Respectful maternity care in contemporary obstetric practice: nursing strategies to enhance maternal comfort, safety, communication, and childbirth experience

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Abstract:

Respectful maternity care (RMC) is a central component of safe, high-quality obstetric practice. It recognises every woman as a rights-holder and an active participant in decisions about pregnancy, labour, birth and the postnatal period. Respect is demonstrated through dignity, privacy, confidentiality, informed consent, clear communication, freedom from discrimination and abuse, emotional support, and timely evidence-based clinical care. Despite international guidance and national quality initiatives, disrespectful treatment continues to be reported in diverse maternity settings. Its forms include verbal humiliation, physical or sexual abuse, procedures without valid consent, lack of privacy, discrimination, neglect, abandonment, coercion and health-system practices that prevent women from making meaningful choices. Contemporary nursing practice can reduce these risks by embedding respectful behaviours into routine clinical workflows rather than treating kindness as an optional personal quality. This narrative review synthesises major global guidance and selected peer-reviewed evidence on the principles, barriers, measurement and implementation of RMC, with particular attention to nursing strategies across antenatal, intrapartum and postnatal care. It discusses consent and shared decision-making, trauma-informed communication, birth companionship, comfort measures, cultural safety, equity, emergency care, documentation, staff support and facility-level quality improvement. Evidence indicates that multicomponent RMC programmes and provider training can improve reported care experiences, although certainty about downstream maternal and newborn clinical outcomes remains limited. Recent reviews also highlight variation in definitions and measurement tools, reinforcing the need for local adaptation and transparent monitoring. The review concludes that respectful care is both an ethical obligation and a quality-of-care domain. Sustainable improvement requires capable staff, adequate staffing and supplies, supportive leadership, accountability mechanisms, accessible feedback systems and participation of women and communities. Clinical urgency may change the sequence or speed of care, but it does not remove the obligation to communicate, preserve dignity and seek consent whenever possible.

Keywords:

Respectful maternity care; maternity nursing; person-centred care; informed consent; childbirth experience; communication; maternal safety; women's rights; quality improvement.

1. Introduction:

Pregnancy and childbirth are major life events with physical, emotional, social and cultural dimensions. For many women, the quality of maternity care is remembered not only through clinical outcomes but also through the way staff speak, explain procedures, respond to fear, protect privacy and involve them in decisions. A clinically effective intervention can still be experienced as harmful when it is imposed without explanation, performed in front of unnecessary observers, or accompanied by humiliation. Conversely, respectful communication can help a woman understand risk, participate in care and feel supported during an unpredictable event. Respectful maternity care therefore should not be separated from obstetric safety; it is one of the conditions through which safe care is delivered and trusted. The World Health Organization (WHO) recommends care that preserves dignity, privacy and confidentiality, protects women from harm and mistreatment, and supports informed choice and companionship throughout labour and childbirth (WHO, 2018). Quality-system analyses also emphasise that coverage alone is insufficient without competent, respectful processes and accountability (Kruk et al., 2018).

The need for RMC has become more visible as childbirth has increasingly moved into health facilities. Facility birth can provide prompt access to skilled personnel, medicines, surgery, blood transfusion and newborn resuscitation, but location alone does not guarantee high-quality care. Research has documented experiences of non-consented examinations, disrespectful language, neglect, non-confidential care and discrimination in different health systems (Bohren et al., 2015; Bohren et al., 2019). These experiences can undermine trust and may discourage future use of maternity and postnatal services. RMC is consequently relevant to clinical safety, human rights, equity, service utilisation and public confidence in health institutions (Freedman and Kruk, 2014).

Nurses and midwives occupy a pivotal position because they often provide repeated contact throughout labour, explain monitoring and procedures, support comfort, recognise deterioration, coordinate referrals and communicate with families. Their work operates within teams and systems, however, and individual goodwill cannot compensate for every structural barrier. Overcrowding, understaffing, supply shortages, restrictive routines, hierarchical decision-making and inadequate privacy can make respectful care harder to deliver. A useful review must therefore address both individual interactions and the organisational conditions that support them. The purpose of this article is to explain the principles of RMC and translate evidence into practical nursing strategies for improving comfort, safety, communication and childbirth experience.

