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Barriers and Facilitators of Respectful Maternal Care during Childbirth in Iran: A Scoping Review

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ABSTRACT

Background & aim: Despite efforts to improve respectful maternal care during childbirth in Iran, its advancement remained limited. This study aimed to synthesize barriers and facilitators of respectful maternal care within the Iranian context.

Methods: This review was conducted following Arksey and O'Malley's framework and JBI guidelines. Two independent researchers searched English databases ofCINAHL, EMBASE, MEDLINE, PsycINFO, ProQuest, Scopus, as well as Persian databases of Irandoc, SID, ISC, and Medlib—using keywords related to respectful maternity care, childbirth, mistreatment, dignity, autonomy, and Iran. Original qualitative and quantitative studies conducted in Iran and published between 2010 and 2024 were included. Quantitative data were extracted and integrated with qualitative findings through narrative synthesis, while qualitative data underwent content and thematic analysis.

Results: Of 833 records identified, 24 studies met the inclusion criteria. Most commonly reported disrespectful behaviors were verbal and physical abuse and violations of maternal privacy. Findings were grouped into four main themes: instances of disrespectful care (e.g., neglect, verbal abuse), barriers (e.g., staff shortages, inadequate infrastructure), facilitators (e.g., staff training, family support), and proposed interventions (e.g., educational programs, policy reforms). From healthcare providers' perspectives, barriers included individual and organizational factors, whereas recipients highlighted individual, health-related, and social issues. Facilitators included interpersonal communication, providers' characteristics, involvement of recipients and companions, and governance. Interventions were classified as management-oriented and educational strategies.

Conclusion: This review highlights major disrespectful behaviors and key barriers and facilitators influencing respectful maternal care in Iran. Addressing staff shortages and improving healthcare settings are essential for sustainable quality improvements.

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Introduction

Human dignity stands as a cornerstone of healthcare, fundamentally shaping the delivery of patient-centered care by emphasizing respect for and preservation of each individual's intrinsic worth (1-2). Rooted in Kantian philosophy, the concept of dignity in healthcare

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is closely linked to the principles of rationality and autonomy, highlighting the imperative to honor patients' autonomy and their right to make informed decisions about their care (3).

Upholding dignity within healthcare systems requires addressing systemic inequities, ensuring equitable access to high-quality care, and promoting the fair allocation of healthcare resources (4). This approach aligns closely with the core values articulated by the International Midwifery Confederation (5).

Despite substantial progress made toward the Millennium Development Goals by 2015, particularly in reducing maternal mortality, a persistent barrier remains that deters many women from seeking facility-based childbirth care. Although global improvements in medical infrastructure have been significant, advancements in enhancing women's experiences during childbirth have regrettably stagnated (6).

The childbirth experience is profoundly shaped by the interplay between clinical care and interpersonal dynamics, leaving lasting impressions that resonate throughout a mother's life. For many women, childbirth and motherhood are not solitary journeys but shared narratives within their communities (7). Recognizing this, the World Health Organization (WHO) places respectful maternal care at the forefront of its guidelines for a positive childbirth experience. These guidelines reflect fundamental principles aimed at preventing obstetric violence and ensuring that women receive the dignity and respect they deserve during childbirth (8-10).

Globally, there is growing recognition of the urgent need to protect women's rights amid widespread reports of violations manifested as obstetric violence. WHO data reveal that a significant proportion of women endure disrespectful and degrading treatment in healthcare settings during childbirth (11). Such abuses not only infringe upon women's rights to dignified care but also jeopardize their fundamental rights to life, health, bodily integrity, and freedom from discrimination.

Violence against women during childbirth can take multiple forms, including physical assault, unnecessary medical interventions, verbal abuse, disregard for maternal preferences, inadequate pain management, and breaches of privacy. These violations intensify the inherent pain of labor, profoundly undermining a woman's dignity and contravening essential principles of respect for autonomy as well as physical and psychological integrity (12).

In Iran, efforts to promote respectful maternity care have been spearheaded by the Ministry of Health through a series of targeted programs designed to safeguard maternal dignity throughout the perinatal period. Key initiatives include the Charter of Mother's Rights, an educational curriculum focused on maternal dignity, training workshops for maternity care providers, and the integration of respectful care principles into national guidelines for natural childbirth. However, despite these initiatives, evidence indicates that these measures have yet to yield substantial improvements in the quality of respectful childbirth care (13). A systematic review and meta-analysis conducted by Abdollahpour (2022) reported a troubling overall prevalence of traumatic childbirth experiences in Iran at 51.3% (14).

Midwives and other birth attendants play a critical role in preventing postpartum trauma and its potentially detrimental effects on maternal, familial, and child health by providing respectful, compassionate, and supportive care during labor and delivery (15). While the importance of respectful maternity care is emphasized by numerous studies and international recommendations, significant gaps remain in evidence—particularly regarding data collection systems, observational methodologies, and service delivery practices within healthcare systems across many countries (10, 12-13).

The gravity of maternal mistreatment during childbirth necessitates an in-depth examination of its prevalence, alongside a nuanced understanding of the determinants that influence the provision of respectful care. By identifying these critical factors, the research seeks to inform the development of targeted policies and strategies that enhance respectful maternal care practices. This study aims to explore the barriers and facilitators of respectful maternal care during childbirth in Iran using a scoping review methodology.

Methods

We selected a scoping review approach because our study aimed to map the key concepts and clarify the working definitions and conceptual boundaries related to respectful maternal care in Iran. Additionally, we sought to explore the existing literature, summarize the evidence, and inform future research directions. This scoping review was conducted following the Arksey and O'Malley five-step framework (16) and adhered to the Joanna Briggs Institute (JBI) guidelines for scoping reviews (17).

The review is directed by the following key questions in alignment with the study objectives :

a. What constitutes disrespectful care from the perspectives of midwifery service recipients ?

b. What barriers and facilitators influence respectful maternal care in Iran ?

c. What solutions are proposed to enhance respectful maternal care in this context?

The review process included five key steps: identifying the research questions, searching for relevant studies, selecting eligible studies, charting the data, and finally collating, summarizing, and reporting the results (16,17).

