Comparative Effectiveness Review Disposition of Comments Report

Title: *Respectful Maternity Care: Dissemination and Implementation of Perinatal Safety Culture To Improve Equitable Maternal Healthcare Delivery and Outcomes*

Draft report available for public comment from July 17, 2023, to August 21, 2023.

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Comments to Draft Report

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This document includes the responses by the authors of the report to comments that were submitted for this draft report. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Peer Review and Public Comments and Author Response

Commentator & Affiliation	Section	Comment	Response
Public Comment (PC) 1	General	Thank you for your ongoing work on this. Having a set of clear practice guidelines that are rooted in both the ART and Science of Maternity care is essential to improve outcomes and experiences. I have developed a set of WISDOM PEARLS for Clinical Practice which yield optimal outcomes for patients AND the providers who serve them. There is a national version that I have created with my professional organization. Your report has the potential to highlight and interrupt this pattern. Thank you for your hard work.	Thank you for sharing the Pearls.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer (PR) 4	Main Text General	As was echoed throughout the document, I think it is imperative that the emphasis is not on the efficacy/effectiveness of RMC. Rather the emphasis (due to the findings of the search itself) can and should be on definitions, measurement, and implementation. Even asking the question of whether RMC is effective seems odd --- as I do not believe we need evidence that birthing people should receive care that is free of abuse and centers respect. The title of the document is about dissemination and implementation of RMC. I am curious whether the authors would consider a focus on that KQ and eliminate the effectiveness KQ. Specifically, even if RMC does not improve health outcomes, its implementation still remains an imperative. Examples of areas this could be edited/clarified include: 1. Page 10: main point 1 - "it lacks…evidence of effectiveness" 2. Page 12: future research needs – "this information should serve as a guide to…promote research to evaluate whether widespread implementation improves health outcomes" Ultimately, I am concerned that KQ2 and KQ3 are not clinically meaningful, because even in the absence of data pertaining to effectiveness, the core concepts of RMC are foundational to quality maternal care.	This review aimed to define and measure RMC and the absence of RMC, described as disrespect or abuse, during childbirth and examine effectiveness of strategies on maternal and infant outcomes, and the effectiveness of strategies to implement RMC to improve health outcomes as part of a federal initiative to improve person-centered and equitable care for birthing persons. Please see methods section regarding details on scope and methods, which were determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot delete KQ2 and KQ3.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer (PR) 4 (cont'd)	Main Text General (cont'd)	(comment above)	This is further delineated in the Future Research Needs section (ES-3): When literature review and synthesis does not result in strong evidence about how a particular intervention impacts outcomes, it may be common to conclude that standard care should not be challenged or modified. We caution against this conclusion and recommend that readers focus on this review's findings revealing longstanding and multidisciplinary research on the concept of RMC to catalyze wider instrument development and promote careful consideration of future work to define and test the impact of strategies to deliver RMC.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 2	General	Report is clinically meaningful, in that it addresses a topic of urgent importance both as an end in itself (respectful maternity care) and of relevance to health outcomes for women and infants. However, in that 1) there is no consensus definition of RMC and 2) no studies addressed the impact of RMC on outcomes raises questions about what clinicians or policy makers should do beyond advancing further research. This is particularly strange because key elements of RMC (e.g., dignity, respect for autonomy) are in fact basic to the ethical conduct of medicine (obstetrical and otherwise) and should be advanced regardless of whether they affect these outcomes.	We highlight this issue in the Future Research Needs and Opportunities section of the Executive Summary (page ES-3); Purpose section of the Introduction (p. 2); and the Key Findings (p. 44), Implications (p. 45-47), Limitations of the Evidence (p. 48), and Conclusions (p. 49) sections of the Full Report

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 2	General	What is also somewhat strange in this report is the near absence of any mention of professional OB/GYN societies, given that it is toward these practitioners primarity (though not exclusively) that recommendations might be directed. Has ACOG made no statements/had no role in efforts to improve maternity care? What about the evolution of ethics documents addressing coerced intervention? They are mentioned only once in the text, even as other (nursing, public health) organizations are prominently portrayed. If this document is to be useful to clinicians (in obstetrics) or health policy leaders, it would seem appropriate to foreground their efforts (or frame productively lack thereof). Otherwise it may be understood as an "us vs. them" which is unlikely to have the desired impact. A final comment is that the legal landscape has changed dramatically and given constraints on obstetric practice and procedures that may end a pregnancy RMC is in peril. The absence of any mention of the post-Dobbs landscape fails to attend to the current reality. I note that COVID was mentioned; thus contemporary context seems within purview.	We added additional references and program descriptions for context: - Introduction section 1.1, page 2 (AIM text, reference: Alliance for Innovation on Maternal Health https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim) - Discussion 4.4, page 43 ("*In the U.S., there is an increasing awareness*…", references: Alliance for Innovation on Maternal Health https://saferbirth.org/psbs/obstetric-hemorrhage/ and https://saferbirth.org/psbs/severe-hypertension-in-pregnancy/)

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 2 (cont'd)	General (cont'd)	(comment above)	- Discussion 4.4, page 44 ("*AIM program bundles*…", Alliance for Innovation on Maternal Health https://saferbirth.org/psbs/obstetric-hemorrhage/ and https://saferbirth.org/psbs/severe-hypertension-in-pregnancy/) We also added this point to the discussion (p.45) regarding post-Dobbs: *Recent changes in the post-Dobbs legal landscape have led to constraints on obstetric practice, which may further affect where and how maternity care is delivered and experienced.*

Commentator & Affiliation	Section	Comment	Response
PR 5	General	One thing I think would have made this report stronger is including the prenatal/antepartum period as part of the target time period/population. The impacts of disrespectful maternity care are not limited to the intrapartum and postpartum periods. You can't fully answer the key questions about effectiveness of RMC on maternal and infant health and RMC strategies (KQs 2-4) without including the prenatal period. Disrespectful care can lead to delayed or missed diagnoses, delayed referral to specialized care, and inadequate management of pre-existing and pregnancy-related conditions, so measurement of respectful maternity care interventions and their effectiveness would need to include this period.	While we acknowledge that there are opportunities for the delivery and receipt of both disrespectful and respectful care throughout the prenatal period, this review focuses on RMC during labor and delivery, and immediately postpartum, in an effort to concentrate on areas for future intrapartum research. This decision was determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot change the target time period.
PC 2	General	I encourage you to start simultaneously looking at solutions/interventions that improve respectful maternity care experiences as you clarify measures. We need to measure these experiences since that will improve our ability to hold systems and individuals accountable but we also need to ensure we have mechanisms for shifting care towards more respectful, person-based care. We need to do better now/faster.	Implementation issues addressed in the discussion (section 4.4, page 46).

Commentator & Affiliation	Section	Comment	Response
PC 3	General	Clarifying the ways in which concepts like obstetric racism factor into RMC or are complementary would be helpful.	Please see our text highlighting this important issue in the following sections: • ES: noted anti-racism as part of rights-based frameworks in Future Research Needs • Introduction: Called out dismissal as a racism-related driver, paragraph 1, page 1. • Results: noted approaches to address obstetric racism, and incorporate anti-racism concepts, in section 3.2, 3.2.1, 3.2.2; the PREM-OB tool in Tables 4 and 5; analyses in 3.3.3.1.2.2 and 3.3.3.2.3.1

Commentator & Affiliation	Section	Comment	Response
PC 3 (cont'd)	General (cont'd)	(comment above)	• Discussion: note the need to recognize conditions that lead to obstetric racism in 4.1, including tailored tools such as PREM-OB; the presence of racism in U.S. settings in 4.3; and awareness of need to eliminate racism in 4.4.