2. Review Approach and Scope:

This article is a narrative review intended to integrate global guidance, selected systematic reviews, observational studies, and measurement research and policy documents relevant to respectful maternity care. The evidence base was assembled through focused searches of WHO publications, PubMed-indexed literature, Cochrane resources, peer-reviewed reproductive-health journals and Indian maternity quality guidance. Priority was given to foundational rights-based frameworks, guideline recommendations, systematic reviews and studies that directly examined mistreatment, measurement or RMC interventions. Key concepts included respectful maternity care, mistreatment during childbirth, informed consent, person-centred maternity care, communication, continuous labour support, postnatal experience and quality improvement. The search was purposive rather than a protocol-driven systematic review; it did not apply a formal screening flow diagram or a pooled analysis. The findings should therefore be interpreted as a reasoned synthesis of selected evidence, not as an exhaustive systematic review.

Evidence was interpreted with attention to study design, geography, implementation context and the outcomes actually measured. Descriptive prevalence studies can show the scale and types of reported mistreatment but cannot establish why every event occurred. Intervention studies can suggest feasible strategies but may be limited by small samples, non-randomised designs or short follow-up. Guidelines provide recommendations that combine evidence with values and feasibility considerations; they should be adapted to national law, professional scope and local clinical protocols. The article distinguishes strong ethical duties such as avoiding abuse and seeking valid consent from areas in which the best operational method or effect size remains uncertain. This distinction is

important because uncertainty about the magnitude of benefit is not a justification for undignified treatment.

3. Concept and Core Principles of Respectful Maternity Care:

3.1. Meaning of respectful maternity care:

RMC refers to care that protects dignity, autonomy, privacy, confidentiality and equality while providing clinically appropriate support before, during and after birth. It is broader than politeness. A nurse may speak gently and still provide non-respectful care if a procedure is performed without consent, the woman is denied information, or staff ignore her pain. Equally, a clinically urgent intervention may be respectful when the team explains the immediate danger, seeks consent if the woman has capacity and time permits, uses the least restrictive approach, protects her body and documents the reasoning. WHO's framework links RMC to safety, effective communication, informed choice and continuous support, placing experience of care alongside the provision of evidence-based clinical interventions (WHO, 2018; WHO, 2016).

A useful way to operationalise RMC is to ask what the woman experiences and what the service provides. Experience includes whether she is listened to, believed, treated without humiliation, informed in a language she understands, and included in decisions. Provision includes functioning equipment, skilled staff, medicines, clean facilities, appropriate referral and prompt emergency response. These dimensions are interdependent. A woman cannot exercise a meaningful choice if options are not explained, if a requested analgesic is unavailable, or if the facility has no safe alternative to a routine intervention. Respectful care does not require that every preference be clinically possible; it requires honest explanation, collaborative problem-solving and freedom from coercion.

3.2. Human rights, ethics and professional responsibility:

The human-rights basis of RMC reflects the principle that pregnancy does not diminish a person's rights to bodily integrity, non-discrimination, privacy or participation in decisions. The WHO statement on prevention and elimination of disrespect and abuse describes mistreatment during facility birth as an important public-health and human-rights concern (WHO, 2014). The White Ribbon Alliance charter similarly frames childbearing women as entitled to dignified, equitable and evidence-based care (White Ribbon Alliance, 2011). In professional practice, these principles overlap with beneficence, non-maleficence, autonomy, justice, confidentiality and accountability. Nursing codes of conduct generally require respect for persons, protection of vulnerable patients, competent practice and advocacy within applicable legal and institutional frameworks.

Rights-based care must be applied without assuming that all women have the same needs or define comfort in the same way. One woman may want quiet and minimal conversation; another may request frequent explanations, prayer, music or a family companion. A woman may decline a student examination, a particular analgesic or an offered intervention. The nurse's responsibility is to establish what matters to the individual, explain clinically relevant options, clarify any limits and preserve choice wherever possible. Advocacy is particularly important when language, age, disability, poverty, migration status, caste, ethnicity or social position makes it harder for a woman to challenge authority.

3.3. Respectful care is not opposed to clinical safety:

A false dichotomy sometimes appears in maternity services: either staff act quickly to protect mother and baby, or they pause to obtain consent and communicate. In practice, communication is a safety tool. A concise explanation can reduce confusion, support cooperation and help a woman understand why an urgent change is needed. The amount of discussion will depend on the clinical situation. In a life-threatening emergency, a team may need to