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REVIEW

Respectful maternity care in low- and middle-income countries: a narrative review of evidence, implementation challenges, and future directions

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Respectful maternity care (RMC) is increasingly recognized as a fundamental component of quality maternal healthcare and a basic human right. Despite global efforts to maximize facility-based deliveries, widespread institutional mistreatment, abuse, and neglect continue to compromise maternal safety and undermine public trust in healthcare systems. This narrative review offers a timely, comprehensive synthesis of evidence from low- and middle-income countries (LMICs) between 2015 and 2026. It provides a critical assessment of the multi-level architecture shaping RMC by mapping how individual provider behaviors, facility infrastructure, systemic health policies, and deep-seated socio-cultural norms intersect to influence childbirth experiences. **Methods:** A narrative review framework was utilized to evaluate peer-reviewed articles, international agency reports, and national policy documents published from 2015 to 2026. A structured, four-stage screening process was deployed to select and map core clinical and structural literature regarding RMC implementation, barriers, facilitators, and outcomes across diverse LMIC settings. **Results:** The evidence synthesis was organized into four main areas: defining the dimensions of RMC; examining the consequences of mistreatment; identifying structural and system-level barriers; and describing facilitators of respectful care. Respectful maternity care was associated with greater maternal satisfaction, trust, and utilization of facility-based maternity services; however, implementation was constrained by workforce shortages, professional burnout, inadequate infrastructure, and weak accountability mechanisms. The review also proposes an actionable framework that links interconnected barriers, including facility-level overcrowding and socio-cultural power imbalances, with context-specific, multilevel intervention strategies. This framework provides a practical approach for translating human-rights principles into everyday maternity-care practice. **Conclusion:** Respectful maternity care is a critical component of quality maternal healthcare and a fundamental human-rights concern. Sustainable improvement requires context-sensitive, multilevel strategies that address provider behavior, facility conditions, health-system constraints, community engagement, and accountability. This review provides a synthesis of evidence that may inform clinicians, policymakers, researchers, and other stakeholders seeking to strengthen respectful maternity care across diverse LMIC settings. The proposed actionable framework may support context-specific implementation planning, although further research is needed to evaluate and refine its feasibility and validity.

Keywords Respectful maternity care, Childbirth, Maternal health, Quality of care, Mistreatment, Women's rights

Maternal health services are essential for reducing maternal and neonatal morbidity and mortality¹. Over the past two decades, governments, international organizations, and healthcare systems have invested substantial resources to improve access to maternal healthcare services². These efforts have contributed to significant increases in facility-based deliveries and skilled birth attendance³. However, access alone is insufficient to achieve

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optimal maternal health outcomes. The quality of care received by women during pregnancy and childbirth is also crucial to achieving positive maternal and newborn health outcomes⁴.

Respectful Maternity Care refers to care that maintains the dignity, privacy, confidentiality, and autonomy of women while ensuring freedom from discrimination, neglect, coercion, and abuse⁵. It is grounded in universal human rights principles and recognizes every woman's right to receive compassionate and respectful healthcare during childbirth^{6,7}. The concept gained global attention following reports documenting widespread mistreatment of women during labor and delivery in both developing and developed countries⁸.

The growing recognition of RMC reflects a broader shift in healthcare from provider-centered approaches toward patient-centered care⁹. Childbirth is not only a clinical event but also a significant emotional and social experience¹⁰. Therefore, healthcare providers have a responsibility to ensure that women receive care that is both clinically effective and respectful of their individual needs and preferences¹¹.

Respectful Maternity Care is fundamental to achieving high-quality maternal healthcare¹². Women who experience respectful treatment during childbirth are more likely to trust healthcare providers, adhere to medical recommendations, and seek healthcare services in future pregnancies¹³. Positive childbirth experiences also contribute to improved psychological well-being and satisfaction with healthcare services¹⁴.

