Respectful maternity care in modern obstetric practice: nursing strategies for improving maternal comfort, safety, communication, and childbirth experience

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Abstract:
Respectful maternity care is an essential component of safe, evidence-based and woman-centred obstetric practice. It extends the meaning of quality beyond survival and technical performance to include dignity, privacy, informed choice, effective communication, freedom from mistreatment, emotional support, pain relief and a positive childbirth experience. Contemporary guidance from the World Health Organization (WHO) places the woman's values, preferences and experience at the centre of intrapartum care, while also emphasizing timely recognition of complications and appropriate escalation when maternal or fetal wellbeing is threatened (WHO, 2018). Evidence shows that women value being listened to, receiving clear information, having a trusted companion, maintaining a sense of control, and being treated as active participants in decisions (Downe et al., 2018). Conversely, disrespect, verbal abuse, lack of privacy, non-consented procedures, neglect, discrimination and poor communication can damage trust and may contribute to fear, dissatisfaction and traumatic birth experiences. Nurses and midwives occupy a distinctive position because they are present throughout labour, frequently coordinate communication among the woman, family and multidisciplinary team, and translate clinical plans into day-to-day care. Nursing strategies therefore include respectful greeting and assessment, privacy protection, consent before procedures, plain-language communication, shared decision-making, continuous emotional support, comfort measures, individualized pain management, facilitation of mobility and supportive positioning when clinically appropriate, maintenance of a calm environment, companion inclusion, accurate documentation, rapid recognition of deterioration, safe referral and postnatal follow-up. In India, the Government of India's LaQshya programme explicitly incorporates respectful maternity care, positive birthing experience, quality improvement and beneficiary satisfaction into labour-room improvement efforts. This article reviews the concept and principles of respectful maternity care, determinants of childbirth experience, the role of nurses across the continuum of labour and birth, communication and shared decision-making, pain and comfort management, safety and emergency readiness, culturally responsive care, companion support, trauma-informed approaches, postnatal care, documentation, quality improvement, audit indicators and implementation challenges. The discussion is designed for nursing and obstetric practice and emphasizes that respectful care does not replace clinical vigilance; rather, respectful care and clinical safety should be delivered together. The overall practice goal is a maternity service in which every woman receives appropriate evidence-based treatment while also experiencing dignity, clear communication, emotional support, privacy, participation and continuity across the childbirth journey.

Keywords:
Respectful maternity care; obstetric nursing; positive childbirth experience; maternal comfort; communication; informed consent; shared decision-making; labour support; patient safety; birth companionship; trauma-informed care; quality improvement.

1. Introduction:

Pregnancy and childbirth are major life events that involve physical, emotional, social and cultural changes. Modern obstetric practice has made important advances in preventing maternal and newborn morbidity and mortality, but the quality of care experienced by women cannot be judged only by whether a serious complication was avoided. The WHO quality-of-care framework emphasizes two connected dimensions: the provision of care and the experience of care. Safe clinical care must therefore be accompanied by communication, respect, emotional support, privacy and a service environment in which women are treated with dignity (WHO, et al., 2016). This broader approach is particularly relevant at a time when global maternity services are managing both underuse of effective care and overuse of interventions. (Miller, et al., 2016) described these extremes as too little, too late and too much, too soon, noting that both can undermine equity, outcomes and women's experience. Globally, maternal mortality remains a major health priority. WHO and partner agencies estimated approximately 260,000 maternal deaths in 2023, with preventable causes related to pregnancy and childbirth continuing to affect women disproportionately in low- and middle-income settings (WHO, et al., 2025). The persistence of maternal deaths means that respectful maternity care must never be interpreted as an alternative to emergency obstetric readiness. Instead, respect is part of the quality of care delivered while clinicians diagnose, monitor, treat and refer. A woman can be treated with urgency and still be informed, addressed respectfully and included as much as circumstances allow. In this sense, respectful maternity care is not a luxury reserved for uncomplicated births; it is a standard that applies across normal labour, induction, operative birth, complications and high-dependency care. The modern concept of respectful maternity care is also connected with human rights. Freedom from physical and verbal abuse, privacy, confidentiality, informed consent and the opportunity to participate in decisions are central to ethical maternity practice. Freedman and Kruk (2014) argued that disrespect and abuse should be understood within the broader quality and accountability agenda rather than treated as isolated interpersonal incidents. (Bohren, et al., 2015) further demonstrated that mistreatment can include physical and verbal abuse, stigma and discrimination, failure to meet professional standards, poor rapport, non-consented care and neglect. These categories are important for nursing because many harmful experiences arise not from a single dramatic event but from repeated small actions such as failing to introduce oneself, talking over the woman, performing an examination without adequate explanation, or leaving unanswered questions. A positive childbirth experience is similarly multidimensional. (Downe et al., 2018) found that women value effective communication and reliable information, respectful and supportive relationships, emotional safety, a sense of control, adequate practical and physical support, and confidence that clinical care will be available when needed. These priorities reveal that women do not necessarily equate positive birth with an intervention-free birth. A woman may have an induction, instrumental birth or caesarean birth and still report a positive experience when she is treated respectfully, informed about options, supported through uncertainty and reassured that decisions are being made for valid clinical reasons. Conversely, an uncomplicated physiological birth may be remembered negatively if the woman felt ignored, frightened, exposed or excluded from decision-making. For nurses, respectful maternity care is therefore both an interpersonal skill set and a systems responsibility. The bedside nurse influences communication, comfort, privacy, pain management, observation, documentation and escalation. The nurse also recognizes the structural factors that shape care, including workload, staffing, space, policies, language barriers, supply availability and hierarchical communication. (Renfrew et al.,2014) highlighted the value of skilled, relational maternity care that strengthens women's capabilities while maintaining access to effective management of complications. This supports a model in which nurses are not simply task performers but active contributors to a therapeutic environment and to quality improvement. The remainder of this article presents a practical framework for integrating respectful maternity care into modern obstetric nursing. It links ethical principles with specific nursing actions across admission, labour, birth and the immediate postpartum period. Particular attention is given to maternal comfort, communication, informed consent, shared decisions, companion support, culturally responsive practice, trauma-sensitive care and clinical safety. It also examines documentation and measurement so that respectful care becomes a quality standard that can be observed, audited and improved rather than an abstract ideal.

2. Meaning and Scope of Respectful Maternity Care:

Respectful maternity care can be understood as care that preserves a woman's dignity, privacy, autonomy and physical and emotional safety while providing timely, evidence-based clinical treatment. It is woman-centred because it recognizes the woman as a person with preferences, values, fears, expectations and rights rather than viewing her only through a diagnosis or stage of labour. WHO recommendations for intrapartum care place positive childbirth experience within a model that combines effective clinical care with respectful communication, emotional support and attention to the woman's circumstances (WHO, et al., 2018). The scope of respectful maternity care extends from antenatal counselling through labour, birth and the postnatal period.

