Review

Women's Experiences During Childbirth: A Systematic Review

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Women's Experiences During Childbirth: A Systematic Review

Running head: Women's experiences during childbirth

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Abstract

Background: In the context of reproductive health, women have the right to positive birth experiences that safeguard both physical integrity and emotional well-being. Within this framework, we conducted a systematic review aiming to synthesize evidence on women's experiences -both positive and non-positive- during childbirth in formal healthcare settings, classify these experiences, describe their prevalence, and assess their impact on women's self-perceived health. **Methods:** The protocol was prior registered, and the review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Searches were conducted in PubMed, CINAHL, PsycINFO, ProQuest Dissertations & Theses, and Google Scholar. The risk of bias was assessed using the Joanna Briggs Institute tools. **Results:** A total of 40 studies from 14 countries were included, encompassing 80,295 women. Findings revealed a broad spectrum of positive and non-positive experiences, latter with prevalence rates ranging from 4.5% to 61.3%. Moreover, 7 of the 40 studies (n = 50,395 women) documented instances of disrespectful and abusive care practices. Reported prevalence ranged from 2.4% to 83.4% for non-consensual procedures, 0.8% to 24.4% for non-dignified care, and 5.4% to 48% for abandonment of care. **Conclusions:** Our findings suggest that there is room for improvement related to the childbirth experience. Promoting positive birth experiences and sensitizing healthcare professionals to improve respectful maternity care are key priorities. In this regard, adopting a patient-centered model may represent a paradigm shift, empowering women to make informed decisions and enhancing maternal health outcomes.

Keywords: childbirth practices; labor-related settings; women´s experiences; patient-centred care; systematic review

Key points

- This review offers a comprehensive synthesis of women's childbirth experiences—both positive and non-positive—within formal healthcare facilities.
- To our knowledge, it represents the first systematic attempt to classify women's experiences of disrespectful and abusive care during facility-based childbirth.
- The findings highlight the urgent need to ensure physical and emotional support that respects women's preferences, beliefs, and values, fully aligned with the principles of patient-centered care.

Introduction

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Concerning the reproductive health context, women's body integrity and their emotional welfare are considered outcomes of quality of care relevant to public health [1]. The quality of care concept involves skilled providers, appropriate use of technologies, and effective interventions to ensure the safety both of mothers and new-borns during childbirth [2–5]. This care should be framed within a human rights perspective, which includes different issues, such as the legal rights of women to obtain the necessary information for decision making taking decisions, to be treated with dignity and respect, and to be protected from not evidence-based practices. The women´s informed consent should be also stated, with the possibility of refusing medical interventions, thus promoting respect for women´s autonomy [3,5–8].

Even during emergency procedures, respect and gentleness are considered essential [3]. The International Federation of Gynaecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), the International Paediatric Association (IPA), the White Ribbon Alliance (WRA), and the World Health Organization (WHO) developed the Mother and Baby Friendly Birth Facility (MBFBF) criteria [3,9]. This initiative emerged because of the low quality of care and disrespectful actions observed in healthcare settings during childbirth, namely "disrespectful and abusive care during childbirth in facilities (DACF)" [3]. This phenomenon seems to be widespread all over the world, and includes the following seven categories: "physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities" [10,11].

Moreover, women's subjective experiences of childbirth have been increasingly recognized as critical determinants of maternal health, influencing both immediate postpartum recovery and long-term psychological outcomes such as post-traumatic stress disorder or postnatal depression [12,13]. Positive experiences, characterized by respectful communication, supportive companionship, and shared decision-making, have been linked to higher satisfaction and improved maternal-infant bonding [14]. Conversely, non-positive experiences associated with coercion, neglect, or unnecessary interventions can undermine trust in healthcare systems and discourage women from seeking institutional care in future pregnancies [15,16]. Addressing these experiential dimensions is therefore essential for achieving truly woman-centered care and for strengthening public health systems globally [17].

Objectives

In this context, this systematic review aimed at synthesizing available evidence on women who experienced childbirth in healthcare institutions in the countries of the Schengen area. The specific objectives were to:

1. Describe women´s experiences during childbirth in formal healthcare institutions.
2. Classify women´s experiences during childbirth in formal healthcare institutions.
3. Describe the prevalence of these experiences across different countries and cultures.
4. Determine the impact of these experiences on self-perceived women's health in aspects related to physical, psychological, and social domains.

Method

This systematic review followed the Preferred Reporting Items for Systematic reviews and Meta-Analyses guidelines (PRISMA) [18], and the protocol was prior registered *(link removed for blinded review)*.

Information Sources

Searches were conducted in PubMed, US National Library of Medicine, by the National Center for Biotechnology Information (NCBI); CINAHL, Cumulative Index to Nursing and Allied Health Literature, by EBSCOhost; PsycINFO, Psychological Information, by Proquest; WOS (Web of Science

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CORE) by Thomson Reuters, ProQuest Dissertations &Theses Global, and Google (up to 300 results), were used to search for grey literature.

Search Strategy

Supplementary Table S1 shows the search strategy, which included search terms for the following concepts: a) Childbirth; b) Women´s experiences, and c) Labor-related settings. The initial search was carried out in November 2022 and search alerts were set. All filters were adapted for all databases and not language limitations were set. First updated was in November 2023, and second update was in May 2024.The search strategy followed the Preferred Reporting Items for reporting Literature searches in Systematic Reviews (PRISMA-S) [19].

Inclusion and Exclusion Criteria

Studies aiming at reporting women's experiences during childbirth. Studies focusing on the perspectives/experiences of providers, stakeholders, students, and health workers were excluded.

Study Design

Empirical primary qualitative studies (e.g., phenomenology, grounded theory, ethnography, interview studies), and quantitative studies (e.g., cross-sectional, cohorts, case-control). Clinical trials, case studies series, single-case studies, psychometric studies aimed at developing or validating an instrument, as well as guidelines, protocols, opinion reports, and letters to the editor, were excluded.

Study Participants

Women who had experienced childbirth in formal healthcare settings. Exclusion criteria: women with specific birth experiences (e.g., traumatic births or negative experiences); women who had experienced childbirth in formal health facilities but also at home and reporting only aggregated data.

Geographical Location

Studies conducted in the countries of the Schengen area, due to cultural similarities.

Time Frame

The search was limited to studies published from 2014 onwards to capture contemporary perspectives consistent with the World Health Organization's 2014 vision for quality maternity care, which promotes respectful, woman-centred, and evidence-based practices [14].

Outcome/s

Experiences and opinions of women who have experienced childbirth in formal healthcare institutions.