Conversely, experiences of disrespect and abuse can have profound consequences. Women who encounter verbal abuse, neglect, discrimination, non-consented procedures, or breaches of confidentiality may develop fear and mistrust of health facilities. Such experiences may discourage them from seeking skilled care during subsequent pregnancies, thereby increasing the risk of adverse maternal and neonatal outcomes^{15–17}.

Research from various countries has demonstrated that disrespectful maternity care remains a significant challenge. Common forms of mistreatment include physical abuse, verbal humiliation, discrimination based on socioeconomic status or ethnicity, denial of companionship during labor, lack of informed consent, and neglect during childbirth. These practices violate women's rights and undermine efforts to improve maternal health outcomes^{18–20}.

This narrative review aims to synthesize existing evidence regarding respectful maternity care, identify barriers and facilitators affecting implementation, and discuss strategies for strengthening respectful care within maternal healthcare systems.

Methods

Review design

A narrative review methodology was used to provide a comprehensive overview of current evidence related to respectful maternity care.

Review timeframe

The literature search and review process were conducted over a two-month period, from February 2026 to March 2026. Articles published between 2015 and 2026 were included to capture recent developments and implementation experiences related to respectful maternity care.

Literature search strategy

Relevant literature was identified through a structured search of electronic databases including PubMed, Scopus, Web of Science, Google Scholar, and institutional reports from international organizations. Search terms were developed using combinations of keywords and Boolean operators such as:

("Respectful Maternity Care" OR "Respectful Childbirth" OR "Maternal Respect") AND ("Implementation" OR "Barriers" OR "Facilitators" OR "Maternal Health" OR "Low- and Middle-Income Countries").

Study selection procedure

Studies were selected through a structured four-stage screening process to ensure transparency and relevance. Initially, titles and abstracts were reviewed, followed by full-text assessment of potentially eligible studies based on predefined criteria. Studies focusing on respectful maternity care (RMC) implementation, experiences, barriers, facilitators, or policy implications were included. Eligible sources comprised peer-reviewed articles, institutional reports, and quantitative, qualitative, mixed-methods, and review studies published in English. Editorials, opinion papers, conference abstracts lacking methodological detail, unrelated studies, and duplicate publications were excluded. This systematic screening approach enhanced the rigor and reproducibility of the review findings. (Fig. 1)

Data extraction approach

Relevant information was extracted manually using a standardized extraction matrix. Information collected included the author, publication year, country, study design, sample characteristics, and principal findings related to the implementation of respectful maternity care.

Theme generation and evidence synthesis

Extracted findings were synthesized narratively using a thematic approach. Findings from included studies were systematically grouped into recurring categories, including the current status of respectful maternity care implementation, key barriers to effective implementation, facilitators and enabling factors, and implications for maternal health policy and clinical practice. The development of themes was an iterative process, involving repeated comparison and refinement of findings across studies to identify consistent patterns as well as areas of variation across different settings.