We systematically searched multiple electronic databases including CINAHL, EMBASE, MEDLINE, PsycINFO, ProQuest, Scopus, Irandoc, SID, ISC, and Medlib to identify peer-reviewed articles published between January 2010 and October 2024. The search strategy combined keywords and Boolean operators and included terms such as delivery OR perinatal care OR perinatal care OR maternal health care OR maternal service OR maternal services OR maternal health service AND childbirth OR delivery AND disrespect OR respect OR abuse OR neglect OR violence OR humiliate OR non dignified OR undignified OR dignity (Table 1).

Table1. Complete Search Strategy (PubMed/MEDLINE)

(("delivery, obstetric"[Mesh] OR "perinatal care"[Mesh] OR "perinatal care"[tiab] OR "perinatal healthcare"[tiab] OR "perinatal health care"[tiab] OR "perinatal service"[tiab] OR "perinatal services"[tiab] OR "perinatal health service"[tiab] OR "perinatal health services"[tiab] OR "maternal health services"[Mesh] OR "maternal care"[tiab] OR "maternal healthcare"[tiab] OR "maternal health care"[tiab] OR "maternal service"[tiab] OR "maternal services"[tiab] OR "maternal health service"[tiab] OR "maternal health services"[tiab] OR "maternity care"[tiab] OR "maternity healthcare"[tiab] OR "maternity health care"[tiab] OR "maternity service"[tiab] OR "maternity services"[tiab] OR "maternity health service"[tiab] OR "maternity health services"[tiab]) AND (birth*[tiab] OR childbirth*[tiab] OR delivery[tiab] OR deliveries[tiab])) AND (disrespect*[tiab] OR respect*[tiab] OR abuse*[tiab] OR neglect*[tiab] OR "confidentiality"[tiab] OR "confidential"[tiab] OR "non-confidential"[tiab] OR "informed consent"[tiab] OR violence [tiab] OR violent[tiab] OR humiliate*[tiab] OR condescend*[tiab] OR intimidate*[tiab] OR yell*[tiab] OR "non dignified"[tiab] OR "non-dignified"[tiab] OR undignified [tiab] OR discriminate*[tiab] OR abandon*[tiab] OR detain*[tiab] OR "human rights"[tiab] OR maltreatment [tiab] OR maltreated [tiab] OR "mistreatment"[tiab] OR "mistreated"[tiab] OR "dehumanized"[tiab] OR "dehumanization"[tiab] OR dignity[tiab] OR dignified[tiab] OR undignified[tiab] OR stigma[tiab] OR bully*[tiab] barrier*[tiab] OR obstacle*[tiab] OR hurdle*[tiab] OR hindrance*[tiab] OR impediment*[tiab] OR preventer*[tiab] OR challenge*[tiab] OR disincentive*[tiab] OR incentive*[tiab] OR motivat*[tiab] OR enabler*[tiab] OR facilitator*[tiab] OR belief*[tiab] OR perception*[tiab] OR perceiv*[tiab] OR perspective*[tiab] OR view*[tiab] OR attitude[tiab] OR equity[tiab]) AND (Iran[ti] OR Iran[pl] OR Iran[ad])

Searches were restricted to studies conducted in Iran and published in English or Persian languages. Study selection was performed independently by two researchers (Zh.MR and S.H) using EndNote (version 21.2.0) to manage references and remove duplicates. Titles and abstracts were screened against the inclusion criteria, followed by full-text screening. Disagreements were resolved by consensus with three additional researchers (SA.E , H.AM and N.M). Reference lists of included studies were also screened to identify additional relevant articles. The inclusion criteria comprised primary qualitative and quantitative studies focusing on respectful maternal care during labor and delivery, with an emphasis on the experiences of women, families, healthcare providers, beneficiaries, and policymakers. Only full-text articles published in English or Persian were included. Studies were excluded if they were secondary analyses, letters to the editor, abstracts without full text, or focused on prenatal or postpartum periods or on mothers with pregnancy complications.

Data extraction was carried out using a predefined form capturing the first author, year of publication, study location, study design, objectives, data collection methods, and participant characteristics (Table 2).

Table 2. Main characteristics of included studies

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
1	Raesi (2023)(56)	Cross-sectional	Determining respect for the dignity of mother and baby from the point of view of women who have given birth	Women who recently gave birth and were admitted to the postpartum ward	Khaf	Questionnaire developed by the researcher	Women rated respect for maternal and newborn dignity at a moderate level overall. Respectful communication scored highest, while respect for individual autonomy scored lowest and was below average; privacy and respectful communication were rated moderate.
2	Hosseini Tabar (2023)(31)	Cross-sectional	Determining the prevalence of disrespect during childbirth and its related factors in women hospitalized in	Women who recently gave birth and were admitted to the postpartum ward	Paveh	Checklist of disrespect during childbirth, midwifery characteristics questionnaire	All participants experienced at least one type of abusive care; non-consented care (100%) and neglect/abandonment (92.4%) were the most common forms. Drug interventions during childbirth were the only significant predictor of disrespect and abuse..

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
			the postpartum ward				
3	Abdollahpour (2023)(57)	Semi-experimental	Determining the effect of the training workshop on honoring pregnant mothers on midwives' knowledge and performance	Midwives working in the delivery room	Sardasht	Researcher's questionnaire about the knowledge and performance of midwives in the field of honoring the pregnant mother	A training workshop significantly improved midwives' knowledge and performance regarding respectful maternity care ($p < 0.0001$). ($p<0.0001$).
4	Mirzania (2022)(28)	Cross-sectional	Determining knowledge, attitude and practice of healthcare providers on mistreatment of women during labour and childbirth	All gynecologists, midwives and midwifery students	Tehran	A self-report questionnaire prepared using the typology of mistreatment of women during childbirth provided by Bourne et al	Most providers had poor knowledge about maternity mistreatment, including physical/verbal abuse, poor rapport, and failure to meet professional standards of care.
5	Rezaei (2022)(58)	Cross-sectional	Determining the amount of respect for pregnant mothers and factors related to their hospitalization	Mothers who have given birth are literate, healthy, without severe stress and mental problems	Sanandaj	Questionnaire of honoring the mother	Respectful maternity care was moderate (64.4 ± 9.6) and was significantly associated with income, insurance type, childbirth method, birth attendant, and breathing techniques for pain relief.
6	Moridi (2022)(30)	Cross-sectional	Determining midwives'	Midwifery experts working	Tehran	MKP-RM scale	Midwives scored highest in providing safe care and lowest in preventing mistreatment