Commentator & Affiliation	Section	Comment	Response
PR 5	General	While inequities in care, and racism and discrimination are mentioned in this report as components of disrespectful care, the one tool that measures obstetric racism was not included as part of this review (not even among the excluded studies). It is not clear why it is not even mentioned since that tool addresses themes of the rights-based framework that are not as directly addressed with other tools. (White VanGompel E, Lai JS, Davis DA, Carlock F, Camara TL, Taylor B, Clary C, McCorkle-Jamieson AM, McKenzie-Sampson S, Gay C, Armijo A, Lapeyrolerie L, Singh L, Scott KA. Psychometric validation of a patient-reported experience measure of obstetric racism© (The PREM-OB Scale™ suite). Birth. 2022 Sep;49(3):514-525. doi: 10.1111/birt.12622. Epub 2022 Mar 17. PMID: 35301757; PMCID: PMC9544169.)	The suggested article was reviewed during manual searches as supporting the Contextual Question and is referenced in section 3.2.1 just above Table 2, in recognition of issues of obstetric racism/violence. This specific tool was reviewed for KQ1 and has been incorporated in the section on tools focused on childbirth or not directly focused on RMC, as well as in the discussion.
PR 1	General	This is an excellent report that was extremely well thought through. Very minor issues. My one suggestion is to address the element of validating (at least in the US) across minoritized populations. Not sure how generalizable studies of low and middle income countries are to our minoritized populations as we fact a 400 + year of structural and systemic racism.	Issues of implementation, validation, and applicability are addressed in discussion section 4.2.

Commentator & Affiliation	Section	Comment	Response
PR 5	General	It is also noted that other Patient-Reported Experience Measure (PREM) tools were not included in this review, although PREMs are currently being used to measure respectful care as part of maternity care quality improvement initiatives. A matter of fact, there isn't much discussion about how these tools that were evaluated are already being used, and how they have been adapted for use as part of many statewide birth equity and respectful care initiatives. Any further evaluation of tools to measure respectful care should include these tools. The discussion would be improved by acknowledging this current use of PREMs in addition to the RMC tools evaluated in this review. Also see recent review of these tools - Bull C, Carrandi A, Slavin V, Teede H, Callander EJ. Development, woman-centricity and psychometric properties of maternity patient-reported experience measures (PREMs): A systematic review. Am J Obstet Gynecol MFM. 2023 Jul 28:101102. doi: 10.1016/j.ajogmf.2023.101102. Epub ahead of print. PMID: 37517609.	Patient centered and patient reported outcomes were considered in our scope (see PICOTS table). We appreciate the additional context for PREMs; however, the study suggested does not meet inclusion criteria for this review. Notably, many of the tools cited in the review are already included for KQ1 and are within scope (see Table 2 and Appendix Table C-1).

Commentator & Affiliation	Section	Comment	Response
PR 5 (cont'd)	General (cont'd)	(comment above)	PREM tools are likely a promising metric for future evaluation of RMC. We have added text addressing the need for more tailored tools in the final paragraph of Discussion section 4.1.: A tool such as the PREM-OB Scale™ is one example of a tool that is tailored to better capture birthing experiences (specifically, obstetric racism and poor outcomes) among Black birthing people,[101] and signals the need for tailored measures that capture the lived experiences of specific populations most at risk for disrespect.
PC 5	ES Abstract	Suggest incorporating into the Conclusions paragraph of the ABSTRACT considerations discussed later in the paper (e.g. on page 12, first paragraph under Future Research Needs and Opportunities), as they are important to contextualize RMC as something we should strive for, even if literature review and synthesis does not result in strong evidence about how a particular intervention impacts outcomes. If we don't underline this early and often, those who are resistant to RMC may use the conclusions to not incorporate it into their practice.	The conclusion is a brief summary of study findings. This issue is addressed in the ES and the discussion but we are limited to high level summary of evidence points for the abstract itself.

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PC 3	ES Main Points	In the Executive Summary of the draft report, respectful maternity care is described as "commonsense" - but the lack of universal practice and accountability suggests that the concept is not yet fully recognized or valued as an essential part of ethical, effective healthcare. Further, please consider replacing that descriptor with "rights-based" to emphasize that this concept is not only about eliminating harms, but also providing assurances for people to be safe and well. The final bullet point of the Executive Summary (on page 10) is currently phrased, "Before implementation, goals for RMC must include further testing..." Consider replacing this opening statement with "Alongside the urgent need to implement respectful maternity care, the goals for RMC must include further testing..." Also, please consider adding a bullet point to offer, "To further operationalize respectful maternity care, qualitative research with birthing people, companions, and health care team members is needed to describe their perspectives on respectful maternity care and its components."	We changed the wording for accuracy and clarity to "rational approach" We agree with the need to emphasize these assurances. Our two overarching frameworks include both disrespect and abuse and rights-based. Final main point bullet edited using the suggested language ("Alongside…"). This concept was added to the ES future research needs section: To further operationalize respectful maternity care, qualitative research would help elucidate perspectives of those who are pregnant or postpartum, companions, and health care team members on respectful maternity care and its components.

Commentator & Affiliation	Section	Comment	Response
PR 4	ES Introduction	On page 2, under the purpose and scope of the review, the first sentence is difficult to follow. Specifically, the phrase “including disrespect or abuse during childbirth” seems out of place with the rest of the sentence. In the last sentence of this same section (on page 2), I am curious whether “and disrespectful” could be omitted, as it seems to be the inverse of the aforementioned respectful care.	We have revised the text for clarity as suggested, stating, *“This systematic review synthesizes research for defining and measuring RMC and identifying the absence of RMC, described as disrespect or abuse, during childbirth.”*

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PR 2	ES Introduction	The review team describes the following two frameworks for respectful maternity care. These are essential elements of maternity care; however, might there be an opportunity to aspire to a positive experience of birth, rather than a lack of negative experience? The 2018 "WHO recommendations: intrapartum care for a positive childbirth experience" offers the following definition of a Positive childbirth experience: Women want a positive childbirth experience that fulfils or exceeds their prior personal and sociocultural beliefs and expectations. This includes giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from birth companion(s) and kind, technically competent clinical staff. Most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision making, even when medical interventions are needed or wanted. They note in the document, "The focus of the global agenda has also gradually expanded beyond the survival of women and their babies, to also ensuring that they thrive and achieve their full potential for health and well-being." This framing resonates with Dr. Joia Crear Perry's call to action at the 2018 Black Mamas Matter conference: "We spend a lot of time asking what it would look like to have #moms survive #pregnancy? But what does it look like to thrive? When are we going to want #mothers to have a joyous #birth?" I fully recognize that this is a systematic review of definitions of respectful maternity care, and that the instruments that are reviewed focus on absence of mistreatment. However, given that a positive birth experience has been elevated by the WHO as a reasonable goal for low resource settings, I wonder whether we might similarly aspire to the presence of joy, rather than the absence of abuse, as the goal for maternity care. I also wonder about addressing the contextual elements that enable respectful care earlier in the document. This review focuses on patient experience measures for care; however, patient experience is a function of processes and structures within birthing facilities. These factors are explicitly named in the WHO report (Table 3.1, Main resource requirements for respectful maternity care (RMC), page 22), including requirements for staff, training, supplies, equipment, infrastructure, and supervision and monitoring. By framing the definition of respectful maternity care in terms of patient experience, without holding health facilities accountable for human working conditions and safe staffing ratios, I worry that we imply that "bad clinicians" are the root cause of disrespectful care, rather than a just culture framing that considers systems-level drivers. This is especially relevant given the moral injury that health care teams have endured during the COVID pandemic, with resulting burnout and compassion fatigue(3).	We appreciate this perspective. We used the language and categories from existing RMC frameworks to guide our synthesis. This decision was determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot change the framework that we used. We use our conceptual diagram (Figure 4) to "map" the complexities of these interactions between societal, health system, clinician, and patient levels, centered around the patient experience.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 1	ES Background and Purpose	In the executive summary “Background and Purpose” (pg. 10), this line could be reworded, since as written, it reads like disrespect and abuse during childbirth are components of RMC: “This systematic review summarizes research for defining and measuring respectful maternity care (RMC), including disrespect or abuse during childbirth…” Perhaps say instead, “This systematic review summarized research for defining and measuring respectful maternity care (RMC) and identifying the absence of RMC in the form of disrespect or abuse during childbirth. It also examines the effectiveness of strategies for implementing RMC on health outcomes, particularly for populations at risk for health disparities.” This same sentence structure is observed in the first sentence of section 1.2 on pg. 16 Also, the line following the one above says, “This effort is part of an initiative to improve person-centered and equitable care for birthing persons and incorporate pregnant and postpartum individuals and their identified support networks as part of the multidisciplinary care team.” – might be good here to briefly describe that initiative.	We modified the text, per suggestion in both locations. Additional details and background on the AIM program provided for context in the final paragraph of Introduction Section 1.1.
TEP Reviewer 1	ES Results	In the executive summary “Results” section, for the sentence, “Thirty-five studies were included across all key questions, including the contextual question.” - I’d recommend amending slightly to briefly detail those key questions and the contextual question for the reader	Given space constraints, the ES is intended to be a high-level summary of key points. Additional details are described in the full report.