Antenatal contacts provide opportunities to explain the expected course of labour, discuss warning signs, explore preferences, identify language or accessibility needs and encourage women to ask questions. During labour, respectful care includes repeated communication, privacy, support with coping and pain, involvement in decisions, and avoidance of unnecessary procedures. During birth, it includes preparation for interventions, maintenance of dignity and clear explanation even when urgent action is required. After birth, the mother should receive adequate information, pain assessment, support with feeding and newborn care, and opportunities to discuss the birth experience and ongoing concerns. Respectful care does not mean that every preference can be followed in every situation. A woman's request may sometimes conflict with clinical safety, facility capability, legal requirements or the immediate needs of the fetus or newborn. The ethical response is not to dismiss the request but to explain the situation, discuss alternatives, document the reasoning, and involve the woman in whatever decisions remain open. A key skill for nurses is therefore the ability to communicate limits without using coercion or humiliation. Clear explanations such as, 'This change is needed because the baby's heart rate pattern is concerning; I will explain what we are doing and stay with you while we act,' preserve dignity while supporting urgent care. The concept also includes non-discrimination. Women may differ by age, parity, socioeconomic position, education, disability, migration status, language, ethnicity, religion, marital status or family situation. Respectful practice requires staff to avoid assumptions and stereotypes and to adapt communication to individual needs. The Giving Voice to Mothers study demonstrated that inequity and mistreatment can coexist within health systems, emphasizing the importance of examining whose voices are heard and whose preferences are overlooked (Vedam, et al., 2019). Nurses can counter this by asking open questions, using interpreters where required, checking understanding and ensuring that quieter or socially marginalized patients are included in care discussions. A practical definition can therefore be summarized across six domains: dignity, autonomy, communication, emotional and physical support, clinical safety, and continuity or accountability. Each domain is interdependent. Privacy supports trust; trust supports communication; communication enables shared decision-making; shared decision-making can improve cooperation and comfort; accurate observation protects safety; and continuity helps staff recognize changes from the woman's baseline. The nursing goal is not to provide isolated acts of kindness but to build a consistent experience in which respectful interactions occur before, during and after every clinical procedure.

Table. 1: Respectful Maternity Care

Domain	**What respectful care looks like in practice**	**Nursing indicators**
Dignity	Use the woman’s preferred name, explain care, minimize unnecessary exposure and maintain privacy.	Privacy maintained; respectful language; no humiliating remarks.
Autonomy	Offer choices where clinically possible and support informed decisions.	Consent documented; preferences discussed; questions answered.
Communication	Use plain language, active listening, teach-back and timely updates.	Understanding checked; information provided before procedures.
Comfort	Assess pain, position, hydration, temperature, noise and emotional distress.	Regular reassessment; comfort plan individualized.
Safety	Monitor mother and fetus, recognize deterioration and escalate promptly.	Observations completed; escalation documented; emergency readiness.
Continuity	Maintain coherent information across staff and shifts.	Structured handover; plan updated; woman not required to repeat information unnecessarily.

3. Why Respectful Maternity Care Matters in Modern Obstetric Practice

The emphasis on experience of care has expanded because surviving childbirth is not the only outcome that matters. A woman may remember the manner in which she was spoken to, whether someone stayed during an emergency, whether she was informed before a procedure, whether she was allowed a companion and whether her questions were treated seriously. (Downe, et al.,2018) reported that women commonly describe positive childbirth in terms of emotional wellbeing, feeling safe and supported, being listened to, receiving information,

and having confidence in the people providing care. These domains are directly influenced by nursing practice. Respectful care also matters because communication can affect safety. When women feel able to speak without fear of being dismissed, they are more likely to report worsening pain, bleeding, dizziness, reduced fetal movement before labour, or a sense that something is wrong. Conversely, a dismissive culture may suppress important information. Nurses can improve this safety channel by inviting questions and explicitly stating that reporting a concern is appropriate. A simple statement such as, 'Please tell me immediately if the pain changes, you feel faint, or you become worried about the baby; you are not disturbing us,' can strengthen the woman's role in monitoring. Quality maternity care must also address the risk of excessive intervention. (Miller, et al., 2016) described a global pattern in which some settings experience inadequate access to evidence-based interventions while others experience unnecessary or routine interventions. Respectful maternity care provides a framework for balancing these risks. A woman should receive intervention when it is clinically indicated and be protected from interventions that offer little or no benefit in her circumstances. ACOG guidance on limiting intervention during labour similarly emphasizes individualized care, shared decision-making and avoiding unnecessary practices in low-risk labour when evidence for benefit is limited (Committee on Obstetric Practice, et al., 2017). From a health-system perspective, experience of care can influence trust, future service use and willingness to recommend a facility. The WHO framework identifies experience as part of quality rather than an optional satisfaction component (WHO, 2016. Kruk et al. 2018) argued that high-quality health systems should maximize health outcomes while respecting people's expectations and providing competent care. In maternity services, this means measuring not only mortality, morbidity and intervention rates but also communication, dignity, privacy, companionship and whether women felt involved in decisions. Respectful care also supports staff professionalism. Nurses who use structured communication, consent practices and supportive care are more likely to recognize their work as a therapeutic relationship rather than a sequence of technical tasks. However, implementation must be realistic. Staff shortages, overcrowding, lack of privacy, limited pain-relief options and hierarchical cultures can undermine good intentions. Respectful maternity care therefore requires organizational support, supervision, training, leadership and quality-improvement processes in addition to individual commitment. LaQshya in India illustrates this systems perspective by combining infrastructure, staffing, training, clinical processes, quality circles and respectful maternity care objectives (Ministry of Health and Family Welfare, et al., 2017).

4. Principles of Respectful Maternity Care:

The first principle is dignity. Every woman should be treated as a person whose worth is not altered by parity, age, appearance, level of education, socioeconomic status or the complexity of her pregnancy. Dignity is communicated through basic behaviours: introducing oneself, asking permission before touch, explaining why a procedure is needed, using professional language and protecting the woman from unnecessary exposure. Small actions are significant because labour can increase vulnerability. When a woman is frightened, in pain or surrounded by unfamiliar professionals, a calm introduction and explanation can establish a sense of safety. The second principle is autonomy and informed participation. Autonomy does not mean that the woman has complete control over every clinical outcome; it means that she receives understandable information and has meaningful opportunities to accept, decline or discuss options when decisions are clinically open. (Shareef, et al., 2023) found that birth plans may support shared decision-making by helping women communicate preferences, anticipate possible scenarios and build a common understanding with providers. Nurses can use birth plans as conversation starters rather than rigid contracts, updating them when circumstances change. The third principle is privacy and confidentiality. Labour-room environments are often busy, and privacy may be challenged by multiple students, staff members, family members and equipment. Nurses should use curtains or screens appropriately, limit unnecessary observers, cover the woman during procedures, and discuss sensitive information discreetly. Confidentiality extends to conversations about pregnancy history, HIV status, domestic violence, mental health, reproductive choices and personal relationships. A woman should not have to disclose sensitive information publicly simply because the environment is busy. The fourth principle is non-discrimination. Respectful care requires the nurse to recognize personal bias and avoid stereotyping. For example, a multiparous woman should not be assumed to 'know how to cope', an adolescent should not be treated as incapable of understanding, and a woman with limited literacy should not be treated as less deserving of information. Nurses should use interpreters or communication aids when needed. Communication must be adapted without being infantilizing. The same respectful language should be used when discussing routine birth, operative delivery, pregnancy loss or newborn complications. The fifth principle is emotional support. Emotional safety includes reassurance, validation and presence. A woman in labour may be frightened by unfamiliar sounds, procedures, monitors and urgency. Rather than offering only generic reassurance, nurses can explain what is happening and what the woman can expect next. Continuous support is associated with improvements in several labour outcomes and can contribute to a more positive experience (Bohren, et al.,

2017). Emotional support is particularly important when pain, induction, long labour, operative birth or previous trauma increases distress. The sixth principle is safety. Respectful care is inseparable from timely assessment, accurate observation, infection prevention, emergency readiness and appropriate escalation. The nurse should maintain respectful communication even when acting rapidly. In emergency situations, concise explanations can be provided while the team moves. When time permits, consent and shared decision-making should be maintained. When time is extremely limited, the nurse can explain afterwards what happened, why it was necessary and what the next steps will be.