Settings

Formal healthcare institutions (e.g., delivery rooms, birthing centers, and maternity settings). Exclusion criteria: Community services, home services, and health promotion and prevention settings.

Selection Process

References were managed using Zotero. Duplicates were automatically removed. Two reviewers (SL and MG) independently screened titles, abstracts, and full-text inclusion criteria. When decisions were unable to be made from the title and abstract alone, the full paper was retrieved. Discrepancies were resolved through discussion with a third reviewer (JML and JV). Secondary searches were carried out manually to identify additional studies, and where articles were not

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available, the authors attempted to request them. Interrater agreement for title and abstract screening and study selection was assessed using Cohen's kappa [20].

Data Collection Process

Supplementary Table S2 provides details of the information that was planned to be extracted for each of the studies: authors, year of publication, year of data collection, methodological data, and both the sample and healthcare institutions' characteristics. Information concerning childbirth practices or routines were extracted according to the categories proposed by do Nascimento et al., (2016). The women´s experiences during birthing were classified according to the DACF criteria [3] using the Disrespect and Abuse scale proposed by Ghimire et al., (2021). Finally, the impact and consequences of these experiences on self-perceived women´s health in physical, psychological and social domains were intended to be classified as Garcia (2020) proposal.

Synthesis Methods

The outcomes were presented in tables and figures. Most planned subgroup analyses and evaluations of consequences were not conducted due to insufficient data, except for the country-level analysis.

Risk of Bias Assessment

The risk of bias **(**RoB) was assessed using the Joanna Briggs Institute (JBI) tools for each design, i.e. the checklist for cross-sectional and cohort studies [23] and for qualitative studies [24]. One reviewer (SL) analysed the risk of bias, and two reviewers (JML and JV) monitored ratings. Disagreements were solved through discussion.

Results

Search Results

Figure 1 shows the results of the search strategy, reported according to the PRISMA flowchart. The interrater agreement for abstract and title selection was 100%, so no kappa coefficient needed to be calculated, whereas the interrater agreement for full text selection was kappa k=0.78 (CI95%: 0.59-0.96). After discussion the interrater agreement percentage for full text selection was 100%.

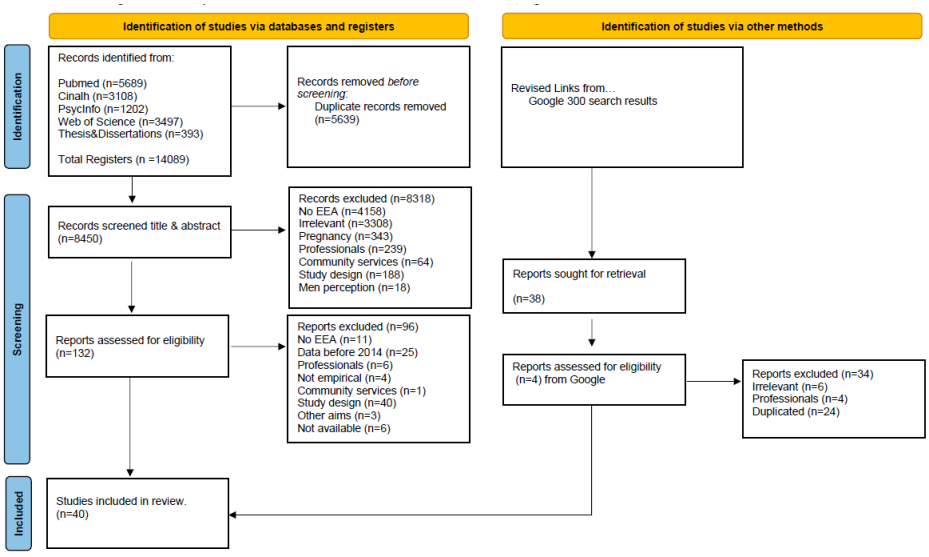

Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources.

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Sample Characteristics

Table 1 shows general data and sample characteristics of the included studies, a total of 40, published between 2016 to 2024, involving 80,295 women. A total of 17 (42.5%) were cross-sectional designs ; 15 (37.5%) were qualitative and 7 (17.5%) were cohort design Considering the country, a total of 10 (25%) were conducted in Spain; 5 (12.5%) in Sweden; 5 (12.5%) in France; 3 (7.5%) in Norway; 2 (5.0%) in Italy, Ireland, the Netherlands and Switzerland, and 1 (2.5%) in Belgium, Denmark, Finland, Lithuania, Poland, Portugal, Romania, Slovenia, and the United Kingdom (UK).

All studies reported inclusion criteria and participant age, but only 13 (32.5%) specified nationality. Regarding birth characteristics, 22 (55.0%) reported type of labor, 34 (85.0%) parity, and 33 (82.5%) mode of birth. Induction rates ranged from 12.8% to 68.2%; instrumental delivery from 2.5% to 34%; and caesarean section from 2.5% to 47.0%, with two studies including only caesarean births [25,26] and another one that included only women who had a normal birth [27]. There was no information on both labour and mode of birth in the following studies [28–32]. Finally, data on the women's level of education, employment and marital status, the companion during birth (e.g., partner, family) and the professional attending the birth were recorded where available but are not presented in tables due to the paucity of information in most of the papers.

Methodological Data of Studies

Supplementary Table S3 shows the methodological details of the studies, classified according to their research design. Concerning the cross-sectional studies, a total of 17 were included, of which 7 (41.2%) were conducted in one or two University hospitals, and 6 (35.3%) studies were conducted in hospitals from different regions, classified as multicenter. Five (29.4%) studies used *ad hoc* questionaries [26,31,33–35], and the remaining used validated questionnaires, such as the Childbirth Experience Questionnaire (CEQ-E) [36,37] the Childbirth Experience Questionnaire 2 (CEQ2) [38], the Questionnaire Assessing Childbirth Experience (QACE) [39,40] and Pregnancy and Childbirth Questionnaire (PCQ) [41,42], as the most common. Despite the generalized use of these validated questionnaires, the quality of these measures was not properly reported, since only 4 (23.5%) studies reported the internal consistency reliability for the sample of the study using Cronbach's alpha [36,38,40,43].

Concerning the cohort's studies, a total of 8 were included, of which 4 (50%) were conducted in one or two University hospitals, and 3 (37.5%) were conducted in regional or community hospitals. A total of 4 (50%) studies used rating and/or visual scales [44–46]; total of 3 (37.5%) used validated questionnaires such as the Questionnaire Assessing Childbirth Experience (QACE), the two versions of the Wijma Delivery Questionnaire and the Childbirth Experience Questionnaire (CEQ) [47–49], and 1 (12.5%) applied open questions [50]. It is noted that the mode of administration (either by mail or face-to-face) was unclear or not properly reported in 3 studies (37.5%) studies. Similarly to cross-sectionals studies, the quality of these measures was not properly reported when applicable, and only one study reported the internal consistency with the coefficient Cronbach's alpha, but for the original validation [48].