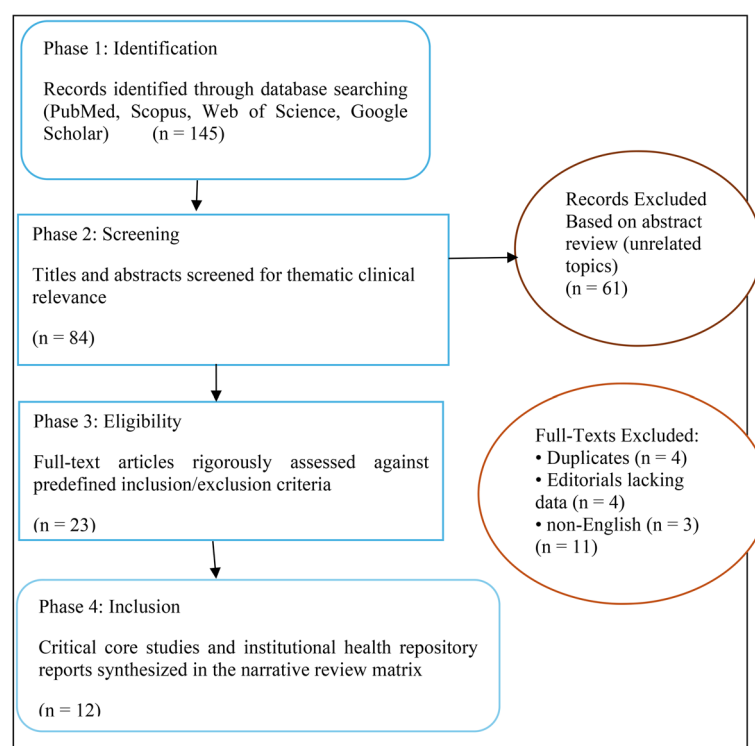


Fig. 1. Flowchart of the literature mapping and study selection framework for Respectful Maternity Care (RMC) in LMICs.⁶

Quality consideration

As this study employed a narrative review design, no formal risk-of-bias tool or quantitative quality score was applied. Nevertheless, evidence quality was considered during synthesis by examining study design, setting, outcome definitions, measurement approaches, and consistency of findings. The evidence was heterogeneous, comprising qualitative, cross-sectional, mixed-methods, review, and intervention studies conducted in different health-system and cultural contexts. Much of the primary evidence was observational or qualitative, limiting causal inference. Intervention studies were generally small or used before–after or other non-randomized designs, and outcomes were often based on women’s self-report. Accordingly, findings are interpreted primarily as recurring patterns and associations rather than as uniformly causal effects. WHO guidance similarly notes that evidence on RMC interventions remains limited and heterogeneous²¹.

Results

The included studies, conducted across diverse low- and middle-income countries, examined the experiences, determinants, barriers, facilitators, and outcomes of respectful maternity care (RMC). Across the reviewed evidence, recurring concerns included disrespect and abuse, inadequate communication, limited privacy, staffing shortages, and health-system constraints. Respectful care was also consistently associated with greater maternal satisfaction, trust in healthcare services, and utilization of facility-based childbirth, although differences in study designs and outcome measures limit direct comparison across settings. (Table 1)

Concept and dimensions of respectful maternity care

Respectful maternity care encompasses multiple dimensions of healthcare quality. The White Ribbon Alliance framework identifies key rights including freedom from harm, informed consent, privacy, confidentiality, dignity, equality, and continuous support during childbirth¹⁵. RMC extends beyond the absence of abuse. It requires active promotion of positive interactions between healthcare providers and women. Components include effective communication, emotional support, shared decision-making, cultural sensitivity, and compassionate care²². Patient-centered maternity care aligns closely with RMC principles. Both approaches recognize women as active participants in their healthcare and emphasize individualized care based on women’s preferences and values²³.

Prevalence and consequences of mistreatment during childbirth

Evidence from multiple LMIC settings indicates that mistreatment during childbirth remains a persistent concern. Studies have documented verbal and physical abuse, neglect, discrimination, and breaches of confidentiality across diverse healthcare settings. Mistreatment has been associated with dissatisfaction, psychological distress, reduced trust in healthcare providers, and reluctance to use maternal health services in the future²⁴. Mistreatment has substantial consequences. Women who experience disrespectful care often