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PC 6	ES Results	While the authors point out that a standard definition and measure for RMC are lacking, they use this as a jumping off point to ignite future research. I appreciate that the authors highlight that, despite the lack of evidence for interventions to increase RMC in high-income settings, they argue that RMC is an essential component of quality of care that warrants urgent investigation beyond description. However, in the executive summary under the Results I found the term U.S.-relevant to be confusing.	We have changed this to "settings relevant to clinical practice in the U.S.," where applicable. Also, please see Methods section 2.3 for clarification on selection of countries categorized as "very high" on the 2019 Human Development Index (United Nations Development Programme. Human development report 2019. New York, NY: United Nations Development Programme; 2019. http://hdr.undp.org/sites/default/files/hdr2019.pdf).

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PC 5	ES Future Research Needs	Is there a difference between birthing and laboring person? Is this definition meant to also include pregnant and postpartum people? We have found that the use of birthing person to be confusing to clinicians who make the association with this only being applicable to people who are in the act of giving birth vs. pregnant postpartum people. We typically use the term used in any given study to describe participants and then use pregnant and postpartum people in our content, but absolutely acknowledge the complexity in this space.	Among the non-gendered terms emerging in this scholarship, we use the term *birthing person* to characterize the study population, which includes those who are postpartum, and acknowledge the current linguistic complexity and importance of centering inclusion in this space. For consistency, we synchronized the text to "birthing person/s."
PC 3	ES Future Research Needs	On page 12, reference to the 2022 AIM Postpartum Discharge Transition change package could be added (https://saferbirth.org/wp-content/uploads/PPDT-Change-Package-Final_5.8.23.pdf), since that document includes the national level recommendation of "leading with resources" for all birthing families to proactively address their intrapartum needs.	We did not add this additional reference since AIM is cited and described throughout the report.

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PR 2	ES Future Research Needs	Page 12, lines 12-14 – "In the U.S., there is an increasing awareness of maternal health disparities and urgent calls for changes in healthcare delivery that improve safety, eliminate racism, and improve health outcomes for all birthing people." Consider noting that in the US, even the most privileged individuals experience worse outcomes than birthing people in other high-income countries. No one is thriving in the current environment.	The ES provides a high-level summary of the purpose of the review and the evidence. The first two sentences of the ES background/purpose highlight that the U.S. has worse severe maternal morbidity and mortality than all comparable countries, with the greatest impact on Black women, to highlight how issues inform the need for RMC. The main report provides more comprehensive background.

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PR 2	ES Future Research Needs	Page 12, lines 24-27 – "When literature review and synthesis does not result in strong evidence about how a particular intervention impacts outcomes, it may be common to conclude that standard care should not be challenged or modified. We caution against this conclusion." Agree – and might elaborate, citing the 1946 WHO constitution: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."	The review of definitions and frameworks is not meant to be exhaustive, but provides context for how studies frame RMC to evaluate the impact of their interventions across diverse populations. Studies cited in **Tables 2** and **3** provide additional references for the application of these frameworks in different countries and settings (see **Appendix C-4**). We recognize there may be additional frameworks, details, or definitions outside this data set and those may be included as measures of RMC in future research.

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TEP Reviewer 2	ES Future Research Needs, Box 1	I also found the proposed definition of RMC (Box 1) to be overly determined. How the authors arrived at this definition is not described well. Is this a consensus definition? What was the process that led to it? Has it been validated? By whom? By patients themselves?	We have described our approach in the Discussion section 4.4. The definition incorporated input from experts, including KI and TEP members, and reflected our synthesis of an extensive body of available literature describing critical components of RMC. We have added text noting that there is a future need to incorporate patient input and validate this definition.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 2 (cont'd	ES Future Research Needs, Box 1 (cont'd)	(comment cont'd) Why do the authors keep mentioning the absence of any mention of coordinated care, but not the absence of connectedness of patients to doctors (this is different than shared decision making) or to their babies?	Care coordination is a component of AHRQ's TeamSTEPPS, and was a specific request from Office of Extramural Research, Education and Priority Populations. We frame this in the discussion and in results section 3.2.2: While care coordination is described as one of AHRQ program priorities, these frameworks do not directly define teamwork or communication as an essential component of RMC. However, the concept of communication is well-represented through elements of shared-decision making and the role of the patient in care decisions.

Commentator & Affiliation	Section	Comment	Response
PR 4	ES Future Research Needs, Box 1	, I am curious whether Box 1's reference to "laboring person" needs to be so specific. It seems as if RMC can (and perhaps should) apply to broader perinatal care cascade.	This review was limited to labor and delivery and postpartum. We agree that this definition could be applied more broadly. Additional context for the population was added to methods section in the ES and methods section 2.3: Among the nongendered terms emerging in this scholarship, we use the term *birthing person* to characterize the study population, which includes those who are postpartum, and acknowledge the current linguistic complexity and importance of centering inclusion in this space. Therefore we changed the language in Box 1 to "birthing people."

Commentator & Affiliation	Section	Comment	Response
PC 3	ES Future Research Needs, Box 1	In Box 1 point #3, consider adding the phrase "...that eliminates harms and provides assurances for holistic health." Also in Box 1, consider adding point #5, "Establishes a meaningful system of accountability as part of an ongoing cycle toward respectful care." This would build on the summary of Green et al. 2021, which is cited in the draft report (Reference #112 on page F-8)	As described in section 3.2, CQ results: The review of definitions and frameworks is not meant to be exhaustive, but provides context for how studies frame RMC to evaluate the impact of their interventions across diverse populations. We recognize there may be additional frameworks, details, or definitions outside this data set and those may be included as measures of RMC in future research and additional ideas that could contribute to future definition versions.

Commentator & Affiliation	Section	Comment	Response
PR 2	ES Future Research Needs, Box 1	Page 13, Box 1: "Communication and shared-decision making centered around the laboring person" Consider reframing as "birthing person" to make clear that respectful maternity care does not end when the cord is clamped, but includes postnatal care.	This is described in our methods (ES and section 2.3): Among the nongendered terms emerging in this scholarship, we use the term *birthing person* to characterize the study population, which includes those who are postpartum, and acknowledge the current linguistic complexity and importance of centering inclusion in this space. For consistency, we synchronized the text to "birthing person/s."
		Page 13, Box 1: "Safety (safe care environment)" Consider elaborating here – from a biomedical standpoint, safety is often framed in terms of process measures, such as "right medication, right patient, right time." However, as Lydon et al4 have argued: Current efforts to support equitable patient participation in patient safety programmes will come up short if safety experts continue to define safety using a limited, traditional biomedical model, and ignore the central role of emotional safety. Safety is a feeling, in addition to a process, and respectful care should incorporate both aspects.	The concept of safety is addressed in multiple frameworks and tools, highlighted conceptually in Table 3 and 4 and considered a standard element of RMC (Box 1). The definition distills each of these concepts into bullet points with further explanation in the surrounding text, section 4.1.

Commentator & Affiliation	Section	Comment	Response
PC 5	Introduction 1.1 Background	Should there be a caveat here that while perceived disrespectful care may be a contributing factor to those who choose out of hospital births, there isn't evidence out of hospital births improves RMC or other outcomes? Additionally, page 22 of the PDF states that home birth settings are excluded from the analysis in the report. With that in mind, is this section relevant or should it be mentioned earlier that, while RMC is a factor for choice of out of hospital births, home births are excluded from the analysis?	Out of hospital births were not within the scope of this review, which was determined a priori. We addressed in the background section 1.1 and in this context: A large uptick in community (out of hospital) births within many U.S. communities may reflect patients who did not feel safe or respected in hospitals, or chose community birth because their support networks were not permitted in hospitals during the pandemic.
PR 5	Introduction 1.1 Background	Recommend including American Indian/Alaskan Natives when referring to groups with the greatest impact of severe maternal morbidity and death. AI/AN women have rates comparable to Black women, and even higher in some states (Fleszar LG, Bryant AS, Johnson CO, Blacker BF, Aravkin A, Baumann M, Dwyer-Lindgren L, Kelly YO, Maass K, Zheng P, Roth GA. Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States. JAMA. 2023 Jul 3;330(1):52-61. doi: 10.1001/jama.2023.9043. PMID: 37395772; PMCID: PMC10318476.)	References updated to capture recent population data in the second paragraph, section 1.1. We included text to highlight that disparities were reported for Alaska Native/American Indian populations (page 1).
PR 5	Introduction 1.1 Background	Recommend updating to the latest maternal mortality rate data for 2021 (Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023. DOI:	We have updated the text with the most recent rate data using the Hoyert 2023 reference.