With respect to the qualitative studies, a total of 15 were included. Two more studies included were designed as mixed methods [32,51]. The settings were different, but the common feature was the method of information collection, which was mainly based on face-to-face semi-structured interviews, with the exception of the mixed-methods study designs, as mentioned above, which used closed questionnaires with open-ended responses, the focus group technique [52], and online interviews with open-text responses [29]. The approach was also similar across the studies, that is, descriptive, inductive or interpretative, synthesizing results through content or thematic analysis.

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Table 1. Cross-sectional studies. Sample characteristics.

Author	Country	Inclusion criteria	Sample (m_age; sd) Range age Groups	Nationality Race or Ethnicity	Labor*	Parity	Mode of birth	Birth Plan	Non-Positive Birth Experience (%)
Basso,AM, 2016	Portugal	Women with internet access	N=519 30 – 35 years	NR	Induction 33.6%	Primip 79.0%	Eutocic 21.6% Inst 49.7% CS 28.7%	Total 13.9%	NR
Carquillat et al., 2016	Switzerland	Women speaking, writing, reading French, primiparous, singleton fetus, gestational up to 37 weeks, and newborn not separated for medical reasons during the maternity stay.	n=291 (30.8; 4.7) Spontaneous n=150 Instrumental n=55 ElectCS n=20 EmergCS n=60	Swiss/ European 86%	Induction 43.2%	Primip 100%	Eutocic 51% Inst 19% CS 30%	Total 20.8%	22.9
Perdok et al., 2018	Netherlands	Women attended during their puerperium by midwifery care.	n=187 (31.4; 4.1) Midwife care primary n=136 Midwife care at labor n=36 ObstCare primary n=15 ObstCare labor n=36	Dutch 98%	Induction 12.8%	Primip 41.7%	Eutocic 87.2 % Inst 9.1% CS 3.7%	NR	27.3
Baranowska et al. 2019	Poland	Women who declared that they had given birth in 2017 or 2018	n=8378 26 – 35 years	NR	NR	NR	Eutocic 61.3 % Inst 2.5% CS 36.2%	NR	NR
Ryan et al., 2019	Ireland	Women with one previous CS.	n=347 (34.9; NR) ElectCS n=62 EmergCS n=285	Irish 79.5%	NR	Primip 0%	Eutocic 0% Inst 0% CS 100%	NR	11 ElectCS; 6.1 EmergCS; 15.9
Baptie et al., 2020	United Kingdom	Participants must have had their baby within the last 12 months and be >18 years old.	n=222 (NR) 18 – 44 years	NR	NR	Primip 63.1%	Eutocic NR Inst NR CS 23.5%	NR	NR
Mena-Tudela et al., 2020	Spain	Women attended to in a Spanish public or private hospital to give birth naturally or by CS, or for miscarriage.	n=17541 (NR) Public Healthcare n=11450 Mixed care n=4261 Private n=1830	NR	NR	NR	NR	Total 73.5%	54.5
Mena-Tudela et al.,2021	Spain	Women attended to in a Spanish public or private hospital to give birth naturally or by CS, or for miscarriage.	n=17541 (NR) Public Healthcare n=11450 Mixed care n=4261 Private n=1830	NR	NR	NR	NR	NR	61.3
Chabbert et al.,2021	France	Women >18 years who gave birth to healthy, full-term, singleton infants.	n=265 (31.5; NR) 18 – 46 years	NR	Induction 37.4%	Primip 46.5%	Eutocic 57.9% Inst 16.5% CS 25.6%	NR	23.3

Note: m_age= mean age; sd= standard deviation; ElectCS=Elective Cesarean; EmergCS; Emergency Cesarean; CS= Cesarean section section, including both emergency and elective cesarean section; Inst= Instrumental; Primp= Primiparous; NR Not Reported. *Labor induction includes augmentation percentages.

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Author	Country	Inclusion criteria	Sample (m_age; sd) Range age Groups	Nationality Race or Ethnicity	Labor*	Parity	Mode of birth	Birth Plan	Non-Positive Birth Experience (%)
González-de la Torre et al., 2021	Spain	Pregnant women with single pregnancy, eutocic vaginal delivery or dystocic-instrumental vaginal delivery.	n=257 (31.6; 5.6) 18 – 45 years	NR	Induction 44.0%	Primip 51.4%	Eutocic 89.9% Inst 10.1% CS 0%	NR	50.5
Oelhafen et al.,2021	Switzerland	Women aged 18 years or older who had given birth in Switzerland within the previous 12 months.	n=6054 (NR) 18 – 46 years	Swiss 81.6%	Induction 28.0%	Primip 57.9%	Eutocic 65.3% Inst 11.4% CS 23.3%	NR	NR
Rodriguez et al.,2021	Spain	Participants with legal age; being able to understand enough Spanish language; having a minimum amount of computer knowledge to answer an online questionnaire.	n=194 (32.8; 5.5) 20 – 48 years High Hospital n=97 Med Hospital n=97	Spanish 85.0%	Induction 40.7%	Primip 53.1%	Eutocic 63.9% Inst 34% CS 3.6%	Total 76.3% High Hosp 78% Med Hosp 74%	33.1
Westergren et al.,2021	Sweden	Healthy women with normal pregnancies and expected to have uncomplicated vaginal births.	n=239 (30.8;4,6) With BP n=129 Without BP n=110	Swedish 90.0%	Induction 68.2%	Primip 46.4%	Eutocic NR Inst 6.3% CS 9.6%	Total 54%	22.8
Deherder et al., 2022	Netherlands	Knowledge of the Dutch language, being 18 years or older, having given birth at least once, being in the postpartum period (between 2-12 months postpartum).	n=617 (NR) 18 – 39 years	NR	Induction 38.9%	Primp 54.3%	Eutocic 48.3% Inst 4.7% CS 47.0%	NR	25.0
Reppen et al., 2023	Norway	Women giving birth, 18 years and above and had given birth to a healthy newborn.	n=680 (31.7; 4.6) 18 – 30 years	Norwegian 77.5%	Induction 25.1%	Primp 51.2%	Eutocic 69.7% Inst 9.4% CS 20.8%	NR	9.0
Viirman et al., 2023	Sweden	Women aged 18 years or older, who gave birth to a live infant, and rated overall childbirth experience.	n=2953 (31.1; 4.4)	Swedish 74.6%	Induction 34.5%	Primip 48.7%	Eutocic 83.5% Inst 6.5% CS 9.4%	NR	6.3
Schönborn et al., 2024	Belgium	Women at least 16 years old; having given birth within the last two weeks; speaking French, Dutch, Arabic, Riff, Peul, English,or Spanish, regardless of health insurance, legal status, or literacy.	N=877 (NR) 25 – 36 years	Belgium 48.8%	NR	Primip 36.3%	Eutocic 79.4% Inst 0% CS 20.6%	NR	14.5

Note: m_age= mean age; sd= standard deviation; CS= Cesarean section, including both emergency and elective cesarean section; Inst= Instrumental; Primp= Primiparous; NR=Not Reported. *Labor induction includes augmentation percentages.