5. Understanding the Childbirth Experience:

Childbirth experience is shaped by both clinical events and the meanings women attach to those events. Two women may undergo the same intervention and report very different experiences. A procedure may be perceived as supportive when the woman understood the reason, agreed to it, felt that her questions were answered and experienced adequate pain relief. The same procedure may be experienced as traumatic when it is sudden, unexplained, and physically rough or accompanied by fear and loss of control. This is why technical quality and relational quality should be considered together. (Downe, et al.,2018) identified recurrent themes in women's accounts of what matters during childbirth, including having trustworthy relationships, being listened to, being treated as an individual, feeling safe, receiving adequate information and experiencing continuity. These themes are useful for nurses because they translate into observable actions. Instead of asking only, 'Did the birth go normally?', the nurse can ask, 'Did she understand what was happening? Did she feel safe? Was her pain addressed? Could she ask questions? Was she involved in decisions? Did she have meaningful support?' Fear and uncertainty are common during labour, but fear should not be dismissed as an emotional problem separate from physical care. A woman who is frightened may tense her body, have difficulty processing information or feel unable to communicate her needs. Antenatal education can help by making the environment and likely procedures more familiar. Recent evidence also suggests that structured prenatal education can reduce fear of childbirth in some populations, although the effect depends on the intervention and context (Karaçam, et al., 2026). Nurses can integrate brief preparation into routine antenatal contacts and admission assessments. Previous traumatic experiences can strongly influence the current childbirth experience. The woman may fear vaginal examination, loss of control, separation from a companion or repeated exposure to situations resembling previous trauma. Nurses should ask permission before touch, provide step-by-step explanations and avoid assuming that a standard procedure will feel neutral to every patient. Trauma-informed practice emphasizes physical and emotional safety, trustworthiness, choice, collaboration and empowerment. It does not mean avoiding necessary care; rather, it modifies how care is delivered so that the woman retains as much predictability and control as possible. The postnatal period is also part of the childbirth experience. A woman may process the birth only after the immediate crisis has passed. A short debriefing conversation can help her understand what happened and identify ongoing physical or emotional concerns. When a birth was complicated, the nurse should not force a detailed discussion immediately, but should ensure that a later opportunity exists. WHO guidance on perinatal mental health supports creating a safe, respectful environment where women can discuss psychological difficulties without stigma (WHO, 2022).



Figure. 1: Respectful Maternity Care: From Admission to Recovery

6. Nursing Assessment on Admission to the Maternity Unit:

The first interaction can shape the woman's perception of the entire facility. The nurse should introduce herself, confirm the woman's preferred name, explain the immediate assessment and indicate what will happen next. Where workload permits, the woman should be shown where she can call for assistance and where privacy will be maintained. Admission assessment should be both clinically complete and relationally respectful. The nurse needs to gather relevant history, assess maternal and fetal status, identify risk factors and clarify the reason for presentation, while also understanding the woman's expectations and concerns. A brief respectful assessment can include questions such as: What are you most worried about right now? Is there anyone you would like involved in your care? Do you have a preferred language? Have you had a previous difficult birth or procedure? What helps you cope with pain or anxiety? Are there cultural or personal practices that are important to you? These questions can reveal needs that are not captured by routine clinical history. If a woman has a birth plan, the nurse should review it with her and document relevant preferences while explaining that safety may require changes. Maternal assessment remains fundamental. Vital signs, pain score or description, contractions, vaginal loss, membrane status, cervical findings when indicated, fetal heart rate and other clinical parameters should be assessed according to the woman's condition and local protocol. The nurse should explain why examinations are needed and ask permission before proceeding. For intimate examinations, privacy and chaperone requirements should be respected. Afterward, the nurse should communicate the findings in understandable language rather than leaving the woman uncertain about what has been discovered. Risk screening should be integrated without creating alarm. Women with hypertension, diabetes, previous caesarean birth, previous postpartum haemorrhage, multiple pregnancy, abnormal fetal position, suspected infection or other risk factors may require closer observation. Respectful care means explaining the increased monitoring instead of portraying the woman as a problem. Statements such as, 'Because of your blood pressure history we will check you more frequently,' are more supportive than unexplained surveillance. The nurse should also identify communication needs at admission. Hearing impairment, visual impairment, limited literacy, language differences and cognitive difficulties require adaptation of teaching. Use professional interpreters where available rather than relying on children or accompanying persons for sensitive clinical conversations. Teach-back is useful: after explaining a plan, the nurse can ask the woman to tell the team in her own words what she understands. This is a safety strategy rather than a test of intelligence.

7. Communication as a Core Nursing Intervention:

Communication in maternity care is not an optional interpersonal skill; it is part of clinical safety. Labour can be unpredictable, and decisions may change rapidly. Women and their families need timely information about progress, monitoring, pain options, procedures and potential changes in plan. WHO intrapartum recommendations emphasize communication and woman-centred care as components of a positive childbirth experience (WHO, et al., 2018). Nurses can operationalize this through a simple communication cycle: prepare, explain, check, listen and close the loop. Preparing means gaining the woman's attention and creating privacy before discussing sensitive information. Explaining means using plain language, avoiding unnecessary jargon and breaking complex information into manageable parts. Checking means confirming understanding through teach-back or direct questions. Listening means allowing the woman to express concerns without interruption. Closing the loop means telling her what will happen next and when she will receive an update. This sequence

can be repeated throughout labour and is especially useful during handovers, transfer to theatre and changes in clinical status. Non-verbal communication is equally important. Tone of voice, facial expression, body position and pace can communicate either calmness or alarm. A nurse who appears rushed and avoids eye contact may unintentionally signal that the woman's needs are burdensome. In contrast, a brief pause, eye contact and an attentive posture can communicate presence. Staff should be aware that kindness does not require lengthy conversations at every moment; a focused sentence delivered with respect can be highly therapeutic when workload is high. Communication should also be tailored to family involvement. Some women want a partner or relative involved in all discussions, whereas others prefer privacy. The nurse should ask the woman who should receive information, while remaining attentive to legal and confidentiality requirements. Where a family member is included, the woman remains the primary patient. This is particularly important when discussing reproductive choices, contraception, operative birth, HIV status, mental health or concerns related to safety at home. When language barriers exist, communication errors are more likely. Nurses should use trained interpreters or approved communication systems and avoid assuming that a nod means understanding. Written information should be provided in accessible language when possible. Visual aids can help with explanations of labour positions, breathing, pain-relief options and newborn care. The objective is not merely to deliver information but to support understanding that the woman can use when making decisions.

Table. 2: Communication as a Core Nursing Intervention

Situation	Nursing communication action	Example wording
Admission	Introduce self, explain assessment and ask about concerns.	"I am your nurse. I will first check you and the baby, then explain what we found and what happens next."
Vaginal examination	Explain reason, steps and permission before proceeding.	"This examination helps us understand how labour is progressing. Is it okay for me to proceed?"
Change in fetal status	State concern calmly, explain immediate steps and update the woman.	"The baby's heart rate has changed, so we are going to reposition you and assess further."
Need for intervention	Explain indication, benefits, risks and alternatives when time permits.	"We recommend this because… Let's discuss what will happen and what questions you have."
Transfer to theatre	Maintain orientation and continuity.	"We are moving you to theatre because… I will stay with you until the team takes over and explain each step."
Postnatal discussion	Invite questions and clarify what occurred.	"Would you like me to go over what happened during the birth?