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
			knowledge and practice of Respectful Maternity Care	in the delivery room			on both knowledge and practice scales, indicating greater emphasis on physical safety than mistreatment prevention.
7	Hajizadeh (2021)(32)	Prospective study	Determining the relationship of post-traumatic stress disorder with disrespect and abuse during childbirth in a group of Iranian postpartum women	Women who have just given birth to a healthy baby, without mental problems and experiencing stressful events	Tabriz	D&A scale[2], PTSD Symptom Scale	Disrespect and abuse during childbirth were significantly associated with increased postpartum PTSD symptoms.
8	Shakibazadeh (2021)(20)	Cross-sectional	Determining the prevalence of disrespectful maternity care in hospitals	New mothers before discharge	Tehran	Respectful Care Questionnaire	Disrespect was universal; restriction of mobility/fluids/companion was highest (99.7%) and stigma/discrimination lowest (4.5%), with associations by age, ethnicity, parity, SES, delivery time, and illness history..
9	Haghdoost (2021)(59)	Cross-sectional	Determining Iranian midwives' awareness and performance of respectful maternity care during labor and childbirth	Midwives working in the delivery room with at least one year of experience	Urmia	MKP-RMC scale	Good RMC awareness but fair performance among midwives; performance was associated with job satisfaction, work experience, and Master's-level education.
10	Hajizadeh &	Cross-	Determining	Women who have	Tabriz	D&A scales	Perceived disrespectful maternity care was

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
	Mirghafourv and (2021) (26)	sectional	prevalence and predictors of perceived disrespectful maternity care in postpartum	just given birth to a healthy baby, without mental problems and experiencing stressful events			common (75.7%); lack of choice of labour position (44.3%)and movement (42.5%) were most frequent. Night delivery increased disrespect, whereas spouse presence and care by private physicians/midwives reduced it.
11	Hajizadeh (2020)(60)	A prospective cohort study	Determining the relationship between respectful childbirth care and childbirth experience among a group of Iranian women	Women who have just given birth to a healthy baby, without mental problems and experiencing stressful events	Tabriz	Respectful childbirth care scale, childbirth experience questionnaire	Higher respectful maternity care was significantly associated with a more positive childbirth experience (P < 0.001).
12	Samsami (2024)(61)	Semi-experimental	Determining of effect of moral case deliberation on midwives' knowledge and practice regarding respectful maternity care	Midwives working in the delivery department	Bushehr	MKP-RMC scale	The Dilemma Method of Moral Case Deliberation significantly improved midwives' RMC knowledge and practice compared with controls (p < .001).
13	Mirzania (2023)(21)	Phenomenology	Explaining of mistreatment of women during childbirth and its influencing factor	Women who have given birth in the postnatal ward, maternity health care providers, managers at the hospital and ministry of health	Tehran	Semi-structured interview	Mistreatment included physical abuse, verbal abuse, painful vaginal examinations, neglect/abandonment, refusal of pain relief, lack of supportive care, and denial of mobility; drivers occurred at individual, provider, hospital, and health-system levels.

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
				level, and policymakers of reproductive health programs.			
14	Hajizadeh (2023)(27)	Qualitative study with conventional content analysis method	Explaining of iranian mothers' views on the determinants of disrespect and abuse during childbirth	Women who have just given birth (vaginal birth) living in Tabriz	Tabriz	Semi-structured interview	D&A included physical/psychological abuse, discrimination, privacy violation, unmet needs/preferences, non-participation in decisions, abandonment, and lack of sympathy; contributing factors included staff/equipment shortages, work overload, poor ward atmosphere, unskilled or fatigued personnel, and disorderliness..
15	Valizadeh (2023)(24)	Qualitative study with conventional content analysis method	Explaining of parturient Women's Privacy Preservation in the Delivery Rooms	Mothers who have given birth, midwives working in the delivery room	Shahrood	Semi-structured interview	Privacy-related findings covered physical, spiritual-mental, informational, and social privacy, with violations in examinations, covering, communication, confidentiality, exposure to others, and women's decision-making autonomy..
16	Pazandeh (2023)(22)	Qualitative study with conventional content analysis method	Explaining of labouring women perspectives on mistreatment during childbirth	Women at 4-6 weeks postpartum who had no medical complications	Tehran	Semi-structured interview	Women reported verbal abuse, neglect, and lack of information as major mistreatment forms. Disrespectful care included lack of empathy, verbal abuse, poor involvement in decision-making, lack of privacy, neglect of labour pain/medical needs, and poor facilities.
17	Tajvar (2022)(29)	Phenomenology	Explaining of challenges and barriers in moving toward respectful	Midwifery experts with a one-year experience working in the	Tehran	semi-structured interview, Focus group discussion	RMC provision was affected by governance, education, structural, process, provider, and recipient-related challenges such as policy conflicts, theory-based training, inadequate space, staff shortages, weak informed consent,