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Table 1. Cohort studies. Sample characteristics.

Author	Country	Inclusion criteria	Sample (m_age; sd) Range age Groups	Nationality Race or Ethnicity	Labor*	Parity	Mode of birth	Birth Plan	Non-Positive Birth Experience (%)
Favilli et al., 2018	Italy	Women aged > 18 years, American Society of Anesthesiologists (ASA) physical status I or II, and single gestation at term.	n=261 (31.9; 5.2) Epidural analgesia n=100 No epidural n=161	White 89.0%	Induction 39.8%	Primip 64.8%	Eutocic 87% Inst 8.8% CS 3.8%	NR	NR
Fenaroli et al., 2019	Italy	Nulliparous, aged >18 years, fluent in Italian, with a singleton pregnancy, and a planned normal vaginal birth.	n=111 (32.3; 5.2) 19 – 46 years	NR	Induction 42.2%	Primip 100%	Eutocic 66.4% Inst 14.2% CS 19.4%	NR	NR
Alexandroia et al. ,2019	Romania	Primiparous patients, interviewed after at least 6 weeks of postpartum, delivery by vaginal method or CS, and patients with live newborns.	n=78 (27.5; 5.2)	NR	NR	Primip 100%	Eutocic NR Inst NR CS NR	NR	NR
Adler et al.,2020	Finland	Women with live singleton pregnancies in cephalic presentation at or beyond 37 gestational weeks with the aim of vaginal delivery.	n=18396 (31.8; 5)	NR	Induction 28.9%	Primp 47.0%	Eutocic 78.7% Inst 11.9% CS 9.4%	NR	4.5
Bouvet et al., 2020	France	Women who consent to participate, without elective cesarean delivery, or emergency cesarean delivery not in labor or intrauterine fetal death, therapeutic abortion.	n=193 (30; NR) 26 – 34 years Oral intake (n=119) No oral intake (n=74)	NR	Induction 59.0%	Primp 49.0%	Eutocic 94.0% Inst 16.0% CS 6.0%	NR	NR
Arthuis et al., 2022	France	All adult women who understood French and gave birth.	n=2135 (39.8; NR) 19 – 45 years	NR	Induction 24.6%	Primip 44.2%	Eutocic 85.6% Inst 17.1% CS 14.3%	Total 36.7%	7.3
Lyngbye et al., 2022	Denmark	Women giving birth to a singleton liveborn child, gestational age 37 to 41.	n= 237 (29.3; 4,3) Nullipara n= 107 Multipara n=130	NR	Induction 51.9%	Primip 45.1%	Eutocic 85.3% Inst 6.3% CS 8.4%	NR	52.0
Leavy et al., 2023	France	Women were included if aged 18 years old or more, spoke French and had given birth to viable and a live-born child	n=123	French 95.9%	Induction 16.6%	Primp 45.5%	Eutocic 73.2% Inst 10.6% CS 16.2%	NR	10.6

Note: m_age= mean age; sd= standard deviation; CS= Cesarean section, including both emergency and elective cesarean section; Inst= Instrumental; Primp= Primiparous; NR=Not Reported. *Labor induction includes augmentation percentages.

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Table 1. Qualitative studies. Sample characteristics.

Author	Country	Inclusion criteria	Sample (m_age; sd) Range age Groups	Nationality Race or Ethnicity	Labor*	Parity	Mode of birth	Birth Plan	Non-Positive Birth Experience (%)
Rönnerhag et al., 2018	Sweden	Women who had given birth in previous 12 months and received care at a labor Ward shortly before and after the birth, speaking Swedish.	n=16 (NR) 23 – 46 years	NR	NR	Primip 37.5%	Eutocic 81.2% Inst 6.3% CS 12.6%	NR	NR
Bringedal Aune, 2019	&Norway	Healthy women, given birth for the first time between pregnancy weeks 37-42, with healthy child, speak Norwegian and had a partner, with vaginal and non-instrumental birth but could have had an epidural or been induced.	n=10 (NR) 24 – 31 years	NR	Induction 20.0%	Primip 100%	Eutocic 100% Inst 0% CS 0%	NR	NR
Pereda-Goikoetxea et al., 2019	Spain	Comprehension of the Spanish and/or Basque language, delivery of a live newborn, pregnancy of 37 weeks or longer, cephalic presentation, 18 years of age or older, written informed consent.	n=43 (34.6; NR) 25 – 43 years	NR	NR	Primip 60.4%	Eutoc 65.1% Inst 23.1% CS 11.6%	NR	NR
Prosen, M., 2019	Slovenia	Women who had given birth in an institutional setting	n=18 (29.3; NR) 20 – 39 years	NR	NR	Primip 44.4%	Eutoc 55.5% Inst 0% CS 44.5 %	NR	NR
Daniels, S., 2020	Sweden	Women who had experienced childbirth during the last 3-20 months.	n=13 (NR) 24 – 37 years	NR	Induction 23.0%	Primip 38.0%	Eutoc 84.6% Inst 0% CS 15.0%	NR	NR
Wiklund et al., 2020	Sweden	Swedish-speaking parents that had given birth to a healthy child and who declared that they had experienced bedside reporting during labour.	n=12 couples (35; 9)	NR	NR	Primip 75.0%	Eutoc 91.6% Inst 8.4% CS 0%	Total 100%	NR
López-Toribio et al. 2021	Spain	Women aged 18 years or older who had given birth at HCB in the previous 12 months.	n=23 20 – 46 years	Spanish 78.0%	Induction 61.0%	Primip 100%	Eutoc 78.0% Inst 9.0 % CS 13.0%	Total 100%	NR
Schantz et al., 2021	France	All women interviewed after delivery had given birth by CS.	284 (31.5; NR) 27 – 36 years	French 67.3%	NR	Primip 62.3%	Eutoc 83.3% Inst 0 % CS 16.8%	NR	13.8
Alba-Rodríguez et al., 2022	Spain	Mothers who wished to collaborate and were willing to share their experiences and feelings being selected.	n=7 (NR)	NR	NR	NR	NR	Total 5.0%	NR

Note: m_age= mean age; sd= standard deviation; Cesarean section, including both emergency and elective cesarean section; Inst= Instrumental; Primp= Primiparous; NR=Not Reported. *Labor induction includes augmentation percentages.

