World Journal of Advanced Research and Reviews
eISSN: 2581-9615 CODEN (USA): WJARAI
Cross Ref DOI: 10.30574/wjarr
Journal homepage: https://wjarr.com/

(REVIEW ARTICLE)

Check for updates

Maternal Care or Mistreatment? A Review of Obstetric Violence in Ghana

Stephen Henry Afakorzi [1, 2, 3, *]

[1] *Africa Centre of Excellence in Public Health and Toxicological Research, University of Port Harcourt, School of Public Health, Nigeria.*
[2] *Ensign Global University, Kpong, Eastern Region, Ghana.*
[3] *Family Health University, Teshie, Greater Accra Region, Ghana.*

World Journal of Advanced Research and Reviews, 2026, 29(02), 739-748

Publication history: Received on 27 December 2025; revised on 11 February 2026; accepted on 14 February 2026

Article DOI: https://doi.org/10.30574/wjarr.2026.29.2.0300

Abstract

Mistreatment of women during childbirth is acknowledged globally as an impediment to achieving maternal health goals. In Ghana, despite improvements in antenatal care use and institutional child delivery policies, reports of obstetric violence remain pervasive. This review draws evidence from twelve peer reviewed sources conducted in Ghana by examining the forms, prevalence, determinants and consequences of mistreatment during childbirth. Findings indicate that verbal and physical abuse, non-consented care, neglect, discrimination, detention, and extortion are widespread and with normalization among healthcare workers. Factors that drive the phenomenon include systemic inadequacies, workload pressures and an entrenched socio-cultural attitude. Including Respectful Maternity Care (RMC) in policy, enhancing quality healthcare provider training and addressing infrastructural deficits in addition to a national commitment to RMC were recommended in order to reduce maternal morbidity and mortality, increase facility-based delivery and promote women's rights.

Keywords: Respectful Maternity Care; Obstetric Violence; Maternal Health; Childbirth Abuse; Skilled Birth Attendance; Ghana

1. Introduction

Mistreatment of women at facility-based childbirth which is variously referred to as obstetric violence (OV) or disrespect and abuse (D&A) is identified as a critical issue worldwide and a persistently acknowledged barrier to achieving maternal health equity (Maya et al., 2018; Savage & Castro, 2017). This phenomenon has been labelled in different ways including "mistreatment of women in childbirth", "obstetric violence", "disrespect and abuse", "institutional violence", and "dehumanizing birth" (Awad et al., 2022; Savage & Castro, 2017). Several literature sources indicated that obstetric violence or disrespect and abuse in childbirth is a worldwide phenomenon and is rife in every health system and occurs regardless of the strength of the health system or the country's income (Khalil et al., 2022; Perrotte et al., 2020). While these terms are often used interchangeably, there is a debate about distinctions about them, with some arguing that "obstetric violence" has the potential to address the structural dimensions of violence within the multiple forms of disrespect and abuse (Perrotte et al., 2020; Sadler et al., 2016; Savage & Castro, 2017). The varying terminologies, operational definitions, lack of consensus on what constitutes poor treatment and the different study designs employed in studying the phenomenon results in wide differences in prevalence findings, thereby making it unclear if these differences truly reflect true variation or methodological issues. Also, the

* Corresponding author: Stephen Henry Afakorzi

timing of the studies significantly impacted reported prevalence as women may report higher rates in community interviews compared to facility exits (Bohren et al., 2017; Kassa et al., 2020; Perrotte et al., 2020).

Globally, maternal mortality remains a significant public health challenge with Sub-Saharan Africa accounting for approximately 70% of all maternal deaths (WHO, 2021). In Ghana, the maternal mortality ratio is estimated at 310 per 100,000 live births which appears significantly higher than the Sustainable Development Goal target of 70 per 100,000 (Yalley et al., 2023). Efforts such as the Free Maternal Healthcare Policy and increased antenatal coverage have improved access to care; however, disparities persist in quality of intrapartum care (Adu- Bonsaffoh et al., 2022; Dzomeku, Boamah Mensah, et al., 2020). Emerging evidence suggests that disrespect and abuse during childbirth deter women from seeking skilled birth services, contributing to adverse outcomes (Maya et al., 2018; Yalley et al., 2023). This review critically synthesizes studies conducted across Ghana to identify the scope, causes and implications of mistreatment during facility-based childbirth and explores interventions to promote respectful maternity care.