Commentator & Affiliation	Section	Comment	Response
PR 2	Introduction 1.1 Background	(Near bottom of page 1 of main text) “These factors signal the need for careful consideration of respectful care for all childbearing individuals, with particular attention to racial inequity and disadvantaged groups, to inform culturally competent care as well as safe maternity care systems” Consider “culturally humble care5,” rather than “culturally competent care.”	We acknowledge the linguistic complexity in this space and have aimed to use consistent terminology throughout when describing respectful care for these groups.
PR 2	Introduction 1.1 Background	(Toward top of page 2): “Careful attention to key components of RMC is important during labor and delivery, when women may experience pain or insecurity and are particularly vulnerable to experiences of disrespect or abuse.” Consider expanding to “Careful attention to key components of RMC is important during the maternity facility stay”	We acknowledge the complexity in this space and have aimed to use consistent terminology throughout. The “timing” for when the RMC intervention is considered is defined in our methods (section 2.1, 2.3, and PICOTs table) and guided by the KQs. We have not used the term “maternity facility stay” as part of the predetermined language to define our inclusion criteria but recognize that this period of time can be described in various ways.

Commentator & Affiliation	Section	Comment	Response
PR 2	Introduction 1.1 Background	"Implementing evidence-based practices39 to train those delivering maternity care may help reduce variations in care and promote effective and respectful delivery of care, while discouraging ineffective, inequitable, unsafe, or potentially harmful interventions or behavior." As noted above regarding burnout and moral injury, focusing explicitly on training suggests that RMC is purely a function of health team member behavior, and does not address the impact of staffing, resources, secondary trauma, and moral injury on team member capacity to engage in respectful care. This is addressed later in the document (page 59, lines 32-37); suggest introducing this concept here as well.	We recognize the complexity of RMC and do not suggest that RMC is purely a function of the health care team. We highlight this in our conceptual diagram and related description (Figure 4, section 3.2.2): Our conceptual diagram represents the levels of influence that impact the continuum of the respectful maternity care experience and the relationships among them. The arc of RMC incorporates influences at societal, health system, clinician, and patient levels.
TEP Reviewer 2	Introduction 1.2 Purpose	Target population (pregnant adolescents and adults, admitted through labor through discharge) and audience (patients, clinicians, health system leaders, policymakers, among others) are both explicitly defined; however it is unclear why adolescents are parsed out of childbearing people generally given that questions specific to adolescent populations (who are likely exposed to more trauma) are not explicitly addressed. Key questions are appropriate and explicitly stated.	Part of our established methods is to define the population. Our aim was to be clear that the pregnant population also includes adolescents who are pregnant. All outcomes were considered for all included populations. No change made.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 2	Methods 2.1	In section 2.1 the following sentence states: “Contextual questions are not reviewed using systematic review methodology.” Here it would be good to briefly state which methodology was used for reviewing the contextual question, instead.	Contextual questions are not abstracted and quality rated using formal systematic review processes, such as risk of bias or strength of evidence. This information may be found in section 2.3 (“Contextual questions are not reviewed using systematic review methodology, such as risk of bias assessment or strength of evidence ratings, but are used to help inform the report”), as well as in the Appendix section 2.1.
PR 5	Methods 2.1	KQs and CQs are based on “AIM program priorities”, but there is no mention of what those priorities are or what “AIM” is. Recommend spelling out Alliance for Innovation on Maternal Health on first mention of AIM and include a brief description of the program and its priorities.	Thank you; we have updated the acronym at first mention (section 1.1). We included additional context in the final paragraph of section 1.1.

Commentator & Affiliation	Section	Comment	Response
PR 2	Methods 2.1	"While we acknowledge that there are opportunities for the delivery and receipt of both disrespectful and respectful care throughout the prenatal period, this review focuses on RMC during labor and delivery, and immediately postpartum…" How was immediately postpartum defined? First hour? Duration of maternity stay?	The population includes 'pregnant adolescents and adults admitted for labor through discharge after delivery' – please see Table 1, PICOTS: Inclusion and exclusion criteria.
PR 5	Methods 2.1	Regarding exclusion of the prenatal period, if the goal is to measure and understand the role of RMC for improving patient experience and maternal and infant health outcomes, the prenatal period must be included (see also comment above under general comments). I do not think this exclusion is justifiable, and future research efforts will also need to include care provided during pregnancy.	This decision was determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot change the time period that we used. We acknowledge this potential limitation in section 2.1 and agree that future research could look evaluate RMC during the prenatal period.

Commentator & Affiliation	Section	Comment	Response
PR 5	Methods 2.1	More work needs to be done to measure RMC during the prenatal period, but there has been some work done to develop tools for this period, and this should be noted in the report. (see also Development of the person-centered prenatal care scale for people of color. Afulani PA, Altman MR, Castillo E, Bernal N, Jones L, Camara TL, Carrasco Z, Williams S, Sudhinaraset M, Kuppermann M. Am J Obstet Gynecol. 2021 Oct;225(4):427.e1-427.e13. doi: 10.1016/j.ajog.2021.04.216. Epub 2021 Apr 20.)	This paper was identified in our search but did not meet eligibility criteria, as the scale is focused on prenatal care rather than the labor and delivery experience. Afulani 2021 is listed in the excluded studies section of the Appendix.
TEP Reviewer 2	Methods 2.1	They are justified, but perhaps not well enough. I am concerned that a paper that speaks to "respectful maternity care" but is limited only to the peripartum period is potentially misleading. Continuity has long been hightlighed as important to patients -- feeling known, connected to providers throughout the pregnancy process. To snip off this bit seems to ignore what women/childbearing people themselves have been emphasizing. More needs to be said about how limiting the analysis in this way is justified. Are periods outside of this timeframe outside of the "respectful maternity care" context (I would think not) or just not addressed here?	This decision was determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot change the time period that we used. We acknowledge this potential limitation in section 2.1 and agree that future research could look evaluate RMC during the prenatal period.

Commentator & Affiliation	Section	Comment	Response
PR 4	Methods 2.1.2 KQs	Under section 2.1.2 KQ2, consider rephrasing “disadvantaged” pregnant persons to use more person-centered and empowering language.	Thank you. We have noted below the Key Questions that this term is used by Cochrane in their PROGRESS-Plus framework, and as such we use this term as reported in the framework. We acknowledge the importance of centering inclusion in this space in the first paragraph of Section 2.3.

Commentator & Affiliation	Section	Comment	Response
PR 5	Methods 2.1.2 KQs	Would recommend considering different terminology other than “disadvantaged pregnant persons”. “Disadvantaged pregnant persons” puts the focus on the patient as if they are deprived, impoverished or, needy, instead of the focus being on the system and/or individuals who may discriminate against them. How about “pregnant persons with characteristics associated with disadvantage”, or “groups who may experience discrimination” or “pregnant persons who may experience discrimination” with the footnote describing the PROGRESS acronym characteristics?	We cannot modify the KQs as they were determined a priori but have modified the wording in recognition of this issue. We have included Cochrane’s PROGRESS-Plus framework definition of *disadvantaged pregnant people* as those who may experience discrimination due to geography, race/ethnicity, age, disability, language, education, SES, etc. or other characteristics associated with disadvantage. As such, we use this term as reported in the framework. We acknowledge the importance of centering inclusion in this space in the first paragraph of Section 2.3.

Commentator & Affiliation	Section	Comment	Response
PR 5 (cont'd)	Methods 2.1.2 KQs (cont'd)	(comment above)	We have also changed the word "disadvantaged" to "populations at risk for experiencing discrimination" for clarity in the text recognizing that this adds additional text to the ES and report, in addition to noting that this terminology was used in the study protocol as worded in the KQs.
TEP Reviewer 2	Methods 2.2 Literature	In Section 2.2 the following sentence states, "This decision was guided by the timing of when the AIM program was established in 2014, which changed the policy context in the U.S." Here it would be good to spell out AIM and describe briefly since this is the first time this is mentioned.	We have briefly introduced the Alliance for Innovation on Maternal Health in the Background section of the report to provide more context.
PC 5	Methods 2.2 Literature	Could you please clarify the policy context in the U.S.? Internally, we are unaware of AIM impact on policy implications.	Additional detail on the AIM program provided for clarity in the introduction (section 1.1).

