

Advancing Respectful Maternity Care: Evaluating Nursing Perspectives and Clinical Practices in Safeguarding Birthing Rights during Complex Labors

Evaluate the
Obstacles to
Providing
Respectful
Maternity
Services in Labor
Room

Doaa Sami Rashash¹, Layla Oun AlWassiti² and Fatima Jaber Shinjar³

ABSTRACT

Objective: To evaluate the obstacles to providing respectful maternity services in the standard labor room

Study Design: Descriptive cross-sectional study

Place and Duration of Study: This study was conducted at the Nasiriyah City, Southern Iraq, from 1st September 2025 to 31st December 2025.

Methods: One hundred and fifty mothers having a child between the ages of 0 and 1 year and answering every question were enrolled.

Results: Empathize giving women-focused care, and protecting rights. Exhibiting empathy include interacting with women and cultivating a cordial relationship and decision-making and women's safety were essential elements of women-centered care. The protection of rights represented the need to uphold dignity, treat everyone equally, and establish a proper environment.

Conclusion: Iraqi midwives saw courteous maternal care as a more all-encompassing concept rather than concentrating on preventing abuse. Being polite and encouraging, the first step towards providing respectful maternity care was to women. Providing safe, treatment based on evidence including women in the care they provide, and establishing a setting that is appropriate for women, family members, and caregivers are all important aspects of promoting respectful care.

Key Words: Maternity care, Clinical practices, Perspective.

Citation of article: Rashash DS, Al Wassiti LO, Shinjar FJ. Advancing Respectful Maternity Care: Evaluating Nursing Perspectives and Clinical Practices in Safeguarding Birthing Rights during Complex Labors. Med Forum 2026;37(9):42-46. doi:10.60110/medforum.370908.

INTRODUCTION

Freedom from harm, privacy and confidentiality protection, informed consent, independence and dignity, family support, effective communication, and continuity of care are all components of respectful maternity care¹. Obstetric aggression, contempt, and abuse can occur throughout pregnancy and labor for women and those giving birth worldwide, despite the

well-established advantages of compassionate maternity care². The words dehumanized care, disrespect and abuse will be used throughout this document, mistreatment, and obstetric violence are frequently and interchangeably used in the literature, but there is no agreement on the vocabulary or typology concerning obstetric violence³. Despite this lack of agreement, instances of obstetric violence are highlighted by gender inequity, over medicalization, the possibility of injury, and an underlying danger to women's rights⁴.

Protecting women's reproductive rights and providing high-quality maternal care are crucial elements of both the global development plan and public health. As the premier UN organization for sexual and reproductive health, UNFPA is crucial to achieving these goals because of its dedication to protecting women's rights and dignity and guaranteeing widespread access to maternal health care services. This vision is reflected in UNFPA's declared mission, to deliver an atmosphere where any pregnancy is desirable⁵.

Every single childbirth is safe and every young person's capacity is fulfilled, highlighting the need of high-quality maternity care and respect for women's rights worldwide. A woman should receive quality medical care throughout her pregnancy in order to maximize her satisfaction during gestation, childbirth, and the

¹. Instructor, Maternity & Neonatal Health Nursing, College of Nursing, University of Thi-Qar

². Instructor, Maternity & Neonatal Health Nursing, University of Sumer, College of Medicine, Nasiriyah City, Iraq.

³. Instructor, Adult Nursing Department, Faculty of Nursing, University of Thi-Qar, Nasiriyah City, Iraq

Correspondence: Doaa Sami Rashash, Instructor, Maternity & Neonatal Health Nursing, College of Nursing, University of Thi-Qar, Nasiriyah City, Iraq.

Contact No: 9647812807085

Email: doaa-s@utq.edu.iq

Received: May, 2026

Reviewed: June-July, 2026

Accepted: August, 2026

postpartum period⁶. The Indian government is trying very hard to develop a number of programs that support institutional delivery for low-income pregnant women by ensuring accessible, skilled medical professionals in order to reduce maternal and newborn mortality and morbidities⁷. These efforts did not have the intended effects; numerous maternal deaths, particularly in underperforming states, underscore the necessity of raising the standard of care for institution births⁸.