2. Methods

In this review, evidence is drawn and synthesized from twelve (12) peer-reviewed studies carried out in Ghana between 2013 and 2023 from PubMed, DOAJ, Google Scholar and BioMed Central databases. Included studies used qualitative (n = 6), quantitative (n = 4) and mixed methods (n = 2) designs. A systematic search using appropriate Boolean Operators and comprehensive search strategies and MeSH terms such as "birth mistreatment", "obstetric maltreatment", "childbirth care violations", "obstetric violence", "reproductive coercion", "birth related violence", "disrespectful maternity care", among others were used to churn out relevant papers. Studies were selected based on their relevance, empirical data, focus and impact of obstetric violence on maternal health. Themes were inductively synthesized into categories including forms of abuse, driver factors, consequences and proposed solutions.

3. Results

3.1. Forms and Prevalence of Mistreatment

Childbirth related mistreatment is a widespread phenomenon across Ghanaian health facilities. Commonly reported forms include physical abuse (such as slapping, pinching), verbal abuse (such as shouting, insults), abandonment, denial of birth companions, non-consented care, extortion and detention for non-payment of bills (Dzomeku, Mensah, et al., 2020; Yalley et al., 2023). Prevalence rates ranged from 65% to 83% of women reporting at least one form of abuse during childbirth (Asare & Tabong, 2023; Maya et al., 2018; Yalley et al., 2023). A cross-sectional retrospective survey of 253 women in a referral facility found that 83% of women experienced mistreatment during childbirth between November 2017 and April 2018. The authors identified various manifestations of mistreatment with detention for non-payment of bills reported as most common (Kuumuori Ganle & Krampah, 2019). Another facility-based cross-sectional study conducted in the Ashanti and Western Regions of the country from September to December 2021 with a sample size of 1,854 mothers reported a 65.3% prevalence of women experiencing at least one form of obstetric violence across rural and urban health facilities (Yalley, 2022; Yalley, 2023). Other studies support the high prevalence of mistreatment with one such study exploring women's perspectives in Koforidua and Nsawam, identified verbal abuse, physical abuse and abandonment as major forms of mistreatments. These findings align with previous studies that documented mistreatment during facility-based delivery (Maya et al., 2018).

Obstetric violence is noted to be most common during the second stage of labour, often involving coercive behaviours to compel women to push (Dzomeku, Mensah, et al., 2020; Yalley et al., 2023). Women living with HIV, adolescents and poor or single mothers face heightened risks of obstetric violence (Adu-Bonsaffoh et al., 2022; Yalley et al., 2023). These findings indicate that a significant proportion of women in Ghana experience mistreatment and abuse during childbirth in healthcare facilities. This high prevalence is recognized as a major impediment to facility-based delivery and a threat to women's health and human rights.

3.2. Factors Driving Mistreatment of Women at Childbirth

Several systemic and interpersonal factors underpin obstetric violence. Health professionals cite heavy workloads, inadequate staffing, lack of resources and perceived non-compliance by birthing mothers as justifications (Adu-Bonsaffoh et al., 2022; Rominski et al., 2017). Cultural norms that equate shouting or physical punishment with care further normalized the situation. Midwives often rationalize mistreatment as a strategy to ensure safe delivery outcomes such as "beating to help them push". Non-consented procedures, such as episiotomies or forced positioning are justified based on providers' clinical judgement and assumptions about women's knowledge (Dzomeku, Mensah, et al., 2020; Yalley et al., 2023).

3.3. Women's Experiences and Perspectives

Women reported feeling humiliated, neglected and unsupported. Verbal abuse is the most cited form of mistreatment followed by physical violence and neglect (Asare & Tabong, 2023; Maya et al., 2018). While some women internalize mistreatment as necessary for safe childbirth, others view it as a violation that deters future facility-based delivery (Maya et al., 2018). Younger mothers and those lacking social support are disproportionately affected, and it was noted that birthing women often lack the capacity to question provider actions or to assert autonomy during labour (Maya et al., 2018; Yalley et al., 2023).

3.4. Provider and Institutional Views

Health workers acknowledge the existence of abuse but perceive it as unavoidable within existing institutional constraints (Adu-Bonsaffoh et al., 2022). Midwives report emotional exhaustion, lack of infrastructure (such as privacy, birth companion inclusion), and limited training on patient-centered care as barriers to respectful care (Dzomeku, Boamah Mensah, et al., 2020; Yalley et al., 2023).

3.5. Impact on Health-Seeking Behaviour

Negative experiences during childbirth significantly reduce women's willingness to return to health facilities for subsequent births (Maya et al., 2018; Moyer et al., 2014). Fear of mistreatment, particularly among adolescents and first-time mothers contributes to reliance on traditional birth attendants or home deliveries (Kuumuori Ganle & Krampah, 2019).