Author (Year)	Country	Study Design	Sample	Key Findings
Bohren et al. (2015)	Multi-country	Systematic Review	Multiple studies	Identified physical abuse, verbal abuse, stigma, discrimination, and poor provider communication as common forms of mistreatment during childbirth.
Rosen et al. (2018)	Kenya	Mixed-methods	Women and providers	Health system limitations constrained implementation of respectful maternity care despite positive provider attitudes.
Sando et al. (2016)	Tanzania	Cross-sectional	Postpartum women	Approximately one-fifth of women experienced disrespectful and abusive care during childbirth.
Sharma et al. (2019)	India	Cross-sectional	Facility-based mothers	High prevalence of non-consented care, poor privacy, and inadequate communication.
Afulani et al. (2020)	Kenya	Quantitative	Facility users	Higher provider communication and dignity scores improved maternal satisfaction.
Kumbani et al. (2017)	Malawi	Cross-sectional	Women receiving maternity care	Limited patient-centered maternity care and restricted birth companionship.
Wassihun et al. (2018)	Ethiopia	Cross-sectional	Facility births	Respectful maternity care implementation remained suboptimal with gaps in dignity and informed consent.
Siraneh et al. (2019)	Ethiopia	Institutional-based cross-sectional	Postpartum women	High prevalence of disrespect and abuse during childbirth services.
Dzomeku et al. (2020)	Ghana	Qualitative	Midwives	Workload, infrastructure limitations, and privacy concerns affected RMC implementation.
Adejumo et al. (2021)	Nigeria	Qualitative	Midwives	Staff shortages and poor organizational support reduced providers' ability to deliver RMC.
Liu et al. (2021)	China	Qualitative	Midwives	Positive childbirth experiences improved through respectful communication and antenatal preparation.
Bradley et al. (2016)	Multi-country LMIC	Literature Review	Multiple studies	Respectful care improved trust, utilization of facility delivery, and maternal satisfaction.

Table 1. Characteristics and Key Findings of Included Studies on Respectful Maternity Care Implementation in Low- and Middle-Income Countries.

report dissatisfaction, psychological distress, and reduced trust in healthcare providers. Negative childbirth experiences may discourage future utilization of maternal health services and contribute to delays in seeking care^{8,9,25–29}. Research has also linked respectful care with improved satisfaction, increased facility delivery rates, and enhanced patient-provider relationships. Consequently, RMC has become a central strategy for improving maternal healthcare quality globally²⁸.

Barriers to respectful maternity care implementation

Despite increasing global recognition of respectful maternity care (RMC) as an essential component of quality maternal health services, implementation remains inconsistent across many healthcare settings. Evidence from low-, middle-, and high-income countries suggests that multiple interconnected barriers at the individual, facility, health system, and societal levels hinder the provision of respectful and woman-centered maternity care. Understanding these barriers is critical for designing effective interventions and promoting sustainable improvements in maternal healthcare quality^{9,28,30}.

Individual-level factors

Healthcare providers play a central role in the delivery of respectful maternity care. Their attitudes, knowledge, communication skills, and professional behaviors directly influence women's experiences during pregnancy and childbirth. Studies have shown that providers who have limited awareness of patient rights or inadequate training in respectful care principles may unintentionally engage in behaviors perceived as disrespectful or neglectful^{31–34}.

Communication challenges are particularly important barriers. Effective communication fosters trust, informed decision-making, and emotional support. However, providers often receive extensive training in clinical management while receiving limited instruction on interpersonal communication, empathy, and patient-centered care. Consequently, interactions between providers and women may become task-oriented rather than supportive and respectful³⁵.

Provider burnout and emotional exhaustion can further compromise respectful care practices. Repeated exposure to stressful clinical environments, high patient volumes, and limited institutional support may reduce providers' capacity to maintain compassionate interactions. In some settings, disrespectful behaviors may become normalized within workplace culture, making them difficult to recognize and address³⁶.

Facility-level factors

The healthcare facility environment significantly influences the quality and experience of maternity care. In resource-constrained settings, overcrowding, inadequate infrastructure, and shortages of essential supplies and equipment can hinder respectful care. High patient loads may limit providers' time for effective communication, emotional support, and privacy, while increasing delays and provider stress³⁷. Lack of private examination rooms, sufficient bed capacity, curtains, or partitions may compromise women's dignity and confidentiality³⁸. Shortages of essential supplies, medications, and equipment can also increase provider frustration and make it difficult to meet patients' needs, potentially affecting patient-provider relationships and overall care experiences³⁹.