8. Informed Consent and Shared Decision-Making:

Informed consent in maternity care should be an ongoing process rather than a signature obtained once. Consent requires adequate information, an opportunity to ask questions and freedom from coercion within the clinical context. The nurse supports consent by ensuring that the woman knows what is proposed and by alerting the medical or midwifery team when she appears uncertain or asks for clarification. For routine procedures, the explanation can be brief but should still be understandable. For major interventions such as induction, operative birth or invasive procedures, the discussion should be appropriately detailed according to local law and policy. Shared decision-making is particularly important when more than one reasonable option exists. Birth plans can facilitate conversations about preferences, but they should not be treated as fixed promises. (Shareef, et al., 2023) identified autonomy, control, trust and provider professionalism as themes associated with birth plans. Nurses can ask what is most important to the woman, clarify what choices remain possible and prepare her for the possibility that labour may not follow the expected plan. This approach protects autonomy without creating unrealistic expectations. The nurse also has a role in detecting misunderstanding or pressure. A woman may agree to a procedure because she thinks refusal will cause anger or poorer care. Respectful practice requires staff to avoid threats, shaming or statements suggesting moral judgment. Instead, questions can be phrased neutrally: 'What questions do you still have?' or 'Would you like a few minutes to discuss this with your support person if the situation allows?' When urgent intervention is necessary, the team

should explain the reason as clearly as the emergency permits and provide a post-event explanation when immediate consent could not be fully discussed. Documentation should reflect the decision-making process. Notes can include the indication for an intervention, the information provided, the woman's response, any preferences, and changes in plan. Good documentation supports continuity between shifts and protects both the patient and the healthcare team. It also allows quality-improvement teams to identify recurring communication problems, such as procedures frequently being performed without recorded explanation or repeated requests for preferences not being communicated to the next team.

9. Maternal Comfort and Non-Pharmacological Support:

Maternal comfort includes pain, position, temperature, hydration, bladder care, emotional state, noise, lighting and the feeling of control over the environment. Comfort assessment should be repeated because labour is dynamic. Nurses should not rely on a single numeric pain score; a woman may describe pain as intense while coping well, or may report a moderate score while feeling overwhelmed. The nursing response should therefore combine the intensity of pain with coping, function, anxiety and the woman's preference for support. Position changes can improve comfort and may help women remain active where clinically appropriate. Depending on the stage of labour and maternal-fetal condition, women may benefit from upright positions, side-lying, hands-and-knees positions, supported sitting, movement or use of a birth ball. The nurse should explain available options and ensure that monitoring, intravenous therapy and other equipment do not unnecessarily restrict safe movement. When a clinical indication requires reduced mobility, the reason should be communicated rather than simply imposed. Breathing, relaxation, massage, touch, warm applications and other non-pharmacological measures can be offered according to local resources and the woman's preferences. A systematic review by (Smith, et al.,2018) found evidence supporting relaxation approaches for pain management in labour, although effects vary by technique and context. A broader network meta-analysis also reported benefits from several non-pharmacological interventions in low-risk populations, emphasizing that evidence quality and applicability differ among interventions (Hu, et al., 2021). Nurses should therefore present these methods as supportive options rather than guaranteed pain elimination strategies. Pain relief should be individualized and inclusive of pharmacological methods where clinically appropriate. Women should not be shamed for requesting analgesia, nor should they be discouraged from using non-pharmacological methods if they prefer them. The nurse's role includes assessing eligibility, monitoring response, explaining expected effects, maintaining safety and reassessing comfort. The choice of analgesia may change during labour; respectful care accepts this flexibility. Comfort is also influenced by the environment. Noise, bright lights, frequent interruptions and unnecessary exposure can increase distress. Simple environmental changes, such as reducing avoidable noise, grouping care activities and protecting privacy with curtains, can improve the woman's sense of safety. Where staffing permits, continuity of a familiar nurse is valuable because repeated introduction and explanation can be tiring during prolonged labour.

10. Continuous Support and Birth Companionship:

Continuous support has a strong place in modern maternity care. The updated Cochrane review by (Bohren, et al.,2017) examined continuous one-to-one intrapartum support and concluded that support can improve several outcomes and the childbirth experience. The supportive person may be a nurse, midwife, doula, partner, family member or other chosen individual, depending on facility policy and the woman's preference. WHO recommends supporting women to have a companion of choice during labour and childbirth (WHO, et al., 2020). The nurse's role is not necessarily to replace a chosen companion but to integrate that person into safe care. The nurse can explain how the companion can help with hydration when permitted, position changes, breathing, reassurance, massage, communication of preferences and encouragement. The companion should also understand when staff need privacy or when clinical procedures require a more controlled environment. Clear guidance prevents the companion from feeling excluded while maintaining safety and professional boundaries. Companion inclusion may be particularly important for women who feel isolated in hospital environments. However, not every woman wants a companion. Respectful care means offering the choice rather than assuming it. Some women may prefer a female relative, some a partner, some a doula, and some may want private time. Cultural expectations should be acknowledged without imposing them. The woman should remain the decision-maker unless another legally authorized arrangement applies. Nurses should also recognize that companionship can become difficult during emergencies, operative birth or infection-control restrictions. Even when the companion cannot enter a procedure room, the team can explain why, provide updates where appropriate and facilitate reconnection as soon as safely possible. Restricting a companion should be based on a clear clinical, legal or infection-control reason rather than convenience or routine habit.

11. Clinical Safety within Respectful Care:

Respectful maternity care and patient safety are complementary. The nurse must maintain systematic maternal and fetal assessment, identify deterioration, activate emergency pathways and communicate changes promptly. WHO's Labour Care Guide was developed as a practical tool to support evidence-based, respectful care, with emphasis on safety, supportive care and avoidance of unnecessary interventions (WHO, et al., 2020). This approach is important because the way labour is monitored can influence whether interventions are triggered too early or too late. Accurate observation is one of the nurse's most important safety responsibilities. Maternal pulse, blood pressure, temperature, respiratory status, pain, bleeding, urine output and level of consciousness may change quickly. Fetal heart-rate assessment should be performed according to the clinical context and local protocol. When abnormalities occur, the nurse should not simply record them; she should interpret them within her scope, repeat assessments as indicated, communicate concerns and escalate according to the facility's emergency pathway. Emergency communication should be structured. SBAR or another standardized handover format can help the nurse communicate the situation, relevant background, assessment and immediate recommendation. Respectful communication during emergencies is possible when the team uses short explanations: 'We are concerned about the bleeding; we are calling the obstetric team now and preparing treatment.' This reduces uncertainty and preserves trust even when the environment becomes busy. Infection prevention is another component of safe care. Hand hygiene, aseptic technique, appropriate personal protective equipment and safe disposal are essential. Respectful practice includes explaining infection-control measures so that women do not interpret them as rejection. When restrictions are required, the nurse can explain the reason and offer alternatives for support. This is especially relevant during outbreaks or when local infection-control policies limit visitors. The nurse should balance vigilance with avoidance of unnecessary intervention. Monitoring must be clinically justified, and routine procedures should not be performed simply because they are traditional. ACOG's guidance notes that many common practices have limited or uncertain benefit for low-risk women in spontaneous labour and recommends shared decision-making around labour management (Committee on Obstetric Practice, 2017). Respectful nursing practice therefore involves knowing the protocol, understanding the rationale and speaking up when practice appears inconsistent with current guidance or the patient's needs.