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
			maternity care (RMC) in labor and childbirth	delivery room			low job satisfaction, poor birth preparedness, and low rights awareness..
18	Taghizadeh (2021)(23)	Qualitative study with conventional content analysis method	Explaining the negative consequences of childbirth violence on health	Mothers who have given birth, 1 week to 3 years after giving birth, with experience of childbirth violence	Ilam	Semi-structured interview	Consequences of disrespectful/abusive care included maternal/newborn injuries, psychological trauma, disrupted mother–newborn bonding and family relationships, distrust/hatred toward the health system, and hatred of childbearing..
19	Taheri (2020)(62)	Qualitative study with conventional content analysis method	Explaining the perceived strategies to reduce traumatic childbirth amongst Iranian childbearing women	Mothers who have given birth with a history of traumatic birth and their spouses, mothers with a positive birth experience, health professionals	Tehran	Semi-structured interview	Prevention strategies for PBT included birth preparedness, maternal mental health support, respectful and supportive caregiving, trust-building, reduced medicalization, labour pain relief, continuity and coordination of care, efficient management, and improved physical structures.
20	Moridi (2020)(33)	Qualitative study with conventional content analysis method	Explaining the perceptions of Iranian midwives regarding respectful childbirth care during labor and delivery	Midwifery experts with a one-year experience working in the delivery room	Tehran	Semi-structured interview	RMC was conceptualized as empathy, women-centered care, and protection of rights, including friendly relationships, presence with women, safe care, participation in decision-making, dignity, equal care, and an appropriate environment..
21	Mohammadi (2020)(63)	Qualitative study with conventional content analysis	Explaining the caregivers' perception of women's dignity in the	Professional caregiver (nurse-midwife) working in the delivery room	Southeast of Iran	Semi-structured interview	Women's dignity was maintained through respecting physical-sexual, psychological, and informational privacy; respecting treatment decisions and religious beliefs; bedside presence, attention to women's needs, and

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
		method	delivery room: Explaining the iranian Mothers' Perspectives about Aspects and Determining Factors of Respectful Maternity Care During Labor and Delivery				avoiding discrimination.
22	Mirghafourv and (2024)(64)	Qualitative study with conventional content analysis method		Mothers who have given birth have obtained 10% of the upper and lower limits of the respectful care score of the quantitative phase of the study	Tabriz	Semi-structured interview	RMC included respectful communication, meeting women's needs and preferences (pain relief and companion presence), involvement in decision-making and informed consent, continuity and timely care, empathy and emotional support, adequate staff and facilities, and measures preventing disrespect and abuse (staff selection, motivation, professional ethics training).
23	Mirzania (2024)(13)	Qualitative study with conventional content analysis method	Explaining the challenges to the implementation of a multi-level intervention to reduce mistreatment of women during childbirth in Iran	Key stakeholders at different levels of the health system (including health care providers, managers, experts, policy makers and decision makers)	Tehran	Semi-structured interview	RMC implementation challenges occurred at individual, provider, hospital, and health-system levels, affecting childbirth preparation classes, birth companionship, in-service RMC training, provider performance evaluation, and pain-relief guideline implementation.
24	Haseli (2024)(25)	Qualitative study with conventional content analysis method	Explaining the experiences of midwifery students regarding the threat to	Midwifery students who are in the 5th semester of bachelor's degree and above	Kerman shah	Semi-structured interview	Threats to maternal dignity included professional incompetence, abuse of power, neglect of mental health, and structural system issues such as non-evidence-based practices, humiliation or beating, discrimination, ignoring maternal anxiety and

No	First author (Publication year)	Type of study	Purpose of the study	Characteristics of participants	Study location (City in Iran)	Data collection method	Main findings
			women's dignity during childbirth				companion needs, staff fatigue, and inappropriate environment..

MKP-RMC scale: Midwives' Knowledge and Practice Scale on Respectful Maternity Care
D&A scale: Disrespect and abuse scale

Furthermore, data on categories of disrespectful maternal care, barriers and facilitators of respectful care, and proposed improvement strategies were extracted and organized for analysis Data from quantitative studies (including N, %, and reported associations) were also extracted and integrated with qualitative codes through a narrative synthesis approach. The extracted quantitative findings were initially grouped into preliminary themes, which were subsequently refined and triangulated with qualitative themes to form the final categories, such as barriers and facilitators. This combined approach enabled meaningful integration of heterogeneous data sources while maintaining the integrity of qualitative methods. Throughout the coding process, codes were extracted and categorized based on their frequency in the literature, facilitating the identification of the most prevalent disrespectful behaviors

.To further elucidate the themes surrounding respectful care, we adopted a thematic analysis framework (19). This involved synthesizing data on the barriers and facilitating factors influencing respectful maternal care, alongside proposed solutions for enhancement. An open coding procedure was conducted on the extracted data, enabling the consolidation of related codes into overarching categories, sub-categories, and finer sub-subcategories. This rigorous analysis aimed to provide a nuanced understanding of the factors that either hinder or promote respectful maternal care.

Results

In this review, a comprehensive search yielded 834 articles across various databases. After the removal of duplicates, 564 unique articles were identified. A subsequent screening of titles and abstracts allowed for the exclusion of irrelevant studies, leading to the review of 31 full texts. A subsequent screening of titles and abstracts allowed for the exclusion of irrelevant studies, resulting in 8 reports being excluded due to the following reasons: protocol studies (n=2), design and psychometric tool studies (n=4), instructional design (n=1), and conference articles without full text (n=1) . Ultimately, 24 articles were selected for inclusion in this analysis; this includes one additional article identified through the references of the included studies, as depicted in Figure 1.