Health system factors

At the broader health system level, workforce shortages remain a major barrier to respectful maternity care implementation. Insufficient numbers of skilled maternity care providers relative to patient demand can result in excessive workloads, extended working hours, and occupational stress⁴⁰. Heavy workloads may limit opportunities for individualized care and meaningful communication, leading providers to prioritize urgent clinical tasks while unintentionally neglecting women's emotional and psychosocial needs. Consequently, women may perceive their care as neglectful, abandoned, or disrespectful³⁶.

Provider burnout, driven by persistent stress, inadequate remuneration, limited professional development, and poor working conditions, may further affect provider attitudes and behaviors toward patients. Weak accountability systems also impede implementation, particularly where monitoring mechanisms and safe, accessible channels for reporting mistreatment are poorly developed. Without effective accountability structures, disrespectful practices may persist and become embedded within institutional culture²⁶.

Policy gaps represent another important challenge. In some settings, RMC principles are not fully integrated into national maternal health guidelines, quality improvement initiatives, or healthcare provider training curricula, potentially limiting institutional commitment and resource allocation for respectful care interventions²⁹.

Socio-cultural factors

Respectful maternity care is influenced not only by healthcare systems but also by broader social and cultural contexts. Gender norms, social hierarchies, and cultural beliefs shape expectations regarding childbirth and interactions between women and healthcare providers. Power imbalances between providers and patients may discourage women from expressing concerns, asking questions, or participating in decision-making processes^{19,41}. In some contexts, healthcare providers are viewed as authority figures whose decisions should not be questioned, potentially limiting opportunities for shared decision-making and informed consent.

Social inequalities can also contribute to discriminatory treatment during childbirth. Evidence suggests that women from marginalized groups, including those with lower socioeconomic status, limited education, rural residence, adolescent mothers, and ethnic minorities, may face greater risks of disrespect and abuse within healthcare facilities⁴².

Cultural misunderstandings between healthcare providers and patients may further affect care experiences. Failure to recognize and respect cultural preferences, beliefs, and practices related to childbirth can create tensions and reduce patient satisfaction. Therefore, culturally sensitive care is an important component of respectful maternity care implementation³⁵.

Facilitators of respectful maternity care

Although substantial barriers exist, numerous studies have identified factors that facilitate successful implementation of respectful maternity care. These facilitators operate at multiple levels and can contribute to sustainable improvements in maternal healthcare quality.

Provider training and capacity building

Education and training are important strategies for promoting respectful maternity care. Training programs that emphasize communication skills, ethical practice, human-rights principles, and patient-centered care may improve provider knowledge, attitudes, and behaviors when supported by appropriate organizational and health-system conditions¹⁷.

Capacity-building initiatives help healthcare providers understand the importance of dignity, privacy, informed consent, and emotional support during childbirth. Simulation-based learning, mentorship programs, and continuous professional development opportunities can reinforce respectful care competencies and improve provider confidence in delivering woman-centered services⁴³. Furthermore, integrating respectful maternity care concepts into pre-service education ensures that future healthcare professionals enter the workforce with a strong foundation in compassionate and respectful care practices.

Supportive leadership and organizational culture

Leadership plays a crucial role in shaping workplace culture and promoting respectful maternity care. Healthcare facilities with strong leadership commitment are more likely to establish policies, standards, and accountability mechanisms that prioritize respectful care. Supportive leaders can foster positive work environments by recognizing staff contributions, encouraging teamwork, and addressing workplace challenges. Such environments promote provider motivation and professional satisfaction, which are associated with improved patient interactions^{44,45}. Institutional commitment to respectful care also helps establish clear expectations regarding professional conduct. When respectful maternity care becomes an organizational priority, healthcare providers are more likely to adopt and maintain respectful behaviors²⁰.

Community engagement and women's empowerment

Community involvement is another important facilitator of respectful maternity care implementation. Women who are informed about their rights during pregnancy and childbirth are better positioned to advocate for respectful treatment and participate actively in healthcare decisions. Community awareness programs can increase understanding of respectful maternity care principles and encourage demand for quality services. Engagement of community leaders, women's groups, and civil society organizations can further strengthen accountability and support health system improvements. Empowering women through education and participation contributes to greater autonomy and shared decision-making during maternity care. Women who

feel empowered are more likely to communicate their preferences, seek clarification when needed, and report concerns regarding their care experiences^{23,46,47}.