Despite the international rules on respectful mother care (RMC) of pregnant women, pregnant women are allegedly abused, mistreated, and neglected during the whole pregnancy cycle, especially in low- and middle-income countries (LMIC). This jeopardizes women's rights to life, health, physical integrity, and freedom from discrimination, as well as their rights to RMC and evidence-based institutional care⁹. At least one instance of abuse is found in a comprehensive analysis of obstetric violence in India¹⁰.

Respectful mother care in LMICs reveals that constraints including cleanliness, equipment availability or quality, provider competency, or conduct cause women to be dissatisfied with health facilities. Adaptation to parenthood and competent caregiving behaviors depend heavily on maternal parental self-efficacy, which is especially important for primiparous women¹¹. Women's confidence can be damaged by unpleasant and disrespectful labor experiences, which may result in reduced maternal-infant wellbeing and long-term emotional pain¹². Conversely, mothers' self-efficacy and coping skills are linked to positive and polite care experiences. Although respectful maternity care has gained more attention recently, educational contacts with women about childbirth may not always reflect actual care practices¹³.

METHODS

This descriptive cross-sectional study was conducted at Nasiriyah city, Southern Iraq from 1st September to 31st December 2025 vide letter No. 7 dated 7th June 2025. One hundred and fifty mothers having a child between the ages of 0 and 1 year, consenting to take part in the study, and answering every question on the questionnaire were the requirements for inclusion. Due to the possibility of introducing confounding variables and the distinct clinical and emotional processes involved in cesarean delivery, they were eliminated. To find participants, snowball sampling was employed. Initially, the researchers used private communication networks to distribute the survey link to mothers they knew. These women were asked to fill out. Only mothers who met the requirements to be included in the survey received the link and the survey. The sample size was calculated using a correlation-based power analysis with an effect size of 0.50, an alpha level of 0.05, and a confidence level of 99% using the G*Power 3.1 software was employed to ascertain the minimal

sample size required before data collection, resulting in 200 mothers. Because the survey was done online, the sampling process was deliberately prolonged to increase representativeness and guard against potential data loss due to incomplete or inaccurate responses. As a result, 150 mothers who met the inclusion criteria and filled out the survey completely were included. A post-hoc based power analysis utilizing the final sample size revealed that the statistical significance was larger than 0.99, suggesting a high degree of accuracy and dependability in the study results¹⁴. The SPSS-17 was used to analyze the data. Chi square was calculated to determine the relationship between thoughtful maternity care and demographic characteristics. Statistical significance was considered as $P < 0.05$.

RESULTS

Thirty six (24%) had completed senior or high school, 37 (25%) lived in rural areas, 80 (53%) worked for the government, and 60 (40%) were employed by the government. The majority of women had one child 60 (40%), two children 50 (33%), and more than two children 40 (27%). Female healthcare workers performed 80 (53%) of the spontaneous vaginal births (Table 1).

Table No. 1: The demographic information of the females (N = 150)

Variable	No.	%
Age (years)		
15-19	22	15.0
20-24	28	18.5
25-29	29	19.5
30-34	35	23.0
>35	36	24.0
Education		
Absence of formal schooling	20	13.0
elementary school	30	20.0
Secondary education	28	19.0
High school or senior	37	25.0
A diploma or higher	35	23.0
Residence		
Urban	70	47.0
Rural	80	53.0
Occupation		
Homemaker	50	33.0
Private employment	40	27.0
Government employment	60	40.0
Number of children		
1	60	40.0
2	50	33.0
>2	40	27.0
Current mode of delivery		
Spontaneous vaginal delivery	80	53.0
Vacuum/Forceps	70	47.0

Forty one (28%) of the mothers who were given considerate maternity care stated it was comfortable, and 80 (53%) said keeps the space between beds intact.

Of the 80 (53%) RMC domains, the majority of women reported Records will be kept secure and safe. Conversely, just 10 (7%) HCWs who identified themselves reported care was not consented (Table 2).