4. Discussion

The studies included in the review highlighted a critical disconnect between increased access to maternal health services and the quality of care being delivered. Obstetric violence in Ghana reflects entrenched norms that tolerate coercion and disregard of the autonomy of birthing mothers. Literature sources offered a multifaceted approach to addressing the issues. Key strategies include internalizing RMC training across all levels of provider education (Rominski et al., 2017; Yakubu et al., 2014), incorporating human rights principles into national maternal health policy frameworks (WHO, 2023), implementing supportive supervision and accountability mechanisms, scaling innovative models like group antenatal care which promotes engagement and patient-provider rapport (Lanyo et al., 2023) and upgrading facility infrastructure to support privacy and companion inclusion.

Ghana like many other lower-middle income countries, faces significant challenges regarding mistreatment of women during childbirth in health facilities (Kuumuori Ganle & Krampah, 2019). Literature from Ghana and other countries highlight the various forms and prevalence of mistreatment, the underlying factors, women's and healthcare providers' perspectives and the critical impact on the health-seeking behaviours of pregnant and birthing mothers (Adu- Bonsaffoh et al., 2022; Asare & Tabong, 2023; Moyer et al., 2014; Yalley, 2022).

4.1. Forms and Prevalence of Mistreatment

In Ghana, studies consistently report a high prevalence of mistreatment during facility-based childbirth, encompassing various forms. A cross-sectional retrospective survey at the Tema General Hospital in Ghana found an overall mistreatment prevalence to be 83% among women with many experiencing multiple forms (Kuumuori Ganle & Krampah, 2019). The commonest forms identified were detention for non-payment of bills (43.1%), non-confidential care (39.5%), abandonment (30.8%), verbal abuse (25.3%), discrimination (21.3%), physical abuse (14.2%) and non-consented care (13.3%) (Kuumuori Ganle & Krampah, 2019). Qualitative studies with women in rural northern Ghana further described physical abuse (hitting, beating, slapping), verbal abuse (scolding, yelling, shaming), neglect (leaving women to deliver alone, ignoring pleas for assistance), discrimination (treating women poorly based on characteristics like education or wealth) and denial of traditional practices such as squatting during labour or keeping the placenta (Moyer et al., 2014).

Women's perspectives in Koforidua and Nsawam similarly identified verbal abuse (such as shouting, insults, derogatory remarks), physical abuse (pinching, slapping) and abandonment or lack of support, most commonly experienced during the second stage of labour, especially among adolescents (Maya et al., 2018). Midwives in Ghana also acknowledged the normalization and cultural acceptance of violence in the delivery room, reporting perpetrating or witnessing physical violence, abandonment, stigmatization of HIV-positive women, verbal abuse (particularly shouting) and detention of women for non-payment (Yalley, 2022).

Compared to other countries, Ghana's reported prevalence of mistreatment is notably high. For instance, a study in Kenya found a 20% prevalence and one in Tanzania reported 15%, a study in Ethiopia indicated 78%. In southeastern Nigeria, mistreatment was almost universal, with women reporting at least one form (Kuumuori Ganle & Krampah, 2019). A systematic review and meta-analysis across Sub-Saharan Africa (SSA) reported a pooled prevalence of disrespect and abuse of 44.0% with individual studies ranging from 1.91% in Malawi to 98.9% in Ethiopia and 98% in Nigeria (Kassa et al., 2020). This suggests that Ghana's prevalence of 83% % as reported at Tema General Hospital, is significantly higher than the SSA average and comparable to the highest reported rates in the region (Kassa et al., 2020; Sheferaw et al., 2019).

Globally, mistreatment is multidimensional and challenging to define with terms like "disrespect and abuse", "mistreatment during facility-based childbirth" and "obstetric violence" used interchangeably (McMahon et al., 2014; Savage & Castro, 2017). The World Health Organization (WHO) has categorized mistreatment into seven overarching themes: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers and health system conditions and constraints (Bohren et al., 2018; McMahon et al., 2014; Sadler et al., 2016; Savage & Castro, 2017). These categories largely align with the forms reported in Ghana. In Europe, studies show varied forms, with Poland noting common violations of the right of privacy, information, equal treatment and freedom from violence, often involving unconsented procedures. In Sri Lanka, mistreatment includes emotional, verbal and sexual violence, unnecessary episiotomies, abandonment, lack of empathy and lack of consent for interventions like C-sections (Bohren et al., 2017).