Quality improvement initiatives

Quality improvement initiatives can strengthen RMC through routine monitoring, supportive supervision, clinical audits, patient feedback, and complaint mechanisms. These approaches help identify service gaps, incorporate women's experiences into quality improvement, and reinforce respectful provider practices. Evidence suggests that comprehensive programs combining provider training, leadership commitment, adequate infrastructure, monitoring, and accountability are more likely to achieve sustainable improvements in RMC and maternal health outcomes^{28,44,48}.

Overall, successful implementation of respectful maternity care requires coordinated efforts at individual, facility, health system, and community levels. Addressing barriers while strengthening facilitators can help ensure that all women receive dignified, compassionate, and high-quality care throughout pregnancy and childbirth.

Strategies and interventions for strengthening respectful maternity care

Strategies to strengthen respectful maternity care should be matched to the level and mechanism of the identified problem rather than implemented as isolated training activities. Evidence and WHO guidance support complementary interventions, including provider training in communication, values, ethics, and human rights; supportive supervision and mentorship; facility-based quality-improvement teams; routine monitoring of mistreatment and women's experiences; complaint and dispute-resolution mechanisms; privacy improvements such as curtains or partitions; birth companionship; and community education that enables women to understand and exercise their rights^{21,49}.

Evidence from Ethiopia suggests that combining provider training with facility standards assessments, supportive visits, action plans, and locally appropriate educational materials can reduce reported mistreatment. District-level quality-improvement approaches incorporating coaching, testimonial materials, privacy measures, and birth-companionship strategies have also shown potential to improve RMC, although effects vary across settings^{27,34}. Overall, sustainable improvement requires coordinated interventions addressing provider-, facility-, health-system-, and community-level determinants rather than reliance on a single intervention.

Future intervention research should use clearly defined and context-sensitive RMC outcomes and report both implementation processes and clinical or experiential outcomes. Studies should incorporate women's experiences alongside provider and facility measures and examine whether improvements are sustained beyond the intervention period. At the policy level, RMC indicators can be integrated into routine quality-improvement and accountability systems while simultaneously addressing staffing, infrastructure, provider well-being, and safe mechanisms for reporting mistreatment. The WHO compendium provides practical guidance for program managers and stakeholders seeking to design, implement, and monitor respectful maternal and newborn care across health-system levels²¹.

Discussion

Principal findings

This narrative review demonstrates that respectful maternity care is a multidimensional quality-of-care and human-rights issue shaped by interacting individual, interpersonal, facility, health-system, and socio-cultural factors. Across the reviewed literature, recurring concerns included verbal and physical abuse, inadequate communication, limited privacy, lack of informed consent, discrimination, insufficient emotional support, staffing shortages, infrastructure constraints, and weak accountability mechanisms.

These findings suggest that mistreatment cannot be adequately understood as a consequence of individual provider behavior alone. Provider practices are influenced by workload, organizational culture, leadership, facility resources, health-system capacity, and broader social norms. Consequently, strengthening RMC requires coordinated action across multiple levels rather than reliance on isolated behavioral interventions.

Evidence quality and heterogeneity

The evidence base was heterogeneous in study design, setting, population, RMC definitions, and outcome measures, which limits direct comparison across studies. Much of the available evidence was derived from cross-sectional, qualitative, and observational studies, limiting conclusions about causal relationships. Intervention studies were fewer and commonly used small samples or non-randomized designs, while several outcomes relied on self-reported experiences. These differences may also contribute to variation in reported RMC experiences and intervention effects across countries and health-system contexts. Therefore, the findings should be interpreted as consistent patterns and associations rather than definitive estimates of prevalence or intervention effectiveness. Further research using standardized RMC definitions and validated outcome measures, together with well-designed longitudinal and intervention studies, is needed to strengthen the evidence base and improve comparability across settings^{14,21}.