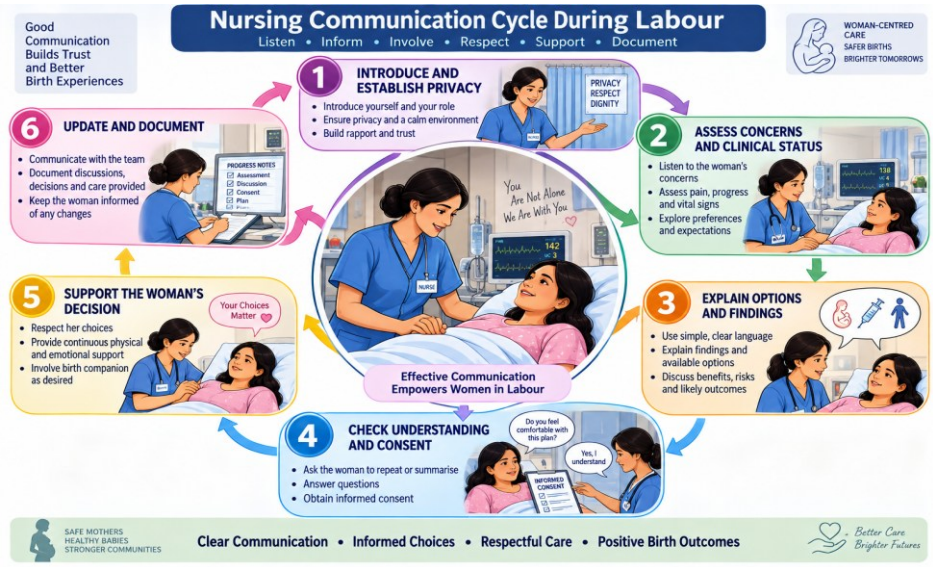


Figure. 2: Nursing Communication Cycle During Labour

12. Respectful Use of Obstetric Interventions:

Modern obstetric care includes interventions that can be lifesaving when appropriately indicated. Respectful practice does not mean avoiding induction, augmentation, operative vaginal birth, caesarean birth, analgesia or continuous monitoring when clinically required. The central question is how these interventions are communicated and whether they are used for appropriate indications. The woman should receive a clear explanation of why the intervention is being considered, what it involves, what benefits and risks are expected, and what alternatives exist when time permits. Induction of labour can be associated with uncertainty because women may have expected spontaneous labour. Nurses can reduce distress by explaining the sequence of steps, expected sensations, possible time course and monitoring requirements. During induction, the plan should be reassessed as labour evolves. If an induction does not progress as expected, the woman should not be blamed. Language that implies failure of the woman's body can be harmful and can undermine confidence.

Augmentation with oxytocin requires careful safety monitoring and clear communication. Nurses should explain the purpose of the infusion, the reason for ongoing observation and what sensations may occur. Changes in contraction pattern or fetal status should be reported promptly. The woman should not be left uncertain about why the dose is changing. The use of medication should be documented clearly, including dose changes, maternal response, fetal assessment and communication with the medical or midwifery team. Operative birth can be emotionally complex. A caesarean or assisted vaginal birth may be expected, unexpected or strongly desired or feared depending on the woman's circumstances. Respectful nursing care avoids assumptions about whether the woman should feel relieved, disappointed, frightened or grateful. Several emotions may occur at once. After the birth, the nurse can invite the woman to discuss what she remembers and what she wants clarified. This may help identify unanswered questions before discharge.

Trauma-Informed and Psychologically Supportive Maternity Nursing:

Trauma-informed maternity care recognizes that some women enter pregnancy or childbirth with previous experiences of violence, sexual assault, difficult medical procedures, pregnancy loss, severe anxiety or traumatic childbirth. The presence of trauma history should not be assumed, and women should not be required to disclose it. Instead, the nurse can create a safer environment through predictable communication, consent before touch, privacy, options where possible and respect for boundaries. Birth-related post-traumatic stress is a clinically relevant concern. A systematic review and meta-analysis by (Heyne, et al.,2022) examined birth-related post-traumatic stress in parents and identified childbirth as a potential traumatic event for some individuals. Another review by (Carter, et al., 2022) examined the relationship between mode of birth and postnatal post-traumatic stress, illustrating that psychological responses can be associated with both the birth event and the surrounding experience. These findings do not mean that a particular mode of birth causes trauma in every woman; they support individualized assessment rather than assumptions. A trauma-sensitive nursing approach begins before a distressing event. The nurse can ask permission before examinations, explain each step, offer a pause when clinically safe, and tell the woman what will happen next. During an emergency, these principles may be compressed but should not be abandoned. Afterward, a short explanation and opportunity for questions can help the woman construct a coherent account of what occurred. This may be especially valuable after unexpected operative birth or maternal or neonatal complications. Psychological support should continue after discharge when needed. Nurses can screen or observe for persistent distress, panic, intrusive memories, sleep disruption, severe anxiety, low mood or difficulty bonding, while recognizing the limits of nursing assessment and local referral pathways. WHO's perinatal mental health guide emphasizes respectful, stigma-free environments for identifying and responding to maternal mental health problems (WHO, et al., 2022). The nurse should know where women can access counselling, mental-health services and emergency support.

13. Cultural Safety and Individualized Care:

Cultural safety involves more than providing a list of cultural practices. It requires curiosity, humility and willingness to ask the woman what matters to her. Childbirth practices may be influenced by beliefs about modesty, family presence, food, touch, position, postpartum rituals, privacy, newborn handling and decision-making. Nurses should distinguish between preferences that can be accommodated safely and practices that conflict with urgent clinical requirements. When a preference cannot be followed, the woman should receive an explanation and, where possible, an alternative. Language is a central component of culturally safe care. Using the woman's preferred language can improve understanding and reduce anxiety. Interpreters should be used for complex or sensitive information. Family members may provide support, but relying on them for interpretation can create confidentiality and accuracy problems. For deaf or hard-of-hearing women, communication should be adapted to their preferred method. The same principle applies to women with learning or communication disabilities: information should be accessible, not withheld. Culturally responsive care must also avoid stereotyping. It is not safe to assume that all women from a particular community want the same labour position, family structure or level of medical intervention. The correct starting point is the individual woman. Asking 'What would make you feel more comfortable?' may reveal preferences that are not anticipated by staff. Respectful care is personalized because people within cultures are diverse. Gender-based violence and reproductive coercion may be relevant in some pregnancies. The nurse should know local protocols for private enquiry and referral. Questions should be asked sensitively and away from accompanying persons when safety permits. Documentation should be factual and secure. The objective is to identify risk and offer support rather than to conduct an investigation at the bedside.

14. Immediate Postpartum Respectful Care:

The immediate postpartum period is a time of transition from intrapartum monitoring to recovery and newborn care. Respect remains important because women may be exhausted, in pain, thirsty, emotionally overwhelmed or processing the events of birth. The nurse should explain immediate assessments, postpartum bleeding checks, uterine assessment, vital signs, pain management and newborn care in clear language. Women should not be expected to understand every procedure automatically simply because delivery has occurred. Early skin-to-skin contact can support maternal-newborn interaction and breastfeeding when mother and newborn are stable. The evidence base supports immediate or early skin-to-skin contact for healthy newborns, while clinical circumstances should guide timing when resuscitation or other urgent care is required (Moore, et al., 2016; Moore, et al., 2025). Respectful nursing practice includes explaining what is happening, facilitating contact when possible, protecting privacy and maintaining safety during skin-to-skin care. Pain and physical recovery must be actively assessed. Perineal trauma, uterine cramping, abdominal incision pain, after-pains, urinary difficulties and mobility limitations may affect comfort. The nurse should assess pain rather than assume that the woman will report it. Non-pharmacological measures and prescribed analgesics should be offered according to clinical need and protocol. The woman should know when pain is expected and when it may indicate a complication that requires review. Emotional assessment is equally important. A woman may feel relief, joy, sadness, disappointment, fear or numbness. The nurse should create space for the woman to express feelings without forcing a particular emotional response. Where concerns about depression, anxiety, traumatic stress or safety are present, appropriate referral should be initiated. Respectful postnatal care therefore connects physical recovery, mental health, newborn wellbeing and social support rather than treating them as separate tasks.

