouraged companion)	(Dynes et al., 2018)

support	• Encourages client to have support person. • Provider encourages client to consume food and fluids during labor, • Provider encourages or assists client to ambulate and assume different labor positions	(Rosen et al., 2015)
	• RMC encourages woman to walk and change position. • RMC at least once ensures if she has taken light food. • RMC asks woman which position she would like to deliver. • RMC allows to give birth in the position she wants.	(Sheferaw et al., 2017)
Engagement and empathy	• The health worker responded to my needs whether or not I asked. • The health worker showed his/her concern and empathy.	(Wassihun & Zeleke, 2018b)
(Non-)Discrimination based upon attributes	• I was allowed to practice cultural rituals in the facility. • Some of the health workers do not treated me well because of some personal attribute. • Some HWs insulted me and my companions due to my personal attributes.	(Wassihun & Zeleke, 2018b)
Security, safety, trust, being seen	• Did you feel comfortable to ask questions during the visit? (Client comfortable asking questions) (micro-latent)	(Dynes et al., 2018)

Table 14: Other

Availability of medical services in facilities	• Were you able to choose your own place of delivery?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Continuity and choice of the care provider	• Were you able to choose your own health care provider? • How well was the continuity of care by one health care provider?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Timely care	• Timely care	(Alvares et al., 2018)
Service and information management	• Was information on the health service's contact, location and parking information clear to you?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Equipment to protect privacy	• Did the examination rooms ensure your privacy?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Cleanliness and hygienic conditions of facility	• How do you rate the quality of the hygiene of the toilets?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Comfortability and conditions of amenities	• Comfortable physical environment.	(Alvares et al., 2018)
	• How do you rate the overall quality of the surroundings, for example, space, seating, fresh air and cleanness?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Provision of safe medical care	• Ensuring that every aspect of her care is meant to do good to the patient.	(Iyoke et al., 2013)

	• Perceived quality of care received.	(Heatley et al., 2015)
Comprehensibility of written information	• Was written information provided in such a way you could understand?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Information on individual proceeding and medical diagnosis	• Not being talked to regarding what the doctor found out on your assessment each day of your visit.	(Iyoke et al., 2013)
Explanation of procedures or exams before proceeding	• Having investigation or treatment without having them explained to you.	(Iyoke et al., 2013)
Information on choices	• Communication about choices	(Heatley et al., 2015)
Encouragement to ask questions	• I was given time to ask questions	(İsbİr et al., 2016)
	• Were you encouraged to ask questions about your health problems, treatment and care? • Were you given time to ask questions about your health problem or treatment?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
(Non-)Effective communication	• Client-centered communication	(Heatley et al., 2015)
	• How well were things explained by your health care provider in a way you could understand?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
(Non-)Consented care	• Having investigation and treatment without asking for your opinion about them.	(Iyoke et al., 2013)
	• Before your caesarean, did your doctor ask for your permission? • Before your induction, did your provider ask your permission? • Before your episiotomy did you doctor ask for your permission?	(Szebik et al., 2018)
	• Were you able to refuse examinations or treatments? (interactional?) • Were you asked permission before testing or starting treatment?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Verbal abuse	• Verbal abuse from your doctor	(Iyoke et al., 2013)
(Non-)Respectful care	• How do you rate the importance of respectful and dignified handling by doctors during your care in this pregnancy and delivery? • Consideration and respect for the religious beliefs of the patient. • Being examined alone by a doctor without the presence of a chaperone.	(Iyoke et al., 2013)
	• Were you treated with respect by your health care provider?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
	• Dignified care (No items available)	(Alvares et al., 2018)

Sexual abuse	• Demand for romantic or sexual relationship from your doctor • Being touched inappropriately by your doctor.	(Iyoke et al., 2013)
Situational privacy/ intimacy	• Being attended to in the presence of too many people without respect for your privacy.	(Iyoke et al., 2013)
	• Were physical examinations and treatments done in a way that respected your privacy?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
(Non-) Confidentiality of health and personal information	• Respect for your privacy including the confidentiality of your case records.	(Iyoke et al., 2013)
	• Was confidentiality kept on the information provided by you? • Was your medical record kept confidential? • Were consultations carried out in a manner that protected your confidentiality?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Encouragement, assistance and support	• Immediate clamping of the umbilical cord • Skin-to-skin contact • Incentive to breastfeeding • Use of non-invasive health technologies • Conditions that allow the contact between mother and child	(Alvares et al., 2018)
	• The staff helped me to try different positions.	(İsbİr et al., 2016)
Pain management	• The staff encouraged me to try new ways of coping (such as breathing) • The staff encouraged me not to fight against what my body was doing • The staff realized the pain I was in	(İsbİr et al., 2016)
Involvement and empowerment	• Asking for and respecting the opinion of the patient in every decision regarding her investigation and treatment • Your personal contribution to decisions on your investigations and treatments.	(Iyoke et al., 2013)
	• Participation in decision-making	(Heatley et al., 2015)
	• How well were you involved in making decisions regarding your examinations or treatments?	(van der Kooy et al., 2017; van der Kooy et al., 2014)
(Non-)Discrimination based upon attributes	• When I had my baby I felt that I was treated poorly by my (midwife, doctor): • Because of my race, ethnicity, cultural background or language. • Because of my sexual orientation and/or gender identity. • Because of my health insurance.	(S. Vedam et al., 2017)
(Non-)Discrimination based upon financial or insurance status	• Being attended to on “first come, first seen” basis. • Consideration of the ability of the patient to pay in choosing investigations and treatment.	(Iyoke et al., 2013)
	• Because of my health insurance.	(S. Vedam et al., 2017)
(Non-)Discrimination based upon disagreement	• When I had my baby I felt that I was treated poorly by my (midwife, doctor): • Because of a difference in opinion with my caregivers about the right care for myself or my baby.	(S. Vedam et al., 2017)
Bodily autonomy	• Was the birth position freely chosen by you?	(Szebik et al., 2018)
Provision/denial of	• How well did you receive prompt attention at your health service?	(van der Kooy et

requested care	• How did you experience the waiting time after you asked for help?	al., 2017; van der Kooy et al., 2014)
	• The staff stopped doing something if I asked them to stop.	(van der Kooy et al., 2017; van der Kooy et al., 2014)
Bribes	• Demand for monetary reward from your doctor before being treated or after treatment	(Iyoke et al., 2013)
Internal control	• (e.g.): • Extremely fearful • The pain was too great for me to gain control over it. • I was mentally calm • I was in control of my emotions.	(Colley et al., 2018; İsbir et al., 2016)
Pain	• (e.g.): • I was overcome by the pain • Extreme pain - no pain at all	(Colley et al., 2018; İsbir et al., 2016)
Anxiety, fear	• (e.g.) • Negative feelings overwhelmed me • Had you, during the labour and delivery, fantasies like for example: fantasies that your child will die during labour/ delivery? • Had you, during the labour and delivery, fantasies like for example: fantasies that your child will be injured during labour/delivery?	(Colley et al., 2018; İsbir et al., 2016)
External control	• (e.g.): • I had control over when procedures happened. • I could influence which procedures were carried out. • I decided whether procedures were carried out or not. • The people in the room took control. • I could get up and move around as much as I wanted. • People coming in and out of the room was beyond my control. • I felt I had control over the way my baby was finally born	(Colley et al., 2018; İsbir et al., 2016)
Trust, security	• (e.g.): • extreme trust - no trust at all	(Colley et al., 2018; İsbir et al., 2016)
Post-traumatic stress	e.g., Impact of event scale: • Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart • I tried not to talk about it.	(İsbir et al., 2016)

Notes

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