Sociocultural context and power

Sociocultural conditions shape both women's experiences of maternity care and the feasibility of interventions. Provider-patient interactions may be influenced by differences in authority, knowledge, education, and decision-making power, which can affect women's ability to ask questions, participate in decisions, or report mistreatment²¹. In some settings, providers may be regarded as authority figures whose decisions are not readily questioned, potentially limiting shared decision-making and informed consent. Social inequalities may also increase vulnerability to disrespectful treatment among women from marginalized or disadvantaged groups⁴⁹. Norms and expectations may differ across settings regarding family participation, birth companionship,

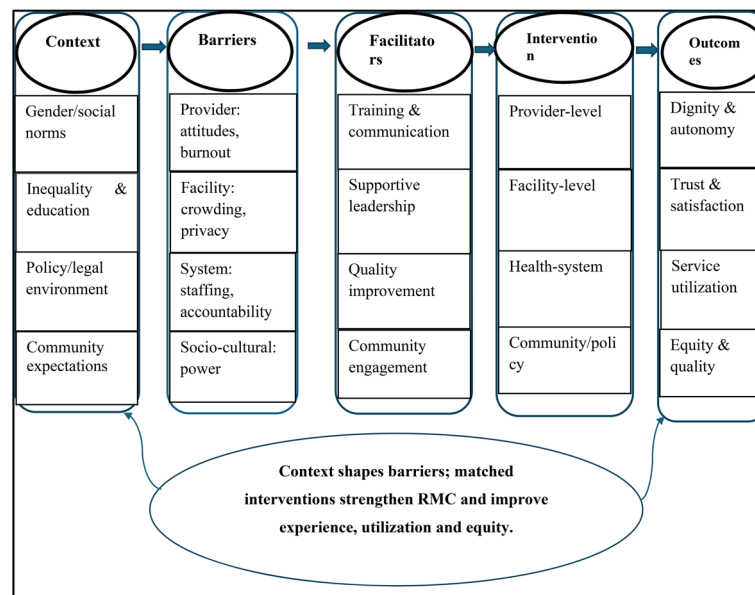


Fig. 2. Actionable Diagnostic Framework for Respectful Maternity Care Implementation.

privacy, communication, pain expression, and acceptable provider behavior. Consequently, culturally sensitive RMC requires local assessment of social norms and power relations, meaningful engagement of women and community representatives, and adaptation of interventions while maintaining core principles of dignity, non-discrimination, privacy, and informed consent^{21,49}.

Actionable diagnostic framework

The Actionable Diagnostic Framework is a proposed organizing model for translating respectful maternity care (RMC) principles into context-specific implementation decisions. It involves five linked steps: identifying the RMC problem, locating its dominant level (provider/interpersonal, facility, health-system, or socio-cultural), identifying the underlying mechanisms, selecting a response matched to the identified problem and level, and monitoring implementation and outcomes.

The framework emphasizes that interventions should be guided by local assessment and stakeholder engagement rather than by applying uniform solutions across settings. It is intended as a conceptual framework to support implementation decision-making rather than as a validated diagnostic or implementation instrument. Further research is needed to evaluate its feasibility, validity, and practical utility across different low- and middle-income country contexts (Fig. 2).

Implications for implementation

The reviewed evidence suggests that RMC interventions may be more sustainable when embedded within broader health-system and quality-improvement strategies. Provider training should therefore be accompanied, where appropriate, by supportive supervision, leadership engagement, adequate staffing, improvements in privacy and infrastructure, routine monitoring, and mechanisms for women's feedback and complaints. Implementation should be context-sensitive and should prioritize locally identified barriers rather than assuming that a standardized intervention will produce equivalent effects across different settings^{49,45}.

Community engagement is also important for strengthening accountability and women's participation in maternity-care decisions. However, community and empowerment interventions should complement rather than replace health-system responsibilities for ensuring respectful, safe, and rights-based care. Sustainable implementation requires alignment between provider behavior, facility conditions, health-system policies, and community expectations^{3,23}.