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Author	Country	Inclusion criteria	Sample (m_age; sd) Range age Groups	Nationality Race or Ethnicity	Labor*	Parity	Mode of birth	Birth Plan	Non-Positive Birth Experience (%)
Esteban-Sepúlveda et al., 2022	Spain	Women being 18years or older and to communicate in Spanish or Catalan.	n= 15 (32.5; 7.9) 19 – 40 years	NR	NR	Primip 62.5%	Eutoc 87.5% Inst 0 % CS 12.5%	NR	NR
Huschke, 2022	Ireland	Women pregnant or had given birth in Ireland in the last 12 months	n=23 (NR) 20 – 47 years	Irish 60.9%	NR	Primip 56.5%	NR	NR	NR
Eri et al., 2023	Norway	Primiparous respondents who had given birth in Norway in a specialized obstetric unit.	n=677 (29; NR)	NR	NR	Primip 100%	NR	NR	NR
Pereda-Goikoetxea et al., 2023	Spain	Women being18 years or older, live newborn, cephalic presentation, pregnancy 37 weeks or longer, speaking Spanish or Basque.	n=43 (34.6; 3.6) 25 – 43 years	NR	Induction 44.2%	Primip 60.5%	Eutoc 65.1% Inst 23.3 % CS 11.6%	NR	NR
Širvinskienė et al., 2023	Lithuania	Lithuania as the country of residence, given birth within the last 5 years in Lithuania.	n=373 (31.9; 4.7)	NR	NR	Primip 45.0%	NR	NR	NR
Pereda-Goikoetxea et al., 2024	Spain	Women being18 years or older, live newborn, cephalic presentation, pregnancy 37 weeks or longer, speaking Spanish or Basque.	n=42 (34.6; 3.4)	NR	Induction 42.8%	Primip 59.5%	Eutoc 64.3% Inst 23.8 % CS 11.9%	NR	NR

Note: m_age= mean age; sd= standard deviation; Cesarean section, including both emergency and elective cesarean section; Inst= Instrumental; Primp= Primiparous; NR=Not Reported. *Labor induction includes augmentation percentages.

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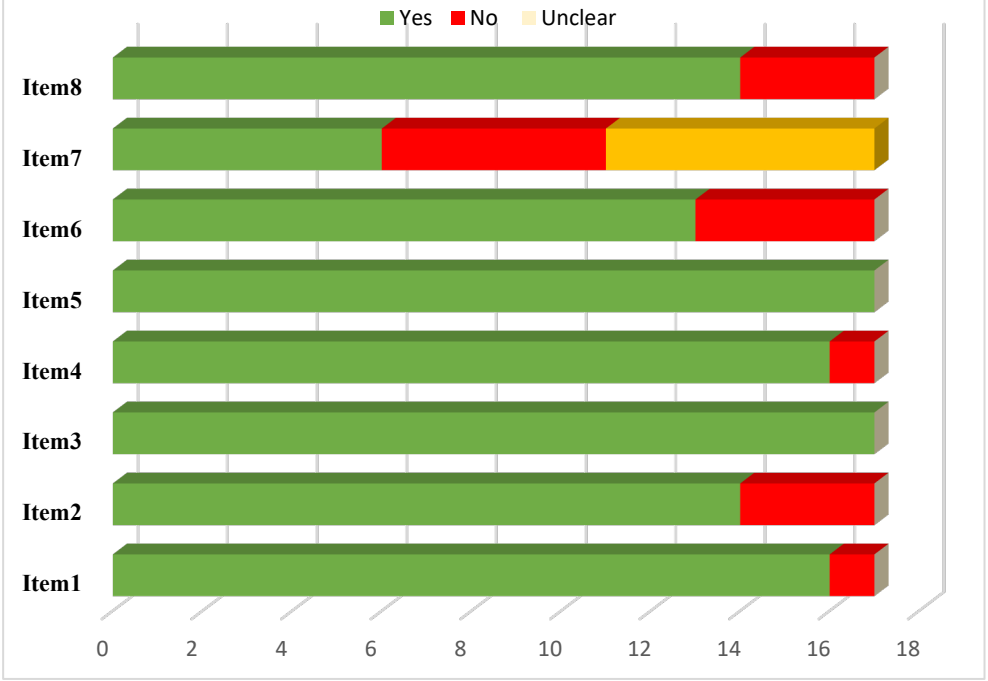
Risk of Bias

Figure 2A illustrates the risk of bias in cross-sectional studies, with 23.5% showing a high risk related to controlling confounding variables and 29.4% presenting uncertainty regarding the validity and reliability of the measures used. Figure 2B depicts the risk of bias in cohort studies, where 50% showed a high-risk concerning group similarity assessment and 75% failed to address incomplete follow-up. Figure 2C presents the risk of bias in qualitative studies, most of which demonstrated high ethical bias, as 93.3% lacked an ethical statement identifying the researcher's cultural or theoretical stance, and 80% did not report the researcher's influence during the investigative process.

Figure 2A
Risk of bias of cross-sectional studies



RoB assessment: IT1.Were the criteria for inclusion in the sample clearly defined; IT2.Were the study subjects and the setting described in detail; IT3.Was the exposure measured in a valid and reliable way? IT4.Were objective, standard criteria used for measurement of the condition; IT5. Were confounding factors identified? IT6.Were strategies to deal with confounding factors stated? IT7. Were the outcomes measured in a valid and reliable way; IT8. Was appropriate statistical analysis used?

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Figure 2B
Risk of bias of cohort studies

Note: IT1. Were the groups similar and recruited from the same population? IT2. Were the exposures measured similarly to assign people to both exposed and unexposed groups? IT3. Was the exposure measured in a valid and reliable way? IT4.Were confounding factors identified? IT5.Were strategies to deal with confounding factors stated? IT6.Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)? IT7. Were the outcomes measured in a valid and reliable way? IT8. Was the follow up time reported and sufficient to be long enough for outcomes to occur? IT9. Was follow up complete, and if not, were the reasons to loss to follow up described and explored? IT10. Were strategies to address incomplete follow up utilized? IT11. Was appropriate statistical analysis used?