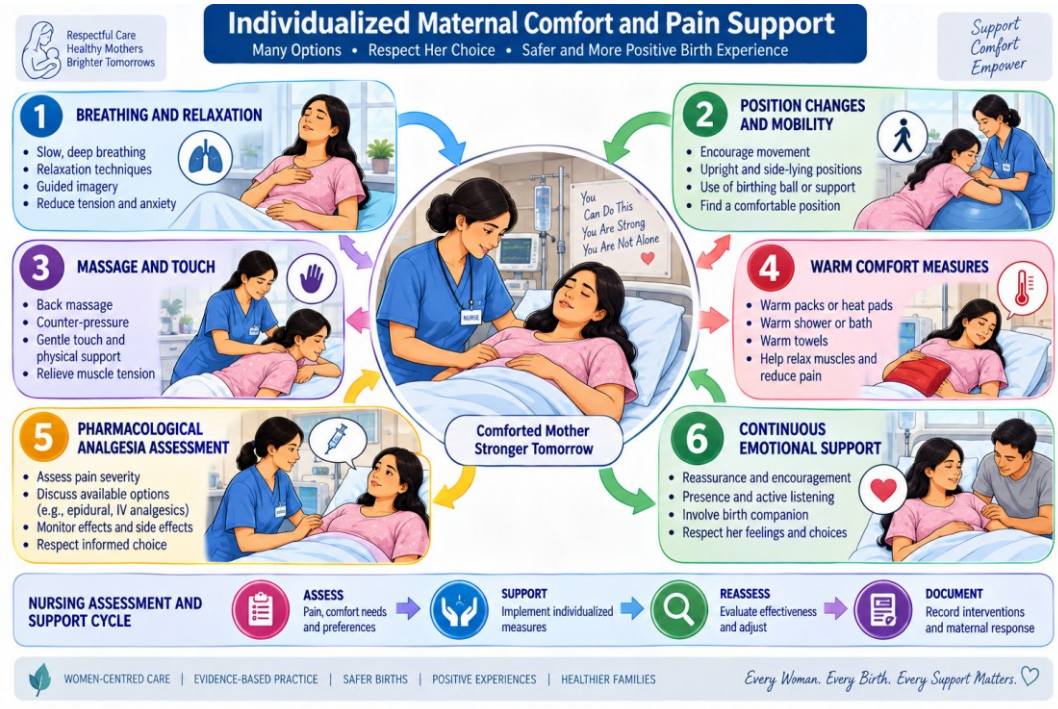


Figure. 2: Individualized Maternal Comfort and Pain Support

15. Breastfeeding, Newborn Care and Respectful Transition to Motherhood:

Respectful maternity care continues into the transition to motherhood. Nurses should provide practical support for feeding without turning breastfeeding into a moral judgment. The woman may have chosen breastfeeding, formula feeding or a mixed approach, and clinical circumstances may affect feeding plans. Support should focus on informed choice, infant safety, maternal comfort and practical skills. When breastfeeding is planned, the nurse can assist with positioning, latch and recognition of feeding cues while respecting privacy and the woman's pace of learning. Newborn care should be explained in a way that includes the mother as a participant. Routine newborn assessments, prophylaxis, identification procedures, thermoregulation and observations can be introduced as steps rather than unexplained tasks. When the newborn requires special care, the mother should receive information about where the baby is going, why the care is needed and how she can remain involved. Clear communication can reduce fear and support early attachment even when mother and newborn

are temporarily separated. Respectful nursing also involves preparing the mother for discharge. Education should include warning signs for maternal complications, newborn danger signs, medication instructions, wound or perineal care, feeding, hygiene, emotional wellbeing and follow-up appointments. Teach-back is valuable because fatigue and stress can reduce retention of information. The nurse can ask the woman to explain what symptoms would require urgent review and how she plans to obtain help.

16. Nursing Role in Continuity of Care and Handover:

Handover is a critical point at which respectful care can either be strengthened or disrupted. Women may feel frustrated when every new staff member repeats the same questions without reading previous documentation, or when preferences are lost between shifts. A structured handover should therefore include not only clinical data but also the woman's priorities, communication needs, pain preferences, companion arrangements, recent decisions and concerns. This helps the next nurse maintain continuity. Bedside handover can be useful when conducted with privacy and consent. The nurse should avoid discussing sensitive information in front of unrelated people and should check whether the woman is comfortable with bedside discussion. The woman can be invited to correct or add information. This converts handover from a staff-only process into an opportunity for patient participation and safety checking. Continuity also matters after transfer to theatre, recovery, high-dependency care or another facility. The receiving team should know what the woman has been told, what questions remain unanswered and what support person is involved. When transfer is urgent, these details may be brief but should still be communicated when feasible. Renfrew et al. (2014) emphasized continuity and relational care as part of quality maternal and newborn care, while WHO standards similarly emphasize coherent care processes across the health system (WHO, 2016).

17. Quality Improvement, Audit and Accountability:

Respectful maternity care becomes sustainable when it is measurable. Facilities can audit both positive behaviours and harmful experiences. Measures may include whether privacy was maintained, whether informed consent was documented, whether companions were supported, whether pain was assessed and reassessed, whether women received explanations before examinations, whether complaints were addressed, and whether women reported feeling respected. Indicators should be used for learning and improvement rather than punitive surveillance alone. The WHO quality framework provides a foundation for measuring both provision and experience of care (WHO, et al., 2016). India's LaQshya programme similarly incorporates quality circles, staff training, process improvement and respectful maternity care into labour-room quality systems (Ministry of Health and Family Welfare, et al., 2017). Nurses can contribute by participating in audits, collecting patient feedback, identifying recurring communication failures and testing small changes through quality-improvement cycles. Patient feedback should include both quantitative and qualitative methods. A short postnatal questionnaire can ask whether the woman felt respected, understood the information, had adequate privacy and was supported during pain. Open-ended questions can identify problems that fixed scales miss. Complaints and compliments should be reviewed for themes. A respectful system does not treat complaints as threats; it uses them as opportunities to understand service failures. Quality improvement can follow a simple cycle: identify the problem, understand the cause, design a small change, test it, measure the result and standardize successful practice. For example, if women frequently report that vaginal examinations were unexpected, the unit can introduce a standard 'explain-and-consent' script, audit use for two months and review patient feedback. If privacy is compromised during busy shifts, the team can redesign curtain use, observer access and room allocation. LaQshya explicitly uses quality-improvement approaches and focused cycles for respectful maternity care and related processes (Ministry of Health and Family Welfare, et al., 2017).

Table. 4: Quality Improvement, Audit and Accountability

Indicator	Possible measure	Source of data	Suggested review question
Respectful communication	Percentage of women reporting clear explanations	Postnatal feedback form	Did staff explain what was happening?
Consent	Documented explanation/consent before relevant procedures	Clinical records and audit	Was consent documented when applicable?

Indicator	Possible measure	Source of data	Suggested review question
Privacy	Reports of adequate privacy during examinations and birth	Patient feedback and direct observation	Was your privacy protected?
Pain support	Pain assessment and reassessment documented	Clinical record audit	Was pain assessed and relief offered?
Companion support	Percentage of women offered chosen companionship when feasible	Admission records	Was your preferred support person facilitated?
Safety escalation	Time from abnormal finding to documented escalation	Clinical records	Were concerns recognized and acted upon promptly?
Experience	Composite positive childbirth-experience measure	Structured patient survey	Did you feel safe, respected and involved?