Commentator & Affiliation	Section	Comment	Response
PR 5	Methods 2.2 Literature	The search strategies were logical, but did not include patient-reported experience measures, such as the PREM-OB Scale (see general comment above). Patient-reported outcome measures are mentioned in relation to strength of evidence, but there is no mention of patient-reported experience measures, which also capture the elements of respectful maternity care.	The included tools in KQ1 were also captured in the patient-reported experiences measures systematic review (Bull 2023). Our inclusion criteria specified a focus on RMC, and as such some of the tools in the Bull 2023 article were not eligible. The PREM-OB™ tool was also reviewed for KQ1 and has been incorporated in the section on tools focused on childbirth or not directly focused on RMC, as well as in the discussion.
PC 5	Methods 2.3 Study Selection	Could you use the gender the cited studies refer to for specificity in your discussion, while also acknowledging that there may be limitations in gender diversity of studies and those effects on RMC?	We have acknowledged this in the first paragraph of Methods section 2.3
PR 4	Methods 2.3 Table 1	In Table 1, under KQ2, the mental health outcomes could be rephrased for clarity. I would consider wording as “mental health symptoms using validated clinical measures (e.g., depression, anxiety, PTSD, suicidality); rates of mental health diagnoses (e.g., depression, anxiety, PTSD).	Eligibility criteria was determined a priori and approved as part of the study protocol.

Commentator & Affiliation	Section	Comment	Response
PR 4	Methods 2.3 Table 1	I had a difficult time understanding the potential harms listed in Table 1 for RMC. How is disrespectful care considered a potential harm of RMC?	Disrespectful care was considered a harm in the context of the effectiveness of RMC. For example, if an RMC program were not effective, disrespectful care may be a harmful outcome. Outcomes were determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot change outcomes that we included.
PC 3	Methods 2.3 Table 1	With regards to the maternal health outcomes in Table 1 for KQ 2, important contributors to health care utilization and engagement are not listed, particularly interpersonal or institutional trust	When reported, outcomes related to utilization would have been considered. These were not reported in any study.

Commentator & Affiliation	Section	Comment	Response
PC 6	Methods 2.3 Table 1	When I looked further into the methods, I see that the protocol excluded studies from LMICs based on certain criteria. I think that this exclusion could possibly be better highlighted in the abstract and executive summary. The term "U.S. relevant" was confusing in that it didn't conjure more common terms like "LMIC" used in the literature. The authors define LMIC using United Nations Human Development criteria, so they are working with an established framework. It might be helpful to spell out the methodology choice succinctly early in the review, given that many of your readers may know that a bulk of the descriptive evidence on RMC hails from LMICs and they may be looking for interventions that come from LMICs addressed in KQ4.	We deleted the term "U.S. relevant" and provide more precise terminology for clarity. Please see Methods section 2.3 for clarification on selection of countries categorized as “very high” on the 2019 Human Development Index (United Nations Development Programme. Human development report 2019. New York, NY: United Nations Development Programme; 2019. http://hdr.undp.org/sites/default/files/hdr2019.pdf).

Commentator & Affiliation	Section	Comment	Response
PC 6	Methods 2.3 Table 1	In examining the inclusion criteria, I was unclear why this validation study was not included in the review: White VanGompel, E., J. S. Lai, D. A. Davis, F. Carlock, T. L. Camara, B. Taylor, C. Clary, A. M. McCorkle-Jamieson, S. McKenzie-Sampson, C. Gay, A. Armijo, L. Lapeyrolerie, L. Singh and K. A. Scott (2022). "Psychometric validation of a patient-reported experience measure of obstetric racismÂ© (The PREM-OB Scaleâ„¢ suite)." Birth 49(3): 514-525. In looking at the exclusion criteria, I was unclear why this study was not specifically listed as an excluded study given that it is one of the few RMC intervention studies, albeit in a LMIC. Many of the other citations from this same scientific group made it into the review (including some of the excluded studies), so it was curious that the search strategy might have missed this citation? Montagu D, Giessler K, Nakphong MK, Roy KP, Sahu AB, Sharma K, et al. (2020) Results of a person-centered maternal health quality improvement intervention in Uttar Pradesh, India. PLoS ONE 15(12): e0242909. https://doi.org/10.1371/journal.pone.0242909	We have reviewed this tool and the related papers. The suggested article was reviewed as supporting the Contextual Question and is referenced in section 3.2.1 just above Table 2 in recognition of issues relating to obstetric racism and violence. This specific tool was also reviewed for KQ1 and has been incorporated in the section on tools focused on childbirth or not directly focused on RMC, as well as in the discussion. The Montagu et al. (2020), study was excluded at the abstract level, as it was a cross-sectional study. We have added it as an example of the PCMC framework in Appendix Table C-1.

Commentator & Affiliation	Section	Comment	Response
PR 5	Methods 2.3 Table 1	- Regarding the chosen outcomes for infants, would recommend also considering APGAR scores.	Outcomes were determined *a priori* and developed through a process that included collaboration with Key Informants (KI), a technical expert panel (TEP), federal partners, and public input on key questions and study eligibility criteria. Therefore, we cannot change outcomes that we included. However, infant outcomes were not reported in any study.
TEP Reviewer 2	Methods 2.3	In Section 2.3, the following sentence reads, "Discrepancies were resolved by discussion and consensus." Were there many discrepancies? Was a third reviewer employed to help resolve any persistent discrepancies?	We have added text to clarify that there were very few discrepancies; disagreements were largely centered around whether to include as background or formally in the Appendix. Rarely, for studies requiring further evaluation, an additional reviewer was consulted. We also refer the reader to additional information in Appendix Section A2.1.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 2	Methods 2.5	In Section 2.5 the following sentence reads, “Criteria described in foundational publications were used to facilitate descriptions of measurement development and validation and to provide general assessment of RMC tools.” Which foundational publications are being referred to here? (The sentence only has one citation).	The other publications have been cited.
PR 5	Results General	Based on the studies that met criteria and were included, this section is clearly described. See above for my comments about inclusion/exclusion of studies. The tool measuring patient experience with obstetric racism is missing, and not even considered among the excluded studies. • White VanGompel E, Lai JS, Davis DA, Carlock F, Camara TL, Taylor B, Clary C, McCorkle-Jamieson AM, McKenzie-Sampson S, Gay C, Armijo A, Lapeyrolerie L, Singh L, Scott KA. Psychometric validation of a patient-reported experience measure of obstetric racism© (The PREM-OB Scale™ suite). Birth. 2022 Sep;49(3):514-525. doi: 10.1111/birt.12622. Epub 2022 Mar 17. PMID: 35301757; PMCID: PMC9544169. • Lett E, Hyacinthe MF, Davis DA, Scott KA. Community Support Persons and Mitigating Obstetric Racism During Childbirth. Ann Fam Med. 2023 May-Jun;21(3):227-233. doi: 10.1370/afm.2958. Epub 2023 APR 3. PMID: 37019478; PMCID: PMC10202510.	We have reviewed this tool and the related papers. The suggested article was reviewed as supporting the Contextual Question and is referenced in section 3.2.1 just above Table 2 in recognition of issues relating to obstetric racism and violence. This specific tool was reviewed for KQ1 and has been incorporated in the section on tools focused on childbirth or not directly focused on RMC, as well as in the discussion. Issues of obstetric violence and racism are addressed in introduction and discussion.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 1	Results Main Points	Does the revised CEQ-2 also have good relevance for US populations similarly to the MADAM, MORi and CHOICES tools?	As discussed in section 3.3.1, The revised Childbirth experience questionnaire (CEQ-2) also demonstrates good overall validity for measuring childbirth experiences and includes RMC components. The CEQ measures childbirth experience but does not address RMC specifically; the tool includes components of RMC. This is also reiterated in the discussion.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 1	Results 3.2	In Section 3.2, the authors do a great job outlining the history of RMC. One movement that seems also highly influential to the understanding of RMC conceptually is the rise of trauma-informed care principles: I see that the authors acknowledge the role of trauma in the discussion, which is good, however, I think that once scholars looking at maternity care became more aware of trauma informed principles that this was likely important to understanding RMC as well as disrespect and abuse in the individual and also systems contexts. Trauma informed care and its application have been described for midwifery, obstetrics, maternity nursing, doula care, etc., and it would be good to mention this overlapping concept here as well as in the discussion. To my mind, providing trauma informed care is part of the "Components of Respectful Care" and could be listed there in Figure 4. Just as, as the authors say, "respectful maternity care is not simply the absence of disrespect and abuse," in describing the rights-based framework, respectful midwifery care also needs to be about recognizing past (or current) trauma in the lives of patients and doing our best to not retraumatize people in the provision of care.	Trauma is addressed in the following sections: • ES: Future Research Needs • Results: 3.2.2 • Discussion 4.4: paragraph beginning "There is growing awareness that obstetric emergencies can lead to traumatic birth experiences for patients.", as well as call for future scholarship to include trauma.
PC 3	Results 3.2 Figure 3	On page 15, Figure 3, and in the body of the report, consider adding the World Health Organization 2022 recommendations on maternal and newborn care for a positive postnatal experience. This is available at https://reliefweb.int/report/world/who-recommendations-maternal-and-newborn-care-positive-post-natal-experience	This resource focuses on postnatal care and was not added since other WHO references are included throughout the report.
PR 2	Results 3.2 Figure 3	I really like this figure, and appreciate the overarching context. Small suggested edit: "Emerging RMC scholarship in higher-resource countries, including legal and civil rights frameworks as well as the push for person-centered care and shared decision making." Consider a different word than "push" here - or is this an intentional pun?	Language in figure modified from 'push' to 'focus on,' per suggestion.