4.2. Factors Driving Mistreatment of Women at Childbirth

Several interconnected factors contribute to the mistreatment of women during childbirth in Ghana ranging from individual provider attitudes to systemic health system deficiencies and broader socio-cultural norms. Health workers and hospital administrators in Ghana rationalize mistreatment by citing limited staff capacity, high workloads and perceived non-compliance or poor attitudes from women (Adu-Bonsaffoh et al., 2022). There is a tendency to blame the woman for poor treatment if she is seen as not complying with clinical requests. Midwives themselves acknowledge these pressures as well as their own low status within the health system hierarchy and often operate within organizational cultures of blame (Adu-Bonsaffoh et al., 2022; Bradley et al., 2019). Some midwives in Ghana admit to perpetrating or witnessing abuse due to the pressures of their profession, women's perceived "poor maternal efforts", women's "disrespect" towards them, disobedience and uncooperative attitudes (Yalley, 2022). They often view obstetric violence not as abuse but as a necessary "delivery strategy" to ensure a successful birth, defined narrowly as alive mother and baby, which reveals an outdated understanding of contemporary delivery practices (Yalley, 2022). Specific triggers for mistreatment include women's inability to push effectively during the second stage of labour, disobedience to instructions and not bringing required childbirth supplies ("mama kit") (Maya et al., 2018).

Financial barriers also play a role; despite Ghana's Free Maternal Healthcare Policy, women face demands for unauthorized money and the National Health Insurance Scheme (NHIS) often does not cover the full cost of C-sections, leading to detention for non-payment (Yalley, 2022). This promotes discriminatory practices, particularly affecting poor women and those who are HIV positive as the latter often face significant stigmatization from health workers (Yalley, 2022; Kuumuori Ganle & Krampah, 2019). The prevalence of midwife-centred care, where women are seen as ignorant of their bodies and the birthing process, further contributes to the denial of women's autonomy, consent and preferred birth positions (Yalley, 2022). The pervasive normalization and cultural acceptance of violence within society also fuel its occurrence in health institutions (Yalley, 2022).

Globally, these drivers resonate with findings from other countries. Mistreatment is often seen as a byproduct of gender inequality and women's low status, reflecting unequal power dynamics within health systems and broader society (Awad et al., 2022; Betron et al., 2018; Savage & Castro, 2017). In the Eastern Mediterranean Region (EMR), obstetric violence (OV) is deeply embedded in patriarchal socio-cultural norms and health systems, making it difficult to recognize (Khalil et al., 2022). Health system weaknesses such as inadequate staff, deficient training, outdated equipment, limited supplies and rundown infrastructure are common barriers to quality care globally (Ijadunola et al., 2019; Khalil et al., 2022).

The "hidden curriculum" in health professional education and poor working conditions for health professionals also contribute to the culture where mistreatment has become normalized (Bradley et al., 2019; Sadler et al., 2016). Moreover, the intersection of socioeconomic status, education, ethnicity, professional status and marital status compounds the vulnerability to mistreatment (Betron et al., 2018; Bohren et al., 2017). Providers in other regions also sometimes rationalize abuse as necessary for patient involvement or good outcomes and may be unaware they are perpetrating OV due to its normalization (Bohren et al., 2017; Khalil et al., 2022).

4.3. Women's Experiences and Perspectives

Women in Ghana often describe a contradictory experience of childbirth in health facilities. While some initially express satisfaction or positive views, they often elaborate on negative aspects upon further probes (McMahon et al., 2014). This includes a consistent underlying fear of mistreatment (Moyer et al., 2014). They frequently report experiencing verbal abuse, such as shouting, insults and derogatory remarks which negatively impact their self-confidence. Physical abuse including pinching and slapping is also reported. Women recount experiences of abandonment, lack of support, neglect and unresponsiveness to their needs. These negative experiences often occur during the second ("pushing") stage of labour (Maya et al., 2018). A concerning aspect of women's perspectives in Ghana is the belief among some that, physical and verbal abuse such as slapping and pinching are acceptable or even necessary means to "correct" perceived "disobedient behaviours" and encourage pushing thereby ensuring the safety of the mother and baby (Maya et al., 2018). This reveals a deep internalization of normalized violence. Women also express having low expectations regarding maternity services, which might contribute to their apparent satisfaction despite poor treatment. They often feel ignored with their calls for intervention dismissed and their rights to consent for medical procedures or choice of birth positions denied (Yalley, 2022).

Comparatively, women in other regions also report similar experiences and a normalization of mistreatment. In Tanzania, women experienced unfavourable conditions, with poorer women more likely to deliver alone, get scolded, discriminated against and subjected to unapproved or unpredictable fees (McMahon et al., 2014). In Poland, women reported violations of privacy, information, equal treatment and freedom from violence, especially concerning unconsented procedures. However, many Polish women expressed satisfaction or did not receive these acts of violations, possibly due to low awareness of their rights or intergenerational normalizing perspectives about childbirth care (Baranowska et al., 2019).