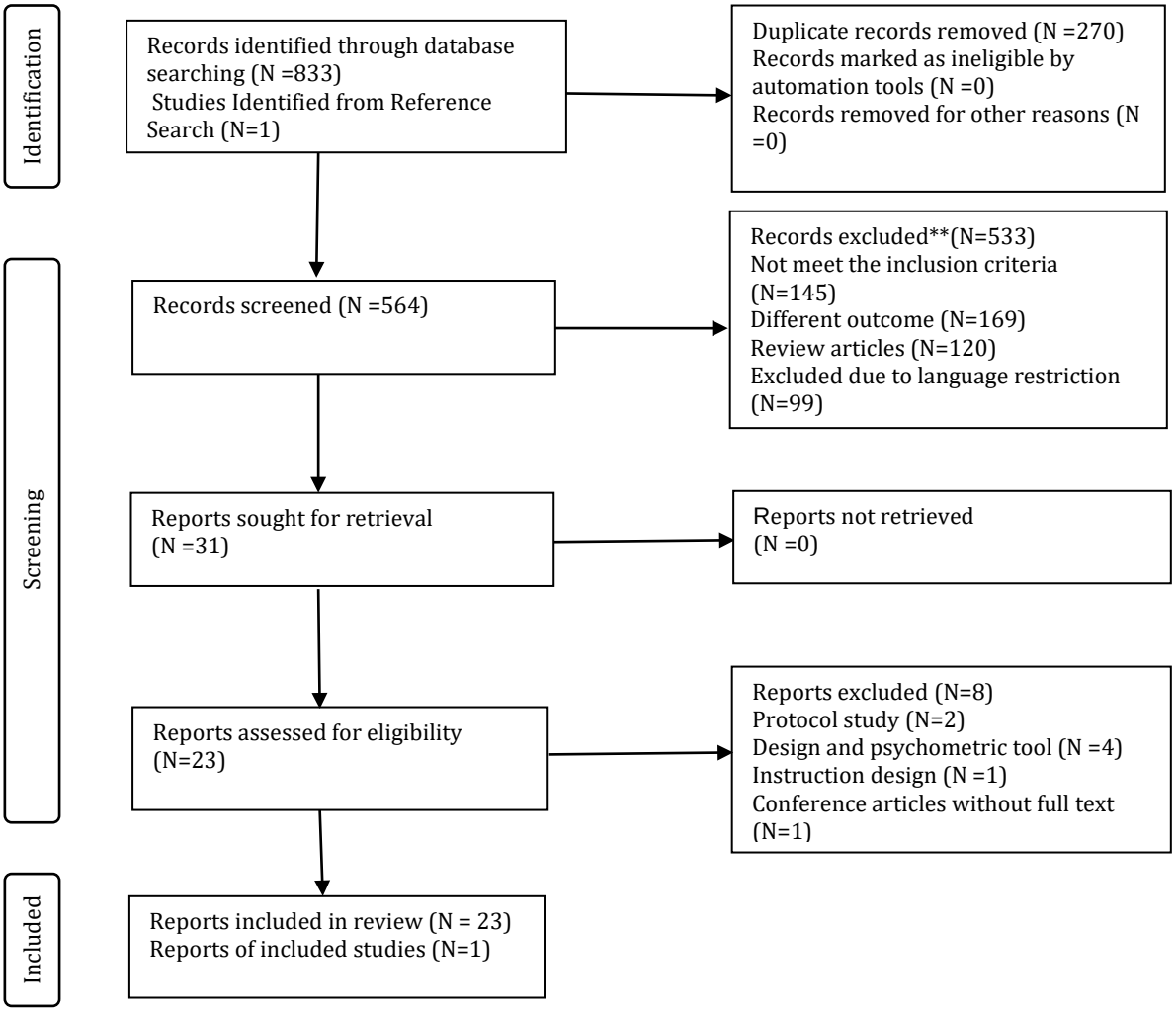

Figure 1. PRISMA 2020 flowchart illustrating the process of selecting eligible studies
*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools

The selected articles were published between 2010 and 2024, with 12 employing qualitative methodologies and 12 utilizing quantitative approaches, as summarized in Table 2.

From the reviewed literature, a total of 496 primary codes were extracted and subsequently categorized into four distinct themes: Examples of Disrespectful Maternal Care, barriers and facilitators to respectful maternal care, and proposed strategies to enhance respectful maternal care.

Examples of disrespectful maternal care

Among the included studies, 158 codes related to various types of disrespectful behaviors were extracted, and the frequency and repetition of these codes across the texts were examined using content analysis. As shown in Figure 2, a total of 28 types of disrespectful behaviors by service providers toward mothers during childbirth were reported.

The most frequent and prominent behaviors included verbal abuse, with 22 occurrences across 11 studies (20-24, 26-29, 30,32). Taghizadeh et al. (2021) reported that verbal

disrespect is a common form of violence during childbirth experienced by Iranian women, leading to increased anxiety, dissatisfaction, feelings of distrust, and emotional harm during labor and delivery (23).