Commentator & Affiliation	Section	Comment	Response
PR 3	Results 3.2 Figure 3	For Figure 3, history of RMC please include ACOG's Respectful Care emodules (2021-2023), These are "free online courses for helping clinicians more effectively offer respectful care in ObGyn and overall patient health".	Modules are not considered landmark historical events or scholarship; however, we acknowledge the multidisciplinary contributions to the historical understanding of RMC and have language addressing that other types of resources may exist outside of our data set in section 3.2: We recognize there may be additional frameworks or definitions outside this data set and those may be included as measures of RMC in future research.
PC 5	Results 3.2 Figure 3	How were some of the timelines and resources selected for inclusion? For example, on page 19 you mentioned AIM as a program that changed the policy context in the U.S., but the program isn't mentioned in Figure 3 as having produced a groundbreaking Reduction of Racial and Ethnic Disparities patient safety bundle related to maternal health in 2016 or having integrated RMC into its patient safety bundles since at least 2020.	We have included AIM as part of the SPCC Phase II-III in the figure.

Commentator & Affiliation	Section	Comment	Response
TEP Reviewer 1	Results Figures 3-4	Figure 3/History of RMC, although well done, is low resolution and a bit hard to read. Figure 4/conceptual design is helpful for understanding the results. Consider adding trauma-informed care principles as components of respectful care as outlined above, as this is important for patient care.	We acknowledge the multidisciplinary contributions to the historical understanding of RMC and have included trauma informed principles in our discussion since these are not represented specifically in RMC frameworks or tools and are thus not included in these figures. Please see in particular the paragraph beginning "There is growing awareness that obstetric emergencies can lead to traumatic birth experiences for patients." in section 4.4. Office for Civil Rights brief addressing obstetric violence and obstetric racism is cited in Figure 3.
PR 2	Results 3.2	consider also citing the WHO 2018 report1, page 22, Table 3.1, which specifically names system resources to support provision of respectful maternity care	We acknowledge the multidisciplinary contributions to the historical understanding of RMC and have included the WHO in Figure 3 and throughout the report.

Commentator & Affiliation	Section	Comment	Response
PC 3	Results 3.2	On page 16, the AWHONN 2022 RMC implementation toolkit is described as extending the Black Mamas Matter Alliance 2016 as taking "it a step further by including respectful communication and collaboration." However, the BMMA publication includes this, including with the following language: The right to safe and respectful maternal health care encompasses a woman's right to actively participate and make informed decisions about her care. To make an informed decision, a woman must be provided with information about her condition, her health care options, and the risks and benefits. Maternal health care providers can empower their patients to become engaged decision-makers by: Centering them, Educating them, and Listening to them.	We have updated the text for accuracy: AWHONN echoes the Black Mamas Matter 2016 framework in describing the need for systems accountability where either individuals or organizations are called to acknowledge and take responsibility for upholding RMC through patient-centered engagement, education, and listening.
PC 5	Results 3.2	We appreciate the distinction made recently in RMC from moving beyond individual providers/patients to the systems in which they operate. We think what is related but missing from this is the idea that RMC is an underlying principle of quality of care for pregnant and postpartum people. (Bottom of page 16)	We have aimed to address the complexity of these influences levels of care in our conceptual diagram: figure 4 and section 3.2.2
PR 4	Results 3.2.1 D&A	In section 3.2.1, in the 3rd paragraph, I wonder whether communication should be considered in the description of disrespectful care.	We have described the use of 'communication' in Table 2 as "Poor rapport between women and providers." Table 3 includes positive aspects of communication.

Commentator & Affiliation	Section	Comment	Response
PC 3	Results 3.2.2 Rights-based	On page 18, in section 3.2.2, the first sentence concludes with "...respectful maternity care is not simply the absence of disrespect and abuse." There is an opportunity to add the point in this transition that rights-based frameworks include attention to "assurances" needed for people to survive and thrive.	We agree with this comment. The following two sentences transition to the concept of thriving: "Rather, rights-based frameworks define RMC as incorporating aspects of reproductive justice, human rights, historical and current social justice, and anti-racism. These frameworks consider the influences of wider social constructs and systems, and center RMC on wellness and thriving rather than exclusively on issues of abuse or disrespect."
PR 2	Results 3.2.2 Rights-based	This section discusses the WHO framework, but does not include "positive childbirth experience" as a goal or element of RMC. As noted in the overarching comments above, this feels like a missed opportunity to elevate childbirth as a formative rite of passage for the birthing person, and the literally origin story for every human being.	While we are unable to describe all of the details of each framework, we aimed to highlight those that are influential with Table 3 used to describe the overlapping components of these frameworks.

Commentator & Affiliation	Section	Comment	Response
PR 4	Results 3.2.2 Rights-based	In section 3.2.2, there is a tension that emerges with the WHO's statement pertaining to "clinician control of birth" and avoiding "practices that could undermine women's autonomy". Many obstetric practices (e.g., induction of labor, tocolysis) insert a medical control of the birthing process, but are done with clinical effectiveness in mind. It is perhaps beyond the scope of this systematic review to discuss further within this document, but I'd encourage the authorship team to consider an accompanying editorial to discuss how medical interventions can be best applied without undermining what can be perceived as a natural process of birth.	We also recognize this important issue. It is beyond the scope of this systematic review to further discuss clinician control of birth processes.
PR 5	Results 3.2.2, Rights-based, Table 3	In Table 3 that summarizes the overlapping components described by each of the rights-based frameworks through broader themes, there are several themes that are described in the Black Mamas Matter Toolkit that is referenced for that framework that are not checked, including: • Freedom from violence: Listed as "Safety and freedom from violence" under Section 3 of the BMMA toolkit - A state policy framework for the right to safe and respectful maternal health care (section starting at page 28, and specifically at page 55).Safety is an essential ingredient for health, yet many Black women, girls, and their families are exposed to high levels of violence—in their homes, their neighborhoods, and in their interactions with the state. " page 55 • Freedom from mistreatment are also included in that toolkit - Section I - Black Women's Maternal Health and Rights at Risk: "Fundamental human rights are violated when pregnant and birthing women endure preventable suffering, including death, illness, injury, MISTREATMENT , abuse, discrimination, and denials of information and bodily autonomy." page 9 of BMMA toolkit. See also page 30 - Steps for applying a human rights based approach to maternal health policy (page 30), and Section V.A Ensure the maternal health and rights of incarcerated women (page 51) • Right to decision making power and autonomy - See also BMMA toolkit page 49 - "C. Build a culture of respect for women's decision making power and bodily autonomy during care" and page 69 - "Respect: States must trust Black women with the decisions and resources that empower them and their families. Health care providers and systems must approach every woman with respect and compassion, build her capacity to engage in informed health care decision-making, and honor her autonomy to make decisions about her body and care."	The table has been updated per your recommendations

Commentator & Affiliation	Section	Comment	Response
PR 4	Results 3.2.2. Rights-based, Figure 4	For Figure 4, I am curious whether the figure was created or adapted. The description in the text diverges from the legend. Also within Figure 4, I was unable to follow what the arrows under the rainbow signify (e.g., access, equity, consent, autonomy). Were these examples of the levels of influence? Ideally that row in the figure could be labeled. A minor point, but there is inconsistent capitalization in Figure 4.	This is an adapted conceptual diagram based on a systematic review of health equity (the reference is provided). We have moved 'the multiple levels of influence…' from the figure title to the legend for clarity. We have added bullet points to clarify the text in the grey boxes, and have fixed the capitalization.