In Sri Lanka, women shared stories of experiencing excessive pain, fear, humiliation or loss of dignity from providers (Bohren et al., 2017). In the EMR, women describe feeling neglected, having to plead for attention, receiving inadequate pain management and giving birth alone, encountering staff described as unfriendly, rude or authoritative. The power imbalance rooted in patriarchal norms often hinder women from recognizing subtle forms of obstetric violence or advocating for their preferences (Khalil et al., 2022). This normalization can lead to inconsistencies where women report high satisfaction despite experiencing abuse. These findings highlight a global issue where women's perceptions of mistreatment can be influenced by cultural norms, low expectations and fear of repercussions (Savage & Castro, 2017).

4.4. Provider and Institutional Views

In Ghana, health workers and hospital administrators demonstrate mixed feelings about the quality of care provided but are largely aware of mistreatment occurring during childbirth. They acknowledge physical and verbal abuse, as well as the denial of preferred birthing positions and companionship. While most express opposition to mistreatment, some justify it as a means to ensure patient involvement or participation and favourable birth outcomes (Adu- Bonsaffoh et al., 2022). This often stems from a perception that women are disobedient or non- compliant, particularly during the pushing stage of labour (Maya et al., 2018; Yalley, 2022). Midwives in particular view their role as ensuring a "successful delivery" (a live mother and baby), and this outcome-focused perspective can lead them to the belief that harsh methods are justified if they perceive them to contribute to their goal (Yalley, 2022).

Many midwives do not even consider obstetric violence as abuse but rather as a legitimate delivery strategy, suggesting outdated training and a poor understanding of its negative impacts. The perceived lack of respect for the midwifery profession also contributes to poor treatment of women (Yalley, 2022).

Institutional perspectives in Ghana point to severe health system constraints. These include limited staff capacity, high workloads, suboptimal supervision, demotivation among staff and unavailability of essential medical equipment and supplies (Adu-Bonsaffoh et al., 2022). The absence of formal channels for women to express dissatisfaction or satisfaction means there is little incentive for providers to change their practices, and thus, poor quality of care continues without ramification (Bohren et al., 2017; Yalley, 2022).

Across other countries, provider and institutional views echo some of these patterns. Providers in the EMR are often unaware they are perpetrating obstetric violence due to the normalization of technocratic care and a lack of accountability. They may hold misconceptions about respectful maternity care (RMC) and believe that patient expectations are being met (Khalil et al., 2022). In South Africa, neglect is a prevalent type of mistreatment, often linked to inequalities in healthcare access (Adu-Bonsaffoh et al., 2022). Globally, studies indicate that medical professionals sometimes resist the use of "violence-centred" terminology, emphasizing a lack of malicious intent and highlighting

their own difficult working conditions in under-resourced health systems (Adu-Bonsaffoh et al., 2022; Sadler et al., 2016; Savage & Castro, 2017). The power dynamics within health facilities often reflect broader gender inequalities and also contribute to the perpetuation of mistreatment. Despite these challenges, there is a growing recognition among providers in some settings of the need to improve compassionate and dignified care (Betron et al., 2018; Kuumuori Ganle & Krampah, 2019; Sadler et al., 2016; Savage & Castro, 2017).

4.5. Impact on Health-Seeking Behaviour

Mistreatment during childbirth in Ghana has a profound negative impact on women's health- seeking behaviours, creating a significant barrier to the utilization of facility-based delivery services. Research indicated that mistreatment acts as a powerful disincentive for women to seek skilled birth services in health facilities for subsequent pregnancies (Kuumuori Ganle & Krampah, 2019; Yalley, 2022). Women may opt to deliver at home or with traditional birth attendants (TBAs), even though home births significantly increase the risk of maternal and newborn morbidity and mortality. The fear of mistreatment, whether from personal experience or from hearing about others' negative experiences, drives this reluctance (Adu-Bonsaffoh et al., 2022; Betron et al., 2018; Maya et al., 2018; Moyer et al., 2014).

In Ghana, despite efforts to increase institutional deliveries, a considerable number of women (35% in recent data) still give birth at home with unskilled attendants, a trend that may be partly linked to the persistence of mistreatment in facilities. The financial burdens such as informal payments and detention for non-payment further discourage poor women from utilizing health services and contribute to discriminatory practices (Maya et al., 2018; Yalley, 2022).

The impact on health-seeking behaviour observed in Ghana is a global concern. In Tanzania, unfavourable birth experiences were identified as a critical factor contributing to the stagnation of facility-based birth rates, especially in rural areas (McMahon et al., 2014).