Geographic and contextual limitations

The evidence reviewed was geographically uneven, with greater representation from African and Asian settings than from other low- and middle-income regions. Several LMIC regions remain underrepresented, limiting the breadth of cross-country comparison. Differences in health-system organization, resource availability, staffing, governance, and maternity-care practices may also influence how respectful maternity care is implemented across settings. Cultural norms, gender and power relations, and expectations surrounding childbirth further vary between communities and may shape both experiences of care and intervention effectiveness^{17,27,34}. Therefore, findings and implementation approaches should be interpreted within their local contexts, and their transferability to underrepresented LMIC settings may be limited. Further research from diverse regions and health-system contexts is needed to strengthen the generalizability of the evidence.

Strengths and limitations of the review

A major strength of this review is its multilevel synthesis, linking interpersonal experiences of respectful maternity care with facility-, health-system-, and socio-cultural determinants, while also incorporating intervention and implementation evidence.

Nevertheless, several limitations should be considered. As a narrative review, the study did not involve a formal risk-of-bias assessment or meta-analysis, and the search and study-selection processes may have limited reproducibility and introduced selection bias inherent to narrative approaches. The restriction to English-language publications may have excluded relevant evidence published in other languages. Heterogeneity in study designs, settings, RMC definitions, outcome measures, and methodological quality limits direct comparison and causal interpretation. Publication bias and database-coverage bias may also be present. Therefore, the findings should be interpreted as a thematic synthesis of recurring evidence and implementation patterns rather than as a comprehensive estimate of the global burden or effectiveness of RMC interventions.

Implications for research and policy

Future research should use standardized RMC definitions and validated measures, include women's experiences alongside provider and facility indicators, and prioritize longitudinal and well-designed intervention studies. Research should also expand to underrepresented LMIC regions and examine how contextual and sociocultural factors influence intervention effectiveness. Policymakers should integrate RMC indicators into routine quality-improvement and accountability systems.

Conclusion

Respectful maternity care is a critical component of quality maternal healthcare and a fundamental human-rights concern. Evidence across LMICs demonstrates persistent challenges involving mistreatment, communication, privacy, autonomy, staffing, infrastructure, accountability, and socio-cultural power relations. These challenges are interconnected and are unlikely to be addressed through provider training alone. Sustainable improvement requires context-sensitive, multilevel strategies that combine provider development with supportive leadership, facility improvements, health-system strengthening, community engagement, and accountability mechanisms.

The proposed Actionable Diagnostic Framework provides a conceptual approach for linking identified RMC problems with context-appropriate interventions and monitoring. However, the framework has not yet been empirically validated and should therefore be considered a proposed organizing model. Further research is needed to assess its feasibility, validity, and applicability across diverse LMIC settings.

Data availability

No datasets were generated or analysed during the current study.

Code availability

No custom code, computational tool, algorithm, or software pipeline was developed or used in this narrative review. Therefore, code availability is not applicable.

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Author contributions

Beka Furi Keno (Lead Author) conceived the review, developed the conceptual framework and methodology, conducted the literature search, synthesized and interpreted the evidence, identified key implementation challenges and future research priorities, drafted the manuscript, and coordinated revisions. As Lead Author, he provided the conceptual leadership, ensuring the intellectual direction and overall coherence of the review. Dr. Denebo Jebeso Morketo refined the conceptual framework from an internal medicine and health systems perspective, strengthened the interpretation of implementation challenges, and critically revised the manuscript. Dr. Gobena Teno provided expert guidance on respectful maternity care and obstetric practice, refined the clinical interpretation of the evidence, supervised the work, and critically revised the manuscript. The authors are faculty members at Arsi University, Ethiopia, who collaborated through their complementary expertise in midwifery, internal medicine, and obstetrics and gynecology. All authors reviewed, approved the final manuscript, and accept responsibility for its content.

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Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Additional information

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