18. Barriers to Respectful Maternity Care:

The implementation of respectful maternity care may be limited by staffing shortages, workload, and overcrowding, inadequate privacy, limited access to pain relief, insufficient training, hierarchical workplace cultures and inconsistent leadership. It is important not to frame disrespect simply as an individual personality problem. Freedman and Kruk (2014) argued for attention to broader accountability and quality structures, while Kruk et al. (2018) emphasized the importance of systems that reliably provide high-quality care. A nurse who wants to communicate respectfully may struggle when caring for too many women simultaneously and working within a poorly designed unit. Language and cultural barriers can also create difficulty. In multilingual settings, delays in obtaining interpreters may interfere with informed communication. Institutions should therefore maintain accessible interpretation processes and translated materials. Similarly, privacy is affected by physical design. Curtains, separate examination areas and controlled visitor access can support respectful care, while overcrowded rooms may make confidentiality difficult. Infrastructure is therefore part of respectful practice. Another barrier is normalization of disrespect. Staff may repeat phrases or practices because 'this is how it is done here'. New nurses may learn unhelpful habits from experienced staff unless educators and leaders model alternatives. Training should therefore include role-play, reflective exercises, communication practice, and informed consent, management of aggression, cultural safety and debriefing after emergencies. Orientation programmes should make respectful maternity care an explicit competency rather than an assumed personal quality. Fear of loss of authority may also undermine shared decision-making. Some clinicians may worry that explaining uncertainty or offering choices reduces confidence. In practice, professional authority can coexist with collaborative communication. The nurse can remain clear about clinical recommendations while acknowledging the woman's role in decision-making. Staff should distinguish disagreement from disrespect: a woman can disagree with a recommendation and still be treated calmly and professionally.

19. Strategies for Nursing Education and Professional Development:

Nursing education should prepare students and staff to combine technical competence with relational competence. Simulation can be used to practise admission communication, informed consent, vaginal examination explanation, unexpected change in fetal status, emergency transfer, operative birth communication and postnatal debriefing. Students should receive feedback not only on whether they completed the task but also on their language, privacy practices, listening behaviour and response to patient concerns. Clinical mentorship is important because respectful behaviour is learned through observation. Senior nurses can model how to introduce themselves, ask permission, communicate delays, update families, and remain calm during emergencies. Mentorship should also create space to discuss ethical dilemmas. When a woman's preference conflicts with safety requirements, nurses can learn how to explain the rationale while preserving dignity. Reflective practice can reduce normalization of harmful communication. After a difficult shift, a nurse can ask: Did I listen? Did I explain before touching? Did I assume anything about the woman? Did I preserve privacy? Did I respond to pain? Did I communicate a concern promptly? What could the team change next time? Reflection should not become self-blame; it should support learning and systems improvement. Interprofessional training is particularly useful. Obstetricians, midwives, nurses, anaesthesia

staff, paediatricians and support staff influence the same patient experience. A nurse may create excellent communication that is undermined when another team member communicates abruptly. Shared training and agreed standards can reduce inconsistency. The goal is a culture in which every staff member understands that respectful behaviour is part of clinical professionalism.

20. Role of Nurse Leaders and Managers:

Nurse leaders influence respectful maternity care through staffing, supervision, policy, education and the physical environment. Leaders should monitor workload, protect time for handover, support incident reporting and ensure that policies on consent, privacy, companionship and communication are implemented. A respectful culture cannot depend entirely on individual motivation; leaders must align resources and expectations with the desired standard. Managers should also respond to staff distress. Repeated exposure to emergencies, neonatal loss, maternal complications and high workload can affect staff wellbeing and communication. Debriefing after critical events, peer support and access to professional support may help teams recover and reduce the risk of burnout-related communication problems. Supporting staff does not excuse disrespect, but it recognizes that sustainable quality requires a workforce that can function safely under pressure. Audits should be transparent and linked to action. If patient feedback shows repeated concerns about shouting, lack of explanation or privacy problems, leaders should review root causes and implement targeted changes. Staff should receive feedback on both improvement and remaining gaps. Recognition of good practice can reinforce desired behaviours without creating competition or ranking individuals.

21. Practical Nursing Strategies Across the Childbirth Continuum:

A practical strategy is to treat every encounter as a mini therapeutic intervention. At antenatal visits, nurses can prepare women for what to expect and help identify preferences. On admission, nurses establish trust and assess clinical risk. During labour, they provide information, comfort, observation and advocacy. During birth, they support privacy, communication and safe teamwork. Immediately after birth, they promote mother-newborn contact when appropriate, assess recovery and explain the next steps. Before discharge, they confirm understanding, warning signs, follow-up and emotional support needs. One useful bedside model is 'ASK': Attend, Share information, Keep the woman involved. Attend means being physically and emotionally present, listening and noticing distress. Share information means explaining findings, procedures and changes in plan. Keep the woman involved means offering choices, checking preferences and supporting participation. This is simple enough to remember during busy shifts and can be reinforced during supervision. Another strategy is a 'pause before procedure'. Before an intimate examination, insertion, injection, catheterization or transfer, the nurse pauses briefly to explain what will happen, why it is needed, what the woman may feel, and what will be done afterward. Even when the procedure takes only a few minutes, the pause can prevent the experience of being handled without explanation. In emergencies, the pause may be shortened to one or two sentences but remains valuable when time allows.

Table. 5: Practical Nursing Strategies

Phase	Priority nursing actions	Documentation focus
Antenatal	Education, preferences, risk communication, birth preparation, emotional wellbeing.	Relevant preferences, education provided, referrals.
Admission	Introduce self, privacy, clinical assessment, language needs, companion preference, pain and concerns.	Assessment, preferences, risks, plan.
First stage of labour	Monitoring, comfort, movement, hydration where appropriate, communication, emotional support.	Observations, interventions, response, communication.
Second/third stage	Safe birth support, positioning, privacy, emergency readiness, respectful explanations.	Maternal/fetal status, procedures, outcomes, medications.
Immediate postpartum	Bleeding/vitals, pain, skin-to-skin when appropriate, feeding support, emotional check.	Postpartum assessment, newborn interaction, education.

Phase	Priority nursing actions	Documentation focus
Discharge/follow-up	Warning signs, medicines, newborn care, mental health, contraception and follow-up.	Teaching, understanding, referrals, follow-up plan.

22. Ethical and Legal Dimensions:

Respectful maternity care is closely related to professional ethics. Respect for persons supports autonomy, beneficence supports actions intended to promote wellbeing, non-maleficence emphasizes avoidance of harm, and justice requires fair treatment. Confidentiality and informed consent are also central to ethical practice. Nurses should be familiar with local laws, professional codes and institutional policies regarding consent, confidentiality, minors, emergency treatment and reproductive healthcare. Documentation is an ethical and professional responsibility. Notes should be factual, timely and objective. Avoid stigmatizing labels and emotional judgments. Instead of writing that a woman was 'difficult', document the specific behaviour or concern and the response. Clear documentation protects continuity of care and allows other professionals to understand what has been discussed. It also supports accountability when care is reviewed. Respectful care includes the right to complain and receive a response. Facilities should provide accessible mechanisms for feedback and grievances. Nurses should not retaliate against women who express concerns. Complaints should be reviewed through established procedures. Where a serious safety or dignity issue is identified, appropriate reporting and safeguarding pathways should be followed.