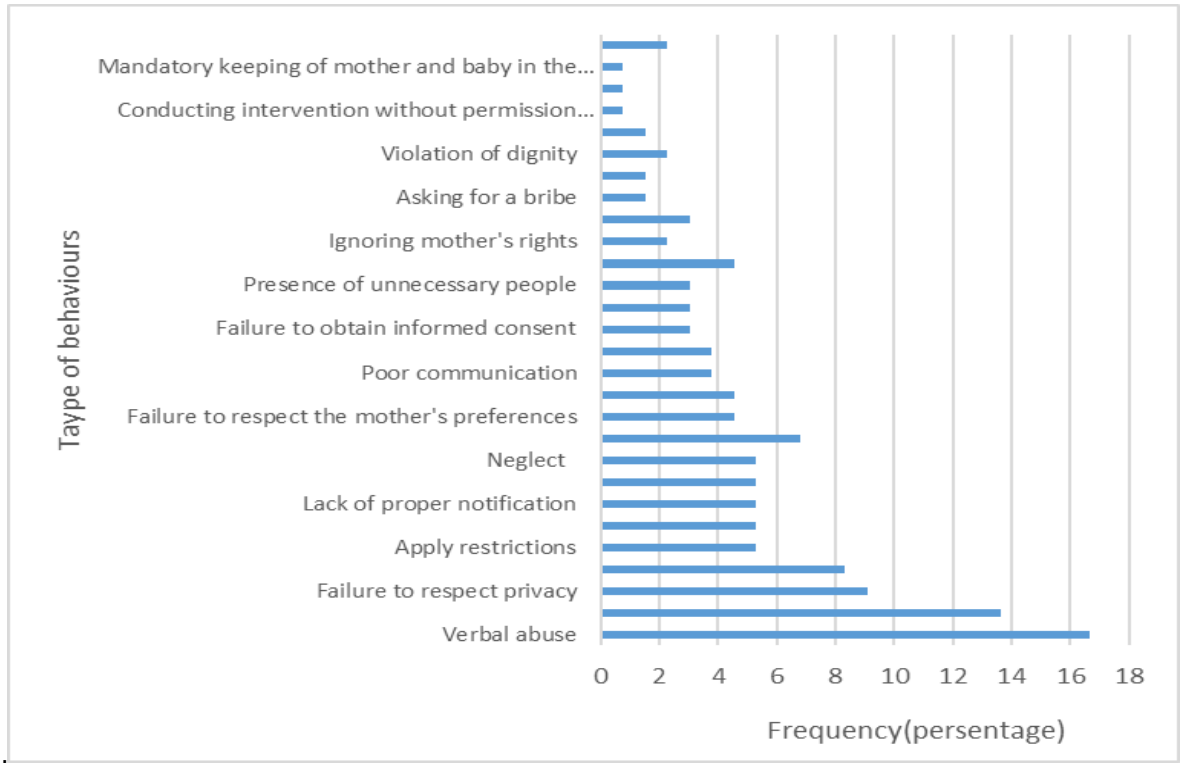

Figure 2. Types and frequency of disrespectful maternal behaviors

Similarly, Hajizadeh et al. (2020) found that disrespect and abuse (D&A) during childbirth—including not allowing women to choose their labor positions and not allowing them to move during labor—were highly prevalent, with 75.7% of women reporting one or more types of D&A. (26). Furthermore, research by Hajizadeh andMirghafourvand (2021) demonstrated a strong association between D&A and increased postpartum post-traumatic stress disorder (PTSD) symptoms. These findings highlight the critical impact of verbal abuse on maternal mental health and emphasize the need for respectful maternity care to prevent psychological trauma (32).

Physical abuse, reported 18 times across 11 studies (20-25, 27-28, 30-32), was notably highlighted by Mirzania et al. (2023), who found that physical mistreatment during childbirth in Tehran's public maternity hospitals commonly included fundal pressure and other forms of abuse. These harmful practices significantly contribute to negative childbirth experiences and underscore the urgent need for interventions to promote respectful maternity care (21). Alongside physical abuse, violations of mothers' privacy were reported 13 times across 10 studies (22, 24-29, 31-33). Valizadeh et al. (2023) emphasized that breaches of physical privacy in delivery rooms—such as frequent unnecessary and violent examinations and inappropriate exposure of parturient women—further increase maternal dissatisfaction and distress. Together, these findings highlight the critical importance of improving both respectful care and privacy preservation to enhance the overall childbirth experience (24).

Barriers to respectful maternal care

The barriers to respectful maternity care from the perspectives of service providers and recipients were identified. During data analysis, 155 initial codes related to this topic were extracted. The barriers to respectful maternity care from the perspective of service providers were classified into 27 sub-subcategories, 7 subcategories, and 2 main categories (individual factors and organizational structural factors). From the perspective of service providers, individual factors hindering respectful maternity care include insufficient knowledge of medical ethics and mothers' needs, lack of awareness about the concept of dignity, and dignity-centered education. Additionally, communication barriers such as poor communication skills and limited time to properly inform mothers contribute to the problem. Misconceptions also play a role, with some providers not recognizing certain behaviors as disrespectful or not prioritizing respectful care (Table 3). Several studies (28-30) identified insufficient knowledge about respectful care principles and limited communication skills as major impediments. For instance, Moridi et al. (2022) found that Iranian midwives scored particularly low in the domain of preventing mistreatment, reflecting insufficient knowledge and practice in this critical area.

Table 3. Subcategories and categories emerged from data analysis on barriers to respectful maternal care from the perspective of healthcare service providers

Sub-subcategories	Subcategories	Main Category
Poor knowledge of medical ethics Lack of awareness regarding mothers' needs Lack of awareness regarding the concept of dignity Lack of dignity-centered education for students	Lack of knowledge and awareness	Individual Factors
Deficient communication skills among providers Inadequate time for information sharing with mothers	Communication barriers	
Failure to recognize certain behaviors as disrespectful Perception that respectful behavior is not a priority Unrealistic expectations shaped by the mother's previous childbirth experience	Misconceptions	
Work-related and legal pressure to ensure the birth of a healthy newborn Stressful delivery environment Heavy workload Intensive work shifts Inadequate staff rest time Shortage of human resources	Critical workplace conditions	
Low motivation and burnout Demotivation due to undervaluation of midwives in the delivery team	Staff lack of motivation	
Inadequate physical space Shortage of childbirth equipment and facilities	Inadequate equipment and physical space	Organizational Barriers
Lack of effective incentive and disciplinary mechanisms for staff Lack of system support for reporting medical errors Lack of effective supervision and control Inappropriate evaluation system for maternity care providers Disregarding respectful care in hospital accreditation Lack of financial incentives in the public sector Natural childbirth policies disregarding maternal rights Unfair payment system Overburdening with non-clinical and administrative tasks	Poor management and flawed policymaking	

This underscores the urgent need for targeted educational programs aimed at enhancing midwives' understanding and ability to provide respectful maternity care, especially in addressing individual factors and preventing maternal mistreatment (30).

Complementing these findings, Mirzania et al. (2022) reported that most maternity healthcare providers in Tehran demonstrated poor knowledge and unfavorable attitudes toward mistreatment during labour and childbirth. Although self-reported mistreatment practices were relatively low, harmful behaviors such as shouting, fundal pressure, and slapping were still present. Together, these studies highlight the necessity of comprehensive interventions—including education, systemic reforms, and cultural change—to improve knowledge, attitudes, and practices among maternity care providers and ensure respectful, woman-centered care (28). In line with this, Tajvar et al. (2022) identified multiple barriers to providing respectful maternity care from the perspective of midwives (service providers), including challenges related to governance, human resource education, structural issues, care processes, and factors associated with both providers and recipients. These barriers exist at all levels of the health system, necessitating coordinated multi-level interventions to improve respectful care during labor and childbirth (29).