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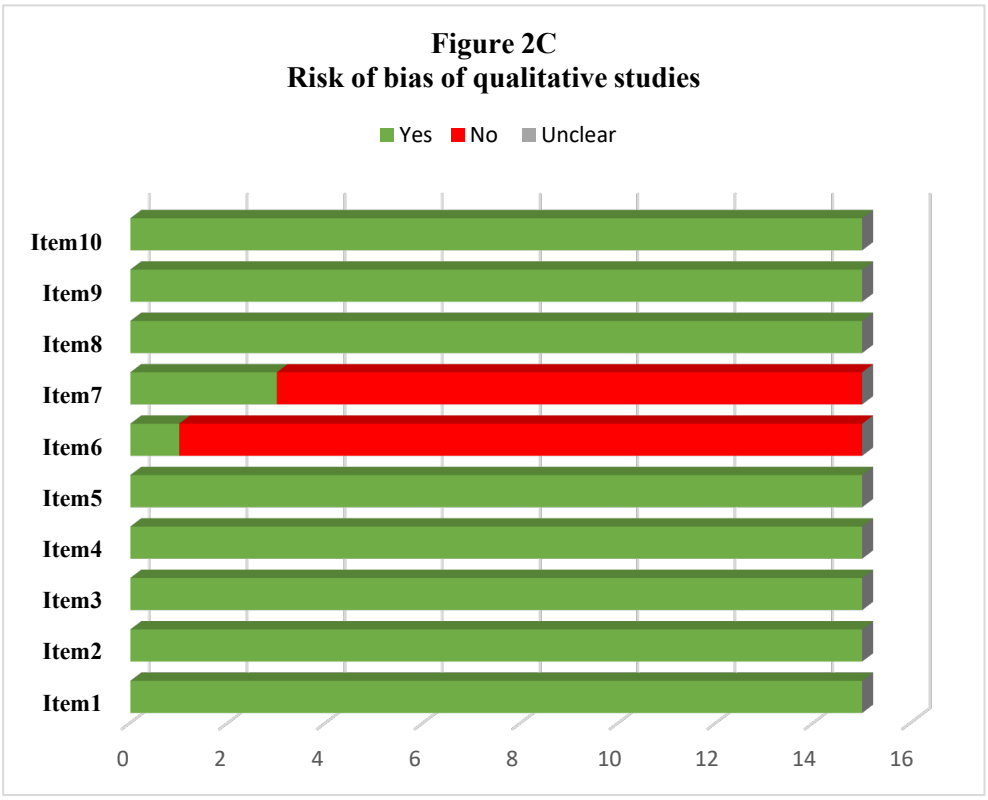

Note: IT1. Is there congruity between the stated philosophical perspective and the research methodology? IT2. Is there congruity between the research methodology and the research question or objectives? IT3. Is there congruity between the research methodology and the methods used to collect data? IT4. Is there congruity between the research methodology and the representation and analysis of data? IT5.Is there congruity between the research methodology and the interpretation of results? IT6.Is there a statement locating the researcher culturally or theoretically? IT7.Is the influence of the researcher on the research, and vice-versa, addressed? IT8.Are participants, and their voices, adequately represented? IT9.Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? IT10.Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Figure 2. Risk of bias assessment.

Women's Experiences

In terms of publication data, most studies exploring the women´s experiences in childbirth were conducted quite recently, between 2016 and 2024. When classifying these experiences by country, the results of cross-sectionals and cohorts studies showed that Spain, with the highest number of publications [31,36,37,53] and Denmark, with the fewest number of publications [49] showed the highest percentage of non-positive birth experiences. On the other hand, Norway [54], Sweden [38], Finland [44] and France [47] showed the lowest percentage of non-positive birth experiences.

Concerning the existence of a birth plan, only 9 studies (22.5%) explicitly reported this aspect [2,28,31,35,37,39,47,55,56]. It should be noted that in qualitative studies, most participants mentioned having a birth plan in their individual interview, but authors did not report the frequency or percentage over the sample. With respect to the birth experience assessment, only 17 studies (42.5%) reported the women´s experience using quantitative data (i.e., percentage). In this regard, it is noted that the authors' results were generally focused on positive experiences, but due to the specific approach of this review on OV, we reported the percentage of non-positive experiences, which

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ranged from 4.5% to 61.3%. Finally, none of the studies included reported information about the Baby Friendly accreditation.

Disrespectful Care During Childbirth in Health Facilities (DACF)

Table 2 shows the findings in relation to birthing practices and disrespectful care. A total of 7 studies (17.5%) involving a total of 50,395 women, explicitly focused on assessing the most common birthing practices in formal facilities and whether women's experiences were abusive. Several practices were common across studies and countries, such as episiotomy, continuous vaginal palpation, artificial rupture of membranes and induction by administration of oxytocin. Regarding disrespectful care, a large and heterogeneous list of actions and/or perceptions was reported. It should be noted that these actions or perceptions were reported as a list by the authors of these studies, but we classified them according to the proposal of Ghimire et al., (2021).

According to this proposal, there are seven categories to classify the disrespectful care. Within each category, we have highlighted the most noteworthy actions as follows; 1) *Physical abuse,* was reported by 2.7% of women [35]; 2) *Non-confidential care,* e.g. lack of respect for intimacy, reported by 19.3% of women [33]; 3) *Discriminatory care*, e.g., no respect and rude manners, reported by 16.3% and 14.2% respectively [33] 4) *Detention in facility*, e.g. forcing legs apart when pushing, reported by 2.8% of women [33] or restricted mobility, reported by 39.5% of women [34]; 5) *Non consented care*, e.g. not giving explicit consent to birth procedures, reported up to 83.4% of women in most procedures ([32,35]), provider did not explain procedures or updates reported between 35.3 % and 45.9% women [31,33,34], or feeling pressured to consent to procedures reported by 16.3% of women [43]. The action of not following the birth plan without giving a reason, reported by 12.6% of women [31] was also included in this category; 6) *Non dignified care*, e.g. inappropriate comments, reported by 24.4% of women, disrespectful expressions by 15.6% of women [33], and being criticized by 34.5% of women [31]; 7) *Abandonment of care,* e.g., feeling insecure, reported by 54.5% of women, feeling difficulty in expressing doubts or fears, by 48%, and not being allowed to be accompanied, by 27.9% [31,34]. Actions such as the lack of support for breastfeeding, reported by 28.8% [33], and undergoing a painful procedure without epidural analgesia, by 65.5% [55] were also included in this category.