Commentator & Affiliation	Section	Comment	Response
PR 4	Results 3.3.2 KQ1 Included Studies	Table 4 is a fantastic summation of the existing literature. However it is difficult to follow. Some areas where clarity may be improved include: -The column labeled “summary of psychometric documentation”. Some columns have a country listed in parentheses. Others have a language listed in parentheses. And most have nothing listed. Since the text describes these studies in detail, perhaps that should be left out and, instead, the study reference included? -Why are the countries with tool adaptations listed? This seems like an area where space could be saved to focus the table on some of the more clinically pertinent columns. -I wonder whether the column of “summary of psychometric documentation” could be formatted as a checklist of what has been established with that tool, rather than a list. It might be easier to discern what is present and what is missing from the literature with this format.	We have removed the country and language references to improve consistency and clarity. For formatting and content purposes we did not modify the column “summary of psychometric documentation” Regarding a ‘checklist’ of what has been established, please see Table D-1. KQ1 Quality Assessment of studies of Validated Tools in the Appendix.
PR 4	Results 3.3.3.1.2.1-2 MADM/ MORi	In section 3.3.3.1.2.1, consider avoiding the term “normal” as this can be perceived as stigmatizing language.	Changed to “uncomplicated” physiologic births. When described as “normal” by study authors, this is now in “quotes”

Commentator & Affiliation	Section	Comment	Response
		In section 3.3.3.1.2.2., I understand why the authors collapsed their detailed analysis of MADM and MORi, however I think the results would be easier to follow if each of these tools had its own subsection (unless these are always intended to be used together).	Most of the validation studies for these tools evaluated both tools. It seemed duplicative to describe the same studies in two places for each tool in the report so these tools were described in the same section (3.3.3.1.2.2).
PR 4	Discussion General	The discussion omits the KQs pertaining to effectiveness. I agree with this, but it raises the question about whether these truly are "key" questions or, rather, the operationalization and tools to measure RMC are the key questions.	As described in the discussion: "There was insufficient evidence to evaluate effective strategies for implementing RMC in order to improve outcomes in any population, regardless of risk for health disparities." Additional limitations of the research also described in the discussion.
TEP Reviewer 1	Discussion General	The findings are clearly stated, and it is a strength that this review helps the field define RMC. I appreciate that the authors prominently acknowledge the role of past trauma on the experience of care as well as current trauma and structural issues that perpetuate disrespectful and abuse care and violence. I would urge the authors to name some of this as discrimination and racism and add literature here that names that. "Disrespect" does not fully portray discrimination/racism.	Issues relating to trauma are addressed in the introduction (section 1.1 paragraph 1), throughout the report (sections 3.2.1) and discussion (section 4.1, 4.3). We also call out the importance of trauma informed care in discussion section 4.4.

Commentator & Affiliation	Section	Comment	Response
PC 3	Discussion 4.1 Key Findings	Clarifying the ways in which concepts like obstetric racism factor into RMC or are complementary would be helpful.	We specifically discuss this in section 3.2: "*Further characterization of mistreatment through these frameworks gave rise to a concerted effort to examine this initiative within higher resource countries. This contemporary focus uses a reproductive justice approach and considers obstetric violence and obstetric racism, highlighting how both may impact efforts to address persistent disparities in maternal morbidity and mortality in the United States.* This concept is addressed in the introduction and discussion (section 4.1).

Commentator & Affiliation	Section	Comment	Response
PC 3	Discussion 4.1 Key Findings	Please see my comments regarding Box 1 that are provided in the Executive Summary section. On page 41, there is reference to "connectedness" of birthing people and their babies and families. The report would be strengthened by expanding on what is meant by connectedness -- is the intent to draw attention to the mutually regulating system of the mother-infant dyad and family? If so, adding this clarification may be helpful in informing understanding of respectful maternity care...the family is a unit and so each member needs to be treated with dignity and evidence-based care.	Throughout the report we describe opportunities to incorporate patients and families, not specifically described as a dyad by any framework or tool, but includes respect for culture and family support: Table 3, section 3.2.2. We have added text to further clarify this meaning: "connectedness between birthing people and their babies and families to recognize the importance of respect for and within the family unit"
PR 2	Discussion 4.1, Box 1	The items are numbered 5-8, rather than 1-4.	These have been updated.

Commentator & Affiliation	Section	Comment	Response
PR 5	Discussion 4.1 Key Findings	Considering that the context of using RMC tools has mostly been clinical quality improvement, it would have been a fuller discussion if it included how these tools are being used and the need to identify effective ways of measuring RMC for this purpose. These tools are already being used and tested, and part of the work moving forward will need to include a more rigorous and systematic collection of data regarding the utility of these tools in the clinical setting, in addition to documenting the strategies for implementing RMC and measuring the impact on care and outcomes.	Please see discussion section implications, 4.4 where we describe this issue: Before the widespread implementation of a particular framework or measurement tool, additional testing as well as research on the effectiveness of RMC for improving outcomes is needed. This work is required both to determine if RMC might improve perinatal outcomes, but also to bring accountability to patient care in the perinatal setting. Importantly, recent scholarship highlights policy, funding, workforce, and workplace systems issues as key contributors to disrespectful care.

Commentator & Affiliation	Section	Comment	Response
PR 5	Discussion 4.1 Key Findings	Although no frameworks were identified that explicitly describe teamwork or communication as part of RMC and no RMC tools that describe teamwork and communication, there is clear descriptions of shared decision making, which requires communication and collaboration, and there are tools that have been used specifically for the purpose of improving RMC that focus on teamwork and communication. While they do not meet the criteria to be included in this review, this work could be mentioned in the discussion with recommendations for additional study of their utility. • Aggarwal R, Plough A, Henrich N, Galvin G, Rucker A, Barnes C, Berry W, Golen T, Shah NT. The design of "TeamBirth": A care process to improve communication and teamwork during labor. Birth. 2021 Dec;48(4):534-540. doi: 10.1111/birt.12566. Epub 2021 Jul 9. PMID: 34245054; PMCID: PMC9290033. • Weiseth A, Plough A, Aggarwal R, Galvin G, Rucker A, Henrich N, Miller K, Subramanian L, Hawrusik R, Berry W, Gullo S, Spigel L, Dever K, Loveless D, Graham K, Paek B, Shah NT. Improving communication and teamwork during labor: A feasibility, acceptability, and safety study. Birth. 2022 Dec;49(4):637-647. doi: 10.1111/birt.12630. Epub 2022 Mar 1. PMID: 35233810; PMCID: PMC9790687. • Spigel L, Plough A, Paterson V, West R, Jurczak A, Henrich N, Gullo S, Corrigan B, Patterson P, Short T, Early L, Bridges M, Pesek E, Pizzitola M, Davis D, Kirby K, Borduz C, Shah N, Weiseth A. Implementation strategies within a complex environment: A qualitative study of a shared decision-making intervention during childbirth. Birth. 2022 Sep;49(3):440-454. doi: 10.1111/birt.12611. Epub 2022 Jan 7. PMID: 34997610; PMCID: PMC9543488	Thank you for the additional resources. Spigel 2022, Aggarwal 2021, and Weiseth 2022 are implementation / QI / feasibility on the provider side and not focused exclusively on RMC for patients.
PC 5	Discussion 4.1 Key Findings	AIM CCI developed the Racial Equity Learning Series (RELS) as a tool to address racism as a leading factor in health systems, which contributes to inequitable care and disparate outcomes for Black birthing persons. RELS modules include but are not limited to the acknowledgement and acceptance of racism, institutional transformation, personal, and systemic change (bottom 41/top page 42)	We added this citation to the discussion section 4.4 (Altman 2023), addressing disparities and racism "…eliminate racism,"
PR 2	Discussion 4.1 Key Findings	(bottom 41/top 42) "This also recognizing ongoing need to identify and mitigate health systems factors that create conditions that lead to disrespect, racism, and/or obstetric violence." Consider explicitly naming health system factors in the boxed definition. I anticipate that readers will cut and paste the box into PowerPoint presentations, and these contextual elements will not be included if they are only stated in the text.	Examples of health systems influences are described in the report, section 3.2.2: health systems (e.g., infrastructure, support, staffing, philosophy); and conceptually in Figure 3 and related text.