From the perspective of service providers, organizational barriers to respectful maternity care include high work pressure and stressful labor environments, heavy workloads, long and frequent shifts with insufficient rest, and staff shortages. Low motivation and burnout among midwives, often due to being undervalued within the delivery team, further impact care quality. Inadequate physical space and lack of necessary equipment also hinder service delivery. Additionally, poor management and flawed policies—such as ineffective incentive systems, lack of support for reporting medical errors, insufficient supervision, neglect of respectful care in hospital accreditation, unfair payment systems, and excessive non-clinical administrative duties—create significant obstacles to providing respectful maternity care (Tables 3). Mirzania et al. (2023) highlighted several key organizational barriers in Tehran, such as high workload, staff shortages, burnout among midwives, inadequate facilities, poor management, and policies that neglect mothers' rights (21). Similarly, Tajvar et al. (2022) identified multiple challenges including governance issues, insufficient human resource education, structural limitations, as well as provider- and receiver-related barriers. Both studies emphasize that these obstacles exist across all levels of the health system, underscoring the urgent need for coordinated, systemic reforms to enhance the quality of maternity care (29).

From the perspective of service recipients, the barriers to respectful maternity care were categorized into 12 subcategories grouped under three main categories: individual factors, underlying medical conditions and necessary interventions, and social factors (Table 4).

Table 4. Subcategories and categories emerged from data analysis on barriers to respectful maternal care from the perspective of healthcare service recipients

Subcategories	Main Category
Limited knowledge of mothers and companions regarding the birth process	Individual factors
Lack of awareness of individual rights	
Ineffective training for mothers during pregnancy	
Lack of motivation of mothers to perform natural childbirth	
Unrealistic expectations of mothers about childbirth	
Inappropriate verbal interaction of mothers with service providers	
Underlying diseases in mothers	Underlying disease and necessary interventions
Providing necessary interventions during childbirth	
Poor socio-economic status	Social factors
Lack of participation culture among mothers	
Absence of relational culture	

Individual barriers included limited knowledge about childbirth, lack of awareness of personal rights, ineffective prenatal education, low motivation for natural delivery, unrealistic expectations, and poor communication with healthcare providers. Medical factors involved underlying maternal health issues requiring interventions. Social barriers encompassed low socio-economic status, limited maternal participation, and a lack of a relationship-centered care culture. Studies conducted in this area included the following (20-24, 26-27, 31-32, 56, 58, 62). Taheri et al. (2020) identified several barriers to respectful maternity care from this viewpoint, including limited maternal knowledge about childbirth, inadequate prenatal education, poor communication with caregivers, and lack of maternal empowerment. They also highlighted social factors such as low socio-economic status, absence of a culture of maternal participation, and insufficient support structures as significant obstacles to providing respectful care (62). Similarly, Rezaei et al. (2022) found that women's perception of respectful maternity care was moderate and significantly influenced by income, insurance type, delivery method, birth attendant, and pain relief-breathing techniques. The study highlighted individual barriers such as limited maternal knowledge, insufficient prenatal education, unrealistic childbirth expectations, and poor communication with healthcare providers, as well as social barriers like low socio-economic status and lack of a culture supporting maternal participation (58).

Table 5. Subcategories and categories emerged from data analysis on facilitating factors of respectful maternal care

Subcategories	Main Category
Effective communication between mothers and service providers Clarifying the delivery process by service providers Involving mothers in decision-making and selection Valuing the individual beliefs of mothers	Interpersonal communication
Obtaining informed consent Provide care without discrimination Maintain confidentiality of information Strengthening decision-making skills in critical situations in midwives Empowering midwifery service providers in the field of preserving the dignity of mothers	Service provider-related factors
Having strong communication skills The mother's social support Perceived support from service providers	Service recipient and companion-related factors
Improving performance monitoring of service providers Optimizing the physical structure of the delivery room Continuation of service and support	Management factors

Facilitators of respectful maternal care

The analysis of the findings in this area included 140 initial codes. As shown in Table 5, the facilitating factors of respectful maternity behaviors from the perspective of service providers and service recipients are categorized into four main classes: interpersonal communication, factors related to service providers, factors related to service recipients and companions, and managerial factors, which are further divided into 15 subcategories.

Mirghafourvand et al. (2024) identified key facilitators of respectful maternity care from Iranian mothers' perspectives, including respect for women, meeting their needs and preferences, active involvement in care, continuity, empathy, and adequate human and material resources. They emphasized that effective interventions require engagement from policymakers and health managers to improve staff attitudes, reduce workload, ensure privacy, and enhance the care environment (64). Similarly, Mohammadi (2020) highlighted facilitators of respectful maternity care such as

maintaining women's dignity by respecting physical, psychological, and informational privacy, honoring treatment decisions and religious beliefs, providing bedside presence, attentiveness to women's needs, and avoiding discrimination. These factors contribute to delivering respectful and dignified care in the delivery room (63).

Proposed strategies to enhance respectful maternal care

In various studies included in the present research, strategies for improving maternal care and enhancing the dignity of mothers during childbirth were presented. The analysis of the findings in this area consisted of 43 initial codes, which were categorized into two groups: managerial strategies and educational strategies (Table 6).

Many studies proposed multifaceted interventions. Management solutions focused on developing clear guidelines promoting respectful care, strengthening supervision, improving staffing, upgrading infrastructure, and fostering a supportive organizational culture (13, 29, 62, 64). Mirzania (2024) highlighted managerial strategies to reduce mistreatment during childbirth, including improving governance, enhancing training programs, organizing childbirth preparation classes, supporting birth companionship, evaluating provider performance, and implementing pain-relief guidelines (13).

Educational interventions targeting healthcare providers through continuous professional development, communication skills workshops, ethical training, and integration of respectful care into curricula were widely advocated (13, 29, 57,61-62, 64). Abdollahpour (2023) demonstrated that conducting training workshops for midwives significantly improves their knowledge and performance in providing respectful maternity care, highlighting the effectiveness of educational interventions in enhancing care quality (57).

Reflective practice and mentorship were also suggested to promote self-awareness and positive attitude changes (29,61,64). Tajvar (2022) identified multiple challenges and barriers to providing respectful maternity care, emphasizing the critical role of both theoretical and practical training. The study highlighted the need for professional support systems, such as mentorship and reflective practice, to enhance healthcare providers' self-awareness, skills, and positive attitudes. Addressing these educational and support-related challenges is essential for improving the quality and consistency of respectful care during labor and childbirth (29).