Finally, only two studies assessed the impact of experiencing disrespect, unconsented practices and violence during childbirth on women´s health [35,57]. Findings of Leavy et al., (2023) showed that n=10 (8.1%) women reported disrespect after three days of birth, and 13 (10.2%) after two months, with actions such as not relieving pain or inappropriate attitudes and language. Regarding practices, Basso's (2016) [35] findings showed that n=108 (42.9%) of women who underwent episiotomy reported physical problems such as painful recovery n=84 (77.8%), painful sexual relations n=78 (72.2%) and/or urinary incontinence n=45 (41.7%). Regarding disrespect and violence, a total of n=200 (38.5%) women felt disrespected and/or verbally assaulted during childbirth. These women reported psychological effects such as feelings of insecurity n=68 (34.0%), fear n=59 (29.5%), anxiety n=49 (24.5%), depression n=39 (19.5%) and sleep disturbance n=26 (13.0%) (35).

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Table 2. Disrespectful care during childbirth in health facilities (DACF).

Author Country	Sample	Childbirth practices*	Disrespectful/abusive care during childbirth in health facilities (DACF)						
			Physical abuse	Non-confidential care	Discriminatory care	Detention in facility	Non-consented care	Non-dignified care	Abandonment of care
Basso, 2016	MA, General	90.2% Vaginal palpations 73.5% Trichotomy 70.5% Enema 55.6% Amniotomy 68.5% Episiotomy 35.0% Kristeller 31.6% Induction	2.7% physical abuse		38.5% No respect 17.4% Feel offended		76.6% of Episiotomy 83.6% of Kristeller 42.6% of Induction 28.8% of Amniotomy 15.6% of Trichotomy 8.7 % of Enema		
Baranowska et al., 2019	General Poland	48.1% Baby bath 46.1% Presence students 43.2% Bottle feeding baby 40.8% Intravenous canula 36.6% Baby drug administration 32.9% Vaginal examinations 30.5% Episiotomy 29.1% Oxytocin 27.3% Baby examination 27.1% Induction 17.4% Shaving vulva 12.4% Baby vaccination 4.3% Enema	0.5% Being poked	19.3% No respect for intimacy	16.3% Not respect 14.2% Rude manners 8.8% Feeling of being discriminated/stigmatized	2.8% Forced legs apart when pushing 0.8% Legs tied to delivery bed	48.1% Baby bath 46.1% Presence students 43.2% Bottle feeding baby 40.8% Intravenous canula 36.6% Baby drug administration 35.3% Provider did not explain procedures/updates 32.9% Vaginal examination 30.5% Episiotomy 29.1% Oxytocin 27.3% Baby examination 27.1% Induction 17.4% Shaving vulva 12.4% Baby vaccination 4.3% Enema	24.4% Inappropriate comments 20.3% Nonchalant treatment 17.1% No answering 15.6% Disrespectful expressions 10.1% Mocking 6.8% Insulting 4.9% Blackmailing with child's/woman's health	32.6% No access to lactation consultant 31% Undelicate care 28.8% No support in breastfeeding 16.6% No support in dealing depression 13% No access to epidural anesthesia
Mena-Tudela et al., 2020	General Spain	NR	NR	NR	NR	NR	83.4% No consent for procedures 45.9% Provider did not explain procedures/updates 12.9% No respect BP without giving reasons	34.5% Critized 31.4% Nicknames	54.5% Felt insecure 48.0% Difficult to voice doubts, fears, concerns 35.0% No support in postpartum 37.6% No support in breastfeeding 44.4% Unnecessary or painful procedures

Note: BP= Birth Plan; ARM=Artificial rupture membranes; IUC=Intermittent urinary catheterization; IFM=Internal Fetal monitoring; NR=Not reported. *If authors reported that these procedures were performed without consent, they were also stated in the column of Non-consented care.

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Table 2. Disrespectful care during childbirth in health facilities (DACF).

Author	Sample	Childbirth practices*	Disrespectful/abusive care during childbirth in facilities (DACF)						
			Physical abuse	Non-confidential care	Discriminatory care	Detention in facility	Non-consented care	Non-dignified care	Abandonment of care
Mena-Tudela et al., 2021 Spain	General	48.3% Oxytocin 39.3% Episiotomy 36.3% Amniorrhexis 34.3% Drink/food restriction 34.2% Kristeller maneuver 32.1% Newborn examination 31.9% Vaginal palpations 23.6% Cupping glass 21.5% Hamilton maneuver 21% Early umbilical clamp 11.2% Removed placenta 9.1% Apply enemas 7.7% Shaving vulva 10.1% Other procedures	NR	NR	NR	39.5% Restricted mobility	42.1% Provider did not explain procedures/updates 13.6% Bottle feeding baby	NR	36.9% Separated baby without reason 27.9% Not allowed accompanied

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Oelhafen et al., 2021 Switzerland	General	24.8% Amniotomy 20% Induction 12.6% Episiotomy 6.8% Fundal pressure	NR	NR	NR	NR	16.3% of women felt pressure to consent for procedures (episiotomy, induction…)	9.5% Insulting	27% Felt intimidated
Westergren et al., 2021 Sweden	General	63.4% IFM 45.2% Oxytocin 44.5% IUC 41.0% ARM 22.7% Induction 5.2% Episiotomy	NR	NR	NR	NR	NR	NR	65.5% Women undergone painful procedures without epidural analgesia
Leavy et al., 2023 France	General	81.3% Episiotomy	NR	NR	1.6% Provider used language difficult to understand	NR	2.4% Not decision-making	3.3% Inappropriate attitude 0.8% Inappropriate language	5.7% Not consider pain

Note: BP= Birth Plan; ARM=Artificial rupture membranes; IUC=Intermittent urinary catheterization; IFM=Internal Fetal monitoring; CS: Cesarean; NR=Not reported. *If authors reported practices or procedures performed without consent, these were also stated in the column of Non-consented care.

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Discussion

This systematic review included forty studies exploring women's childbirth experiences across fourteen countries in the Schengen area, revealing a broad spectrum of both positive and negative experiences. The findings concerning non-positive experiences contrast with the World Health Organization (WHO) recommendations, which emphasize that a "positive experience of childbirth" is a key outcome for all women, encompassing a clinically and psychologically safe environment supported by compassionate, competent professionals and the presence of an emotional companion. [8,14].