Worldwide, mistreatment influences women's decisions to delay or avoid using health services in subsequent pregnancies and births, thereby undermining global health efforts to reduce maternal mortality and achieve universal health coverage (UHC). This can lead to generational birth trauma, mistrust of the health system and continued underutilization of essential services (Kassa et al., 2020; Khalil et al., 2022). While some women might not report abuse or even express satisfaction due to normalized violence or the joy of a healthy baby, the underlying negative experiences can still deter future facility attendance. The global community recognizes that addressing mistreatment is vital not only for human rights but also for improving maternal health outcomes and trust in healthcare systems (Baranowska et al., 2019; Betron et al., 2018; Khalil et al., 2022; McMahon et al., 2014; Savage & Castro, 2017).

5. Conclusion

Obstetric violence is a significant barrier to achieving equitable maternal health in Ghana. Disrespect and abuse during childbirth are systemic, culturally normalized and inadequately addressed. A national strategy that centres Respectful Maternity Care, enhances provider training and empowers women is essential for progress. Ensuring respectful and dignified care for all women during childbirth is not only a matter of human rights but also essential for improving maternal and neonatal health outcomes across the country.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

References

[1] Adu-Bonsaffoh, K., Tamma, E., Maya, E., Vogel, J. P., Tunçalp, Ö., & Bohren, M. A. (2022). Health workers' and hospital administrators' perspectives on mistreatment of women during facility-based childbirth: a multicenter qualitative study in Ghana. Reproductive Health, 19(1), 1–11. https://doi.org/10.1186/s12978-022-01372-3

[2] Asare, A., & Tabong, P. T. N. (2023). Forms of Support and Experiencing Maltreatment and Disrespect During Childbirth at a Health Facility: A Self-Reported Cross-Sectional Study in Ghana. Journal of Patient Experience, 10, 1–9. https://doi.org/10.1177/23743735231174758

[3] Awad, A., Shalash, A., & Abu-Rmeileh, N. M. E. (2022). Women's experiences throughout the birthing process in health facilities in Arab countries: a systematic review. Reproductive Health, 19(1), 1–18. https://doi.org/10.1186/s12978-022-01377-y

[4] Baranowska, B., Doroszewska, A., Kubicka-Kraszyńska, U., Pietrusiewicz, J., Adamska-Sala, I., Kajdy, A., Sys, D., Tataj-Puzyna, U., Bączek, G., & Crowther, S. (2019). Is there respectful maternity care in Poland? Women's views about care during labor and birth. BMC Pregnancy and Childbirth, 19(1), 1–9. https://doi.org/10.1186/s12884-019-2675-y Betron, M. L., McClair, T. L., Currie, S., & Banerjee, J. (2018). Expanding the agenda for addressing mistreatment in maternity care: A mapping review and gender analysis Prof. Suellen Miller. Reproductive Health, 15(1), 1–13. https://doi.org/10.1186/s12978-018- 0584-6

[5] Bohren, M. A., Vogel, J. P., Fawole, B., Maya, E. T., Maung, T. M., Baldé, M. D., Oyeniran, A. A., Ogunlade, M., Adu-Bonsaffoh, K., Mon, N. O., Diallo, B. A., Bangoura, A., Adanu, R., Landoulsi, S., Gülmezoglu, A. M., & Tunçalp, Ö. (2018). Methodological development of tools to measure how women are treated during facility-based childbirth in four countries: Labor observation and community survey. BMC Medical Research Methodology, 18(1), 1–15. https://doi.org/10.1186/s12874-018-0603-x

[6] Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Saraiva Coneglian, F., Diniz, A. L. A., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLoS Medicine, 12(6), 1–32. https://doi.org/10.1371/journal.pmed.1001847

[7] Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., Olutayo, A. O.,Ogunlade, M., Oyeniran, A. A., Osunsan, O. R., Metiboba, L., Idris, H. A., Alu, F. E., Oladapo, O. T., Gülmezoglu, A. M., & Hindin, M. J. (2017). Mistreatment of women during childbirth in Abuja, Nigeria: A qualitative study on perceptions and experiences of women and healthcare providers Prof. Suellen Miller. Reproductive Health, 14(1), 1–13. https://doi.org/10.1186/s12978-016-0265-2

[8] Bradley, S., McCourt, C., Rayment, J., & Parmar, D. (2019). Midwives' perspectives on (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and meta-synthesis. Reproductive Health, 16(1), 1–16. https://doi.org/10.1186/s12978-019-0773-y

[9] Cottingham, J., Ravindran, S., World Health Organization, World Health Organization. Reproductive Health and Research, & United Nations Population Fund. (2015). Ensuring human rights within contraceptive service delivery: implementation guide. 53.