Collectively, these findings underscore the complex, multi-level nature of respectful maternal care in Iran and highlight evidence-based pathways for improvement grounded in both provider and recipient perspectives.

Table 6. Subcategories and categories emerged from data analysis on proposed strategies to enhance respectful maternal care

Subcategories	Main Category
Creation of a punishment system in response to the misconduct of service providers Promoting safe care Setting up an electronic file system for prenatal care recipients Ranking of hospitals based on the quality of delivery services provided Setting up a fair payment system for service providers	Management Solutions
Incorporating the concepts of dignity-based care in students' academic units Continuous employee training focusing on dignity-oriented care Promotion of evidence-based maternity care Education of an efficient and ethical workforce by using appropriate educational resources	Educational solutions

Discussion

The findings of this scoping review reveal that disrespectful maternal care during childbirth remains a significant issue in Iran, predominantly involving verbal and physical abuse as well as violations of maternal privacy. Physical abuse often includes exerting pressure on the abdomen and legs during labor and performing painful vaginal examinations, actions that contravene international childbirth standards and WHO guidelines (8, 34-37). Privacy violations, including the lack of birth curtains, the presence of unnecessary personnel during labor, and breaches of patient confidentiality, further contribute to maternal discomfort and distress (38-39). Although solicitation of bribes was infrequently reported, this may be influenced by cultural norms and potential underreporting (40- 41). These disrespectful behaviors persist despite efforts to promote respectful maternity care, underscoring the need to address critical barriers including insufficient provider knowledge, poor communication skills, staff shortages, and inadequate infrastructure that hinder the delivery of dignified care.

Barriers to respectful maternal care in Iran arise from multiple factors. Healthcare providers often lack sufficient knowledge of dignity-centered care and professional ethics, coupled with inadequate communication skills, which leads to misunderstandings about what constitutes disrespectful behavior. From the mothers' perspective, limited awareness of their rights, existing health issues, and low socioeconomic status significantly contribute to their vulnerability to disrespectful care. Similar findings from a study in Ethiopia indicate that midwives often lack training in compassionate and respectful care, highlighting critical knowledge gaps (42). A systematic review highlights the importance of strengthening interpersonal relationships between midwives and mothers to preserve maternal dignity (43). Moreover, poor communication and limited maternal involvement in decision-making processes have been identified as key barriers to respectful care (24). Given that childbirth care is inherently collaborative, enhancing both communication skills and maternal participation is essential to improving outcomes, as supported by research from Australia and Africa (44-45).

Organizational and systemic challenges also play a crucial role in the prevalence of disrespectful maternity care. Commonly reported issues include adverse work environments characterized by high workloads, low staff motivation, shortages of midwifery personnel, and inadequate resources such as medical equipment and physical infrastructure (42, 46). These factors contribute to provider fatigue and burnout, which negatively affect ethical standards and the overall quality of care. Additionally, ineffective policies, administrative mismanagement, and insufficient physical space further exacerbate these problems, reflecting similar challenges observed in other low-resource settings (29, 46-47). Addressing these systemic issues is imperative to creating an environment conducive to respectful maternal care.

Protecting mothers from verbal and physical abuse while providing continuous psychological and educational support from trained midwives, along with permitting a support companion during labor, are fundamental components of respectful maternity care (8). Key elements to enhance care include building trust, ensuring clear communication, involving mothers in decision-making, and maintaining confidentiality (50-53). Effective strategies for improvement focus on ongoing training, reforms in medical education to enhance provider competencies, and multifaceted interventions aimed at changing provider attitudes, boosting motivation, promoting evidence-based care, engaging communities, and monitoring provider performance (51, 54-55). Future initiatives should emphasize regular monitoring, inclusive policy development, teamwork promotion, and refined incentive systems to reduce mistreatment and improve care quality.

This study represents the first comprehensive review of respectful maternal care in Iran and provides valuable insights for healthcare policy and intervention. However, limitations such as potential biases due to memory recall and professional courtesy among mothers and providers should be acknowledged. Future research should investigate the impact of respectful care on maternal health outcomes to

mitigate such biases. As the evidence base grows, these findings can inform systematic reviews and meta-analyses, underscoring the critical need to prioritize maternal dignity in policy and practice.

Conclusion

The findings of this study highlight that mothers in Iran frequently encounter various forms of disrespect during childbirth, including verbal and physical abuse, systemic discrimination, and neglect. A notable gap exists in maternity care providers' knowledge of dignity-centered care principles and adherence to ethical standards. Moreover, deficiencies in communication skills hinder meaningful and empathetic engagement with laboring women.

Multiple factors contribute to the prevalence of disrespectful care. On the recipient side, limited awareness of maternal rights, compounded by underlying health conditions and socioeconomic vulnerabilities, significantly affect women's childbirth experiences. On the provider and organizational side, challenging work environments characterized by low staff motivation, inadequate staffing levels, insufficient equipment and physical infrastructure, as well as ineffective management and absence of supportive policies, further exacerbate these issues.

Encouragingly, the study also identifies critical facilitators that can promote respectful maternal care. Key among these are fostering effective interpersonal communication between healthcare providers and mothers, providing clear information about the childbirth process,actively involving mothers in shared decision-making, ensuring confidentiality of patient information, and implementing robust performance monitoring and accountability systems. Collectively, these facilitators offer a pathway to improving maternal care quality and safeguarding the dignity of women during childbirth in Iran.

Declarations

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Authors declared no conflicts of interest.

Ethical considerations

Not applicable.

Code of Ethics

Not applicable.

Use of Artificial Intelligence (AI)

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Authors' contribution

ZhMR, SH, SAE, HA and NM made significant contributions to the conception and design of the study. ZhMR and NM conducted the data collection. ZhMR and SH analyzed and interpreted the data. ZhMR drafted the manuscript, while SH, SAE and HAM critically reviewed it for important intellectual content. All authors read and approved the final manuscript and agreed to be accountable for all aspects of the work, ensuring that any questions related to the accuracy or integrity of any part of the work would be appropriately investigated and resolved.

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