However, the findings of this review indicate that these conditions are not consistently fulfilled, either clinically or psychologically. Regarding the mode of delivery, caesarean section rates frequently surpass the WHO's recommended range of 10% to 15%. While caesarean sections can be lifesaving for both mothers and infants, rates exceeding 10% are not linked to reduced mortality and may lead to long-term physical and psychological complications or disabilities [22,34,58]. Our findings would be in line with data on the 27 EU Member States, which showed that caesarean section rates are over 26%, highlighting the seriousness of this situation [59].

Regarding childbirth practices, the findings revealed that women in labour are often subjected to potentially harmful interventions, such as perineal shaving, enemas, and amniotomy to accelerate spontaneous labour, despite the lack of evidence supporting their effectiveness [17]. Additionally, other routinely applied but non-recommended practices by international organizations such as the WHO— including routine episiotomy during spontaneous vaginal birth and the use of fundal pressure in the second stage—were identified. This interventionist approach conflicts with women's and families' needs, values, and preferences, undermines person-centred care and outcomes, and negatively affects women's childbirth experiences [8,34].

In terms of disrespectful care, the findings showed a wide range of non-positive experiences. Concerns included the absence of privacy, insufficient information, and feelings of insecurity. Additional issues involved not allowing women to have emotional support during childbirth, disregarding the birth plan without medical justification, and providing inadequate support in newborn care. These practices may have a severe impact on women's health and are increasingly recognized as forms of obstetric and gynaecological violence within the European Union [59].

However, this violence can also be psychological, for example, by treating the woman in an infantilizing, paternalistic, authoritarian, demeaning, humiliating manner, with verbal insults, depersonalization, or degradation [60]. Furthermore, some approaches consider the violence as institutional violence that is still invisible due to a variety of factors, but also because health professionals are not aware of this phenomenon, or even refuse to accept its existence [60,61].

Within this context, to promote positive birth experiences and to sensitize professionals to the concept of disrespectful actions, some initiatives should be implemented. First, specific training for health professionals to make them aware of this phenomenon through a gender approach, as violence is an abuse of power by institutions and/or health professionals against women's autonomy [60]. Second, promote effective communication between women and professional's healthcare. This fact is directly related to the patient-centred care model, which entails "treating patients as individuals and as equal partners in the business of healing; it is personalised, coordinated and enabling" (Coulter & Oldham, 2016, p 114). This model takes into account the preferences, values and opinions of women and families, and recognises the ability of the individual to manage and improve their own health [62]. Third, endorsement by health facilities to the Mother and Baby Friendly Birth Facility (MBFBF) initiative, which includes the availability of written policies and guidelines with different criteria to promote respectful care during the childbirth. This initiative offers mothers non-discriminatory policies that allow privacy and choice of companion, do not allow physical, verbal or emotional abuse, do not allow non-evidence-based practices or routines (e.g. routine induction of labour), promote skin-to-skin contact between mother and baby, and provide care at an affordable cost, among other proposals [3,63]. Last, but not least, the birth plan becomes essential to establish an

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individual care, with the focus on the women´s and family preferences, thus enabling women to manage their own health and decide about their childbirth experience.

Limitations and Strengths

This review presents several limitations that should be acknowledged. Only studies conducted in the Schengen area and published in English or Spanish were included, restricting the scope to culturally similar contexts. The analysis was further limited by incomplete reporting on factors such as women's education, employment, companionship during birth, attending professionals, and the existence of a birth plan. Moreover, just one study examined the impact of disrespect on women's mental health, preventing a comprehensive understanding of its physical, mental, and social effects. Some studies also presented a high risk of bias, and variations in methods, instruments, and data collection may affect comparability and reliability. Additionally, the lack of information regarding researchers' cultural or theoretical backgrounds in qualitative studies may have influenced result interpretation.

This review also presents several strengths. It encompassed a wide range of methodological designs, including cross-sectional, cohort, and qualitative studies, offering a comprehensive understanding of childbirth experiences. To the best of our knowledge, it represents the first attempt to classify these experiences according to the criteria of Disrespect and Abuse during Childbirth in Facilities (DACF), enabling the identification of gynaecological violence as a form of harmful practice occurring in some countries and healthcare settings. Finally, the review provides practical recommendations aimed at fostering positive birth experiences and raising professionals' awareness of the concept of obstetric violence.

Conclusions

There is a need to prioritize the physiology of childbirth, reducing unnecessary medical interventions and ensuring continuous physical and emotional support that respects women's preferences, beliefs and values [64]. In this sense, it is essential to move towards a paradigm shift in which women take a leading role in the process and can choose the most appropriate option for themselves and their babies. This is why patient-centred care is the new model to follow, where women are empowered to manage and improve their health by making decisions based on the information provided based on scientific evidence. This requires effective communication between women and health professionals. In this regard, the birth plan is an excellent tool to promote communication and understanding of a woman's preferences [28]. However, familiarity with the birth plan does not absolve professionals of the responsibility to communicate effectively with women and to involve them in shared decision-making throughout the process. Finally, to ensure respectful maternity care, a collaborative effort by administrators, institutions, and professionals is needed so that practices described as disrespectful are identified by the different actors involved and can be eradicated [65]. It is important to keep in mind that violence is the most accepted term to describe disrespect and mistreatment as forms of structural violence that contribute to increasing social and gender inequalities [59,66].

Recommendations for Future Research

The findings of this review hold significant implications for clinical practice, maternity care, and future research. Formal healthcare facilities should adopt strategies to minimize disrespectful care and enhance the birth experience, emphasizing respect for birth plans and effective communication between health professionals and women. In this context, implementing the Baby Friendly Initiative is essential, as its standards provide comprehensive policies and guidelines for administrators, facilities, and professionals to ensure respectful and inclusive care in both maternity and neonatal services.

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Furthermore, future research should prioritize the evaluation of women's perceptions of abusive treatment using validated instruments specifically designed for this purpose [67], as well as the incorporation of DACF criteria [10] to classify birth experiences and deepen understanding of women's feelings and perceptions within formal healthcare settings. Lastly, more longitudinal studies are needed to assess the physical, psychological, and social outcomes of childbirth experiences, and greater attention should be given to methodological and demographic reporting to enhance the comparability and interpretation of results across countries.

Relevance for Clinical Practice

The review revealed wide variation in birth outcomes, care practices, and satisfaction, emphasizing the importance of empathetic, patient-centred care. Training in communication, cultural sensitivity, and ethics is key to addressing disrespectful practices and improving trust and quality. Nurses can support initiatives like Baby Friendly, promote informed consent and autonomy, and help implement evidence-based protocols to enhance maternal and neonatal outcomes and ensure positive birth experiences.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org.

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Ethics statement: This systematic review does not require approval from an ethics committee, as it does not involve human experimentation.

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