Commentator & Affiliation	Section	Comment	Response
PC 4	Discussion 4.2 Applicability	Please consider expanding the discussion of the potential role of varying healthcare systems by country and how this might affect applicability of results.	We addressed this in the applicability section as follows: *Therefore, validating tools across settings and populations relevant to clinical practice in the United States, including among populations at risk for experiencing health disparities, would help further characterize the applicability of these findings*.

Commentator & Affiliation	Section	Comment	Response
PR 2	Discussion 4.3 Findings in Relation	"Before RMC is implemented in the U.S., a standard definition with clear performance measures is required to help standardize care delivery to ensure RMC for all birthing people" Pushing back on "before RMC is implemented" - from an ethical perspective, should we keep abusing people until we agree on how to define non-abusive care? Consider rephrasing to underscore the importance of a definition to support implementation, vs. "before RMC is implemented…"	Text has been modified in the ES: *Alongside the urgent need to implement RMC, goals for RMC must include further testing of reliable performance measures and consensus around a clear definition to help standardize care delivery to ensure RMC for all who are pregnant or postpartum*; Future research needs (ES): *Before widespread implementation of tools to measure RMC, further testing of current measures and a clear definition to help standardize care delivery may help assure RMC for all birthing people*; and main text : *Consensus around a standard definition with clear performance measures is needed to help standardize implementation of care delivery in the United States to ensure RMC for all birthing people*

Commentator & Affiliation	Section	Comment	Response
PC 4	Discussion 4.4 Implications	Please consider emphasizing the need for more research on providing respectful maternity care for pregnant individuals with intellectual or developmental disabilities, as communication between patients and providers was reported as one of the most common barriers (Saeed et al., 2022). Clinicians have also reported that there is currently a lack of preparation or training for providing care for pregnant individuals with intellectual or developmental disabilities (Amir et al., 2022; Smeltzer et al., 2018).	This population was included as part of the progress plus framework that recognizes populations at risk for experiencing health disparities (see methods section 2.3), which may vary by geographic location or residence, race/ethnicity/culture, language, disability, age, gender/sex, and others. We also recognize the lack of data informing RMC practice, implementation or effectiveness in these populations (see discussion section 4)
PC 4	Discussion 4.4 Implications	Consider also highlighting in the report how social media may influence pregnant individuals' perceptions on the pregnancy experience and how providers may work to combat the misinformation that may be presented in social media in a respectful manner (Chee et al., 2023).	While this is an important issue it is not within the scope of this review.
PC 5	Discussion 4.4 Implications	(Page 44) Suggest including/discussing the Alliance for Innovation on Maternal Health Community Care Initiative (AIM CCI) Equity Framework, which includes Respectful Care as one of its pillars. In the context of AIM CCI, Respectful Equitable Care is explicitly noted on the AIM CCI website: Inculcating Equity - Alliance for Innovation on Maternal Health Community Care Initiative (aimcci.org)	The AIM program and goals are described throughout the report. This citation has been added to the text on the top of page 46 (discussion section 4.4).

Commentator & Affiliation	Section	Comment	Response
PC 5	Discussion 4.4 Implications	(Bottom of page 44) AIM patient safety bundles could be interpreted as implementation strategies for RMC (KQ2 from pdf page 15), understanding that RMC should be integrated into overall quality of care, hence its incorporation into preexisting patient safety bundles instead of as a standalone resource. Corresponding AIM patient safety bundle resources, such as change packages, provide tangible change ideas for implementing RMC strategies into practice. Likewise, data collection plans provide a foundational support for evaluating outcomes also used to evaluate RMC, such as severe maternal morbidity, and doing so in a way in which teams are encouraged to report disaggregated data to evaluate inequities in care and disparities in outcomes. Other process and structure measures seek to incorporate implementation strategies for RMC, such as patient-provider communications and screening for social needs. Other RMC elements, such as timely care, as also provided as appropriate in data collection and reporting strategies. AIM Respectful Care Measurement Statement: https://saferbirth.org/measurement-of-respectful-care-in-aim-statement/	A recent AIM QI project (Stierman 2023) is described in the discussion as follows: *For example, a recent study of quality improvement projects in Texas and Oklahoma evaluated the implementation of safety bundles for obstetric hemorrhage and severe hypertension and reported differences in adherence for rural versus urban hospitals*.
PR 2	Discussion 4.4 Implications	(page 45) “Notably, ACOG encourages care teams to understand the prevalence and impact of prior and potential trauma on the birth experience.” Consider adding a reference to relevant ACOG guidance.	This reference was added to discussion.
PR 2	Discussion 4.4 Implications	(page 45, last two paragraphs of section 4.4) Consider including a brief discussion of stratified reproduction in US history and policy. I would argue that maternity care is disrespectful in part because our cultural discourse frames birth within groups that have been made marginalized as a problem to be solved, rather than a life event to be honored and celebrated. See writings by Dorothy Roberts6, Harris and Wolfe7, and many others. Throughout the US history, the fertility and childbearing of poor women and women of color were not valued equally to those of affluent white women. This is evident in a range of practices and policies, including black women’s treatment during slavery, removal of Native children to off-reservation boarding schools and coercive sterilizations of poor white women and women of color. Thus, reproductive experiences throughout the US history were stratified. This ideology of stratified reproduction persists today in social welfare programs, drug policy and programs promoting long-acting reversible contraception. 7	The complexity of this issue cannot be understated. We aimed to capture some of this history in the CQ, section 3.2.

Commentator & Affiliation	Section	Comment	Response
PC 5	Discussion 4.4 Implications	Consider pointing to resources currently available that support implementing RMC, such as AIM patient safety bundles. Suggest incorporating into the Conclusions paragraph of the ABSTRACT considerations discussed later in the paper (e.g. on page 12, first paragraph under Future Research Needs and Opportunities) as they are important to contextualize RMC as something we should strive for, even if literature review and synthesis does not result in strong evidence about how a particular intervention impacts outcomes. If we don't underline this early and often, those who are resistant to RMC may use the conclusions to not incorporate it into their practice	A recent AIM QI project is described in the discussion, and additional references have been added. *For example, a recent study of quality improvement projects in Texas and Oklahoma evaluated the implementation of safety bundles for obstetric hemorrhage and severe hypertension and reported differences in adherence for rural versus urban hospitals*.
PR 5	References	The one thing that made it a bit challenging to navigate the report is how the sections were numbered. Also, the multiple reference lists made it difficult to find the references referred to in the text, with some numbers being used more than once in different lists (so hard to find using the "search" option), and some references being listed more than once on different lists. The appendices were helpful, but it would be helpful to improve labeling of reference lists so that it is more clear what part of the report each reference list is referring to (e.g. Appendix pages F-1 to F-8 just says "References" in the heading and in the Appendix Table of Contents). If these are just the references for the appendices, it would be helpful to label them as such in the Table of Contents. It would also be helpful if the heading for each reference list describes what section of the report the references are for (like what was done for the included studies and excluded studies reference lists).	We aimed to organize the report and references according to AHRQ guidance and templates.

Commentator & Affiliation	Section	Comment	Response
PR 5	Appendix C	Table C-5, page C-21, The paper by Green, et al. is referenced for the Black Mamas Matter Alliance framework, although it was developed by staff from the National Birth Equity Collaborative (NBEC, now Reproductive Health Impact) which is a member/partner of BMMA, but a separate organization. The Green paper was not yet published when BMMA released its toolkit that is also referenced in this table. Considering that RH Impact is a separate organization that is being funded specifically to do work regarding respectful maternity care, I would recommend referring to RH Impact (formerly known as NBEC) (See also Reference 112, page F-8 Green CL, Perez SL, Walker A, et al. The Cycle to Respectful Care: A Qualitative Approach to the Creation of an Actionable Framework to Address Maternal Outcome Disparities. International journal of environmental research and public health. 2021;18(9)	The last column in this table provides examples of the frameworks. The source documents are cited in column one.