Table No. 2: Prevalence of compassionate maternity care n=150)

Respectful Maternity Care	No.	%
Abuse of the body		
Considers comfort	41	28.0
Limit drinking	38	25.0
Limit eating	36	24.0
Injure physically	35	23.0
Resources and the physical surroundings		
Create a serene and peaceful atmosphere	70	47.0
Maintains distance between beds	80	53.0
Non-confidential care		
A curtain was used to protect privacy during the inspection	70	47.0
Records will be kept secure and safe.	80	53.0
Non-consented care		
HCWs introduced themselves	10	7.0
Encouraged to ask doubts	20	13.0
Explained prior to every practice or activity	25	17.0
Prior to taking any action or practicing	20	13
Allowed to move	16	11.0
Permitted to select the provision method	14	9.0
Describe the advantages & disadvantages of the delivery method	20	13.0
Monitored delivery progress	25	17.0

DISCUSSION

Women's perceptions of RMC were high, according to the study's findings, which were assessed in the context of the body of current research. Recognized as an essential part of high-quality obstetric care, RMC is based on universal human rights and aims to protect women from abuse while guaranteeing their autonomy, dignity, ability to make informed decisions, emotional support, and the development of mother-infant bonds¹⁵. Miller et al¹⁶ emphasized that without RMC, clinical care cannot be considered superior. The women have high perceptions of RMC (70.2-90%)^{17,18} which is consistent with the current study. However, a different study found a significantly lower average perception score (44.99)¹⁹, and a recent Turkish study found that nearly three out of four women are mistreated after giving birth²⁰.

The subjective and dynamic character of delivery experiences, differences in care environments, and women's expectations shaped by cultural norms could all contribute to these conflicting findings. This

circumstance emphasizes the ongoing need to strengthen standards for compassionate maternity care practices and promote understanding. The results of our survey show that 16.60% of victims had been physically abused. An Indian systematic review reports a comparable percentage of 16.96% physical abuse²¹. A different survey found that 2.7% of victims experienced physical abuse²². Physical abuse was reported at a greater proportion than ours, 23.2%, in a community-based research conducted in Ethiopia²³. However, only 2-2.3% of verbal or physical abuse was found in other studies conducted in the same nation²⁴. Inadequate reporting in some African studies could be due to ignorance or the perception that abuse is widespread²⁵. In this study, 70.55% of women reported continuity of care which is consistent with Ethiopian study results²⁶. The severe staffing scarcity seen in LMICs is likely the cause of the similarities. The majority of respondents (99.20%) reported an adequate environment and resources, which is encouraging according to our study's great environment and resources findings. According to our research, demonstrating empathy for women by interacting with them and building cordial relationships is a crucial component of RMC. In fact, the midwives thought that the primary factor influencing RMC was having a close-knit and encouraging relationship with women. Several studies from Australia, New Zealand, Norway, Sweden, and the UK have documented the development of cordial and pleasant interactions with women²⁷. Additionally, Bradfield and his colleagues defined "being with women" as the core of the midwifery philosophy and practice²⁸. Positive interpersonal and emotional treatment experiences are equally valuable to clinical and contextual environmental elements, according to the experiences of Nigerian and Ugandan women^{29,30}. The midwives in our study also emphasized RMC's capacity to deliver timely, current care with sufficient knowledge to enable a woman to take part in decision-making. A midwife also highlighted the importance of birth centers that might help RMC by providing women with midwifery-style care. Several studies have shown that when informed permission is gained, prompt, safe, effective, and efficient care may be provided. Additionally, several studies have shown that birth centers result in positive birth experiences^{31,32}. The RMC expressed respect for women's customs, religion, nationality, autonomy, and privacy, according to Iranian midwives³³. A thorough analysis revealed that women's delivery experiences were influenced by culture. The quality of birth experiences for women and their families will be enhanced by culturally competent maternal health care³⁴. According to midwives, Behruzi et al³⁵ emphasized the significance of honoring women's traditions, values, and beliefs.

CONCLUSION

During childbirth, the RMC may be helpful measurement tool to assist stop the abuse. Every domain is highlighted in the current study. The RMC from the women and its health-related barriers, the caregivers, improving medical staff's institutional policies, training, and resources were found. Women's rights would be strengthened during childbirth. Quality of care in a way that guarantees women has a good delivery experience and receive evidence-based therapy. The necessity of supply-side RMC barriers, which should be in place to be considered into account in order to support and improve institutional execution help enhance the health of mothers and infants.

Author's Contribution:

Concept & Design or acquisition of analysis or interpretation of data:	Doaa Sami Rashash, Layla oun AlWassiti
Drafting or Revising Critically:	Doaa Sami Rashash, Fatima Jaber Shinjar
Final Approval of version:	All the above authors
Agreement to accountable for all aspects of work:	All the above authors

Conflict of Interest: The study has no conflict of interest to declare by any author.

Source of Funding: None

Ethical Approval: No.7 Dated 07.06.2025

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