[10] Dzomeku, V. M., Boamah Mensah, A. B., Nakua, E. K., Agbadi, P., Lori, J. R., & Donkor, P. (2020). "i wouldn't have hit you, but you would have killed your baby:" Exploring midwives' perspectives on disrespect and abusive Care in Ghana. BMC Pregnancy and Childbirth, 20(1), 1–12. https://doi.org/10.1186/s12884-019-2691-y

[11] Dzomeku, V. M., Mensah, B. A. B., Nakua, E. K., Agbadi, P., Lori, J. R., & Donkor, P. (2020). Erratum: Exploring midwives' understanding of respectful maternal care in Kumasi, Ghana: Qualitative inquiry (PLoS ONE) (2020) 15:7 (e0220538) DOI: 10.1371/journal.pone.0220538). PLoS ONE, 15(8 August), 238278. https://doi.org/10.1371/journal.pone.0238278

[12] Ijadunola, M. Y., Olotu, E. A., Oyedun, O. O., Eferakeya, S. O., Ilesanmi, F. I., Fagbemi, A. T., & Fasae, O. C. (2019). Lifting the veil on disrespect and abuse in facility-based child birth care: Findings from South West Nigeria. BMC Pregnancy and Childbirth, 19(1), 1–8. https://doi.org/10.1186/s12884-019-2188-8

[13] Kassa, Z. Y., Tsegaye, B., & Abeje, A. (2020). Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa: A systematic review and meta-analysis. BMC International Health and Human Rights, 20(1), 1–9. https://doi.org/10.1186/s12914-020-00242-y

[14] Khalil, M., Carasso, K. B., & Kabakian-Khasholian, T. (2022). Exposing Obstetric Violence in the Eastern Mediterranean Region: A Review of Women's Narratives of Disrespect and Abuse in Childbirth. Frontiers in Global Women's Health, 3(April). https://doi.org/10.3389/fgwh.2022.850796

[15] Kuumuori Ganle, J., & Krampah, E. (2019). Mistreatment of Women in Health Facilities by Midwives during Childbirth in Ghana: Prevalence and Associated Factors. Selected Topics in Midwifery Care, February. https://doi.org/10.5772/intechopen.82432

[16] Lanyo, T. N., Zielinski, R., Kukula, V. A., Lockhart, N. A., & Lori, J. R. (2023). Improving respectful maternity care through group antenatal care : findings from a cluster randomized controlled trial . 1–23.

[17] Maya, E. T., Adu-Bonsaffoh, K., Dako-Gyeke, P., Badzi, C., Vogel, J. P., Bohren, M. A., & Adanu, R. (2018). Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study. Reproductive Health Matters, 26(53), 70–87. https://doi.org/10.1080/09688080.2018.1502020

[18] McMahon, S. A., George, A. S., Chebet, J. J., Mosha, I. H., Mpembeni, R. N. M., & Winch, P. J. (2014). Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. BMC Pregnancy and Childbirth, 14(1), 1–13. https://doi.org/10.1186/1471-2393-14-268

[19] Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., & Engmann, C. M. (2014). "They treat you like you are not a human being": maltreatment during labour and delivery in rural northern Ghana. Midwifery, 30(2), 262–268. https://doi.org/10.1016/j.midw.2013.05.006

[20] Perrotte, V., Chaudhary, A., & Goodman, A. (2020). "At Least Your Baby Is Healthy" Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review. Open Journal of Obstetrics and Gynecology, 10(11), 1544–1562. https://doi.org/10.4236/ojog.2020.10110139

[21] Rivera, S. F. (2021). Law on women' s right to a life free of violence . 2021 Researcher. Rominski, S. D., Lori, J., Nakua, E., Dzomeku, V., & Moyer, C. A. (2017). When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out: Justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. In Health Policy and Planning (Vol. 32, Issue 2, pp. 215–224). https://doi.org/10.1093/heapol/czw114

[22] Sadler, M., Santos, M. J., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reproductive Health Matters, 24(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

[23] Savage, V., & Castro, A. (2017). Measuring mistreatment of women during childbirth: A review of terminology and methodological approaches Prof. Suellen Miller. Reproductive Health, 14(1), 1–27. https://doi.org/10.1186/s12978-017-0403-5

[24] Sheferaw, E. D., Kim, Y. M., Van Den Akker, T., & Stekelenburg, J. (2019). Mistreatment of women in public health facilities of Ethiopia. Reproductive Health, 16(1), 1–10. https://doi.org/10.1186/s12978-019-0781-y

[25] United Nations. (2014). Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions. Development, 42, 1–226.

[26] WHO. (2021). Trends in maternal mortality 2000 to 2020: estimates. In WHO, Geneva.