23. Application to the Indian Maternity-Care Context:

In India, respectful maternity care is explicitly included in national labour-room quality improvement through LaQshya. The programme aims to improve quality of care during delivery and the immediate postpartum period, enhance satisfaction and positive birthing experience, and provide respectful maternity care in public facilities (National Health Mission, 2026). Its framework includes infrastructure improvement, human resources, capacity building, quality processes and facility-level quality teams. For nurses, this creates a practical bridge between individual bedside behaviour and institutional quality improvement. The LaQshya approach also illustrates why respectful care should not be separated from emergency capability. Labour rooms need standardized processes, adequate equipment, trained staff, timely management of complications, infection prevention and clear documentation. A respectful service is one in which the woman is treated courteously and safely, while the system is prepared to manage postpartum haemorrhage, hypertensive emergencies, sepsis, fetal compromise, operative delivery and newborn problems. Quality improvement should therefore examine both experience measures and clinical outcomes. Nurses working in Indian maternity settings can apply culturally responsive communication across diverse languages and family structures. The woman should remain the primary focus even when relatives play a strong role. Privacy should be protected during examinations, and education should be accessible to women with varying literacy levels. Where staffing and physical design create challenges, nurses can still use small strategies such as introducing themselves, closing curtains, explaining delays, asking the woman's preferred support person and ensuring that important information is carried forward during handover.

24. Common Nursing Mistakes That Can Undermine Respectful Care:

One common mistake is assuming that clinical competence automatically produces a positive experience. A procedure may be technically correct but psychologically harmful if performed without explanation. A second mistake is over-reassurance, such as repeatedly saying 'Everything is fine' when the woman has genuine concerns. Honest, calm communication is more trustworthy than reassurance that is not supported by the available information. Another mistake is communicating only when something is wrong. Women benefit from brief routine updates about progress, monitoring and what to expect next. Silence can increase uncertainty. Similarly, avoiding questions because the unit is busy can make women feel invisible. A nurse may not have time for a long conversation, but can still acknowledge the woman and explain when she will return. A further mistake is equating respect with agreement. Nurses may need to recommend or support interventions that the woman did not originally want because the clinical situation changed. Respect means explaining the change, involving the woman as much as possible and avoiding blame. It does not mean promising that every preference will be followed regardless of risk. Finally, staff should avoid treating feedback as personal criticism. Patient comments can reveal system problems that are difficult for staff to see from inside the service. Reviewing feedback professionally can help improve communication, environment, privacy and coordination. Respectful maternity care is therefore both something nurses provide and something the service learns from women about their experience.

25. Discussion:

The evidence reviewed in this article supports a view of respectful maternity care as a multidimensional quality construct rather than a single communication behaviour. WHO recommendations, quality standards and the Labour Care Guide connect respectful experience with safe clinical processes (WHO, 2016; WHO, 2018; WHO, 2020). Research on mistreatment demonstrates that harm can occur through abuse, discrimination, poor communication, lack of privacy, non-consented care and neglect (Bohren, et al., 2015). Research on women's priorities emphasizes emotional safety, trust, information, support and a sense of control (Downe, et al., 2018). These strands of evidence converge on the idea that safe care and respectful care should be delivered together. Nursing is particularly well positioned to operationalize this approach because nurses frequently remain at the bedside and observe both clinical changes and emotional responses. The nursing contribution is not limited to monitoring vital signs and administering prescribed treatment. It includes explaining, listening, facilitating choices, protecting privacy, supporting coping, coordinating the team, documenting decisions and advocating when communication breaks down. This is consistent with the evidence-informed maternity-care framework described by (Renfrew et al., 2014), which emphasizes skilled care that strengthens women's capabilities while maintaining timely access to emergency treatment. The evidence also indicates that supportive care can influence childbirth experience. Continuous support can improve several labour outcomes (Bohren, et al., 2017), companion access is recommended by WHO (WHO, 2020), and early skin-to-skin care is supported by systematic review evidence when mother and newborn are stable (Moore, et al., 2016). These interventions share a common feature: they increase connection and participation without replacing clinical assessment. They are therefore highly compatible with nursing practice. At the same time, respectful maternity care should not be reduced to satisfaction scores. Satisfaction can be influenced by expectations, resources, culture and outcome, and a woman may be satisfied despite receiving suboptimal care or dissatisfied despite clinically appropriate care. Quality improvement should therefore combine experience measures with clinical indicators. (Kruk, et al., 2018) emphasize that high-quality health systems should pursue better outcomes, competent care, user experience and equity together. Maternity services can adopt this integrated approach by auditing safety events, intervention rates, communication, privacy, patient-reported experience and complaints. The balance between autonomy and safety is another key issue. Shared decision-making is possible even when options are constrained. In emergencies, the time available for full discussion may be limited, but the woman should still receive a clear explanation when feasible and a debrief afterwards. This approach preserves the underlying ethical commitment to respect while recognizing the realities of obstetric emergencies. The goal is not to create conflict between medical decision-making and patient choice, but to maximize participation within the clinical situation. For India, LaQshya provides a useful implementation platform because it connects respectful maternity care with labour-room quality systems, training, quality circles and process improvement (National Health Mission, 2017; National Health Mission, et al., 2026). Nurses can use these structures to turn respectful care into measurable practice through audits, feedback and focused improvement cycles. The broader lesson is that culture change requires leadership, resources, education and accountability, not only individual goodwill.

Recommended Nursing Practice Checklist:

1. Introduce yourself and use the woman’s preferred name; explain your role and the immediate plan.
2. Protect privacy during examinations, birth and sensitive discussions; limit unnecessary observers.
3. Explain procedures before they occur, obtain consent where required, and check understanding.
4. Ask about pain, fear, previous difficult experiences, communication needs and support preferences.
5. Offer evidence-based comfort measures and reassess their effect rather than assuming they worked.
6. Support mobility and positioning when clinically appropriate and explain restrictions when they are necessary.
7. Facilitate a companion of choice where feasible and compatible with safety and policy.
8. Monitor maternal and fetal wellbeing accurately and escalate deterioration without delay.
9. Use structured handover so clinical information and the woman’s preferences are carried forward.
10. Provide postnatal education, emotional support, warning signs, follow-up and opportunity for questions.
11. Document significant assessments, decisions, education, preferences, interventions and responses.
12. Participate in quality improvement, patient feedback, audits and respectful-care training.

26. Conclusion:

Respectful maternity care is a fundamental component of modern obstetric nursing. It requires more than polite language: it combines dignity, privacy, communication, informed choice, emotional support, individualized comfort, clinical safety, cultural responsiveness, companionship, continuity and accountability. The evidence and international guidance reviewed here indicate that women value being listened to, informed, supported

and treated as active participants while receiving safe and effective clinical care (Downe, et al., 2018; WHO, et al., 2018). Nurses have a central role in translating these principles into practice. Through structured communication, consent before procedures, comfort assessment, support during labour, emergency readiness, respectful handover, postnatal education and quality improvement, nurses can influence both safety and childbirth experience. Continuous support and companion involvement can strengthen emotional and practical support, while trauma-informed and culturally responsive approaches can reduce unnecessary distress. At the same time, nurses must remain alert to clinical deterioration and escalate promptly. Respectful care never means delaying lifesaving treatment. A modern maternity service should therefore aim for a dual outcome: the best achievable clinical outcome and an experience in which women feel safe, respected, informed and involved. Achieving this standard requires individual skills, supportive leadership, adequate staffing, appropriate infrastructure, clear policies and measurement of both clinical and experiential outcomes. In India and elsewhere, quality-improvement programmes such as LaQshya demonstrate that respectful maternity care can be embedded within broader labour-room systems. The nursing profession is well placed to lead this work because its daily practice connects technical care with human experience.

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