[27] World Health Organization (WHO). (2014). newborn and child health and human rights : A toolbox for examining laws , regulations and policies. 1–116.

[28] Yakubu, J., Benyas, D., Emil, S., Amekah, E., Adanu, R., & Moyer, C. (2014). It's for the greater good: Midwives' perspectives on maltreatment during labor and delivery in rural Ghana. Annals of Global Health, 80(3), 213. https://doi.org/10.1016/j.aogh.2014.08.139

[29] Yalley, A. A. (2022). "We Beat Them to Help Them Push": Midwives' Perceptions on Obstetric Violence in the Ashante and Western Regions of Ghana. Women, 3(1), 22–40. https://doi.org/10.3390/women3010002

[30] Yalley, A. A., Abioye, D., Appiah, S. C. Y., & Hoeffler, A. (2023). Abuse and humiliation in the delivery room: Prevalence and associated factors of obstetric violence in Ghana. Frontiers in Public Health, 11(1). https://doi.org/10.3389/fpubh.2023.988961

[31] Zhang, W., Xu, M., Feng, Y., Mao, Z., & Yan, Z. (2024). The Effect of Procrastination on Physical Exercise among College Students—The Chain Effect of Exercise Commitment and Action Control. International Journal of Mental Health Promotion, 26(8), 611–622. https://doi.org/10.32604/ijmhp.2024.052730

6. Appendix A: Glossary of Terms

- Abandonment

Leaving a woman unattended during labour or delivery especially during critical stages, placing here and her baby at risk

- Birth Mistreatment

A general term used to describe any harmful or abusive conduct towards a woman during labour or delivery. It is often used interchangeably with mistreatment, disrespect and abuse.

- Birth-Related Violence

A broad term referring to any violence, abuse or coercion that occurs in the context of childbirth, including verbal abuse, physical restraint or forced procedures.

- Childbirth Care Violations

Violations of a woman's rights to dignity, autonomy and respectful treatment during childbirth, including breaches of consent, privacy or informed decision-making.

- Dehumanizing Birth

Refers to childbirth experiences where women are treated as objects rather than individuals often stripped of dignity, voice or respect particularly through impersonal, harsh or mechanized care (Bohren et al., 2015).

- Denial of Birth Companion

The refusal to allow a support person (e.g. spouse, family member, doula) during labour or delivery, despite evidence showing it improves maternal outcomes and emotional well-being. Detention for Non-Payment of Bills

Holding a woman or her newborn in a health facility against her will due to inability to pay medical fees, a practice condemned as a human rights violation (WHO, 2014).

- Disrespect and Abuse (D&A)

A WHO-adapted term that refers to a range of negative experiences women face during childbirth such as being shouted at, ignored or denied informed consent. It overlaps with but is often seen as a more neutral alternative to "obstetric violence" (WHO, 2021).

- Disrespectful Maternity Care

A term used to describe care that lacks compassion, dignity or respect and may include neglect, humiliation or disregard for women's preferences during childbirth.

- Forced Positioning

Making a woman assume a specific birthing position against her will, often without explanation or consideration for her comfort or cultural preferences.

- Institutional Violence

Structural or systemic abuse embedded in healthcare institutions including resource neglect, systemic discrimination and normalization of abusive practices, rather than isolated actions of individual providers (Sadler et al., 2016)

- Mistreatment of Women in Childbirth

An umbrella term encompassing all forms of disrespect, abuse or neglect experienced by women during childbirth, including physical and verbal abuse, discrimination, non-dignified care, abandonment and violation of rights (Bohren et al., 2017).

  - Non-Consented Care

Medical procedures (e.g. episiotomy, caesarean section, vaginal exams) conducted without the woman's explicit, informed consent.

- Obstetric Maltreatment

A less commonly used term that refers to inappropriate, unethical or harmful treatment by healthcare professionals during pregnancy or delivery, typically involving non-consensual or excessive medicalization.

- Obstetric Violence

A form of gender-based violence experienced by women during pregnancy, childbirth and postpartum care, typically within healthcare settings. It involves dehumanizing treatment, coercion, unnecessary medical interventions, non-consented care and denial of autonomy, often perpetrated by health professionals (Rivera, 2021; Sadler et al., 2016).

- Physical Abuse

Acts such as slapping, pinching, hitting or physically restraining women during labour.

- Reproductive Coercion

The use of pressure, manipulation or force by health workers or systems to influence a woman's reproductive choices including contraception, sterilization or mode of delivery without voluntary informed consent (Cottingham et al., 2015; United Nations, 2014).

- Verbal Abuse

Includes shouting, scolding, insulting, threatening or blaming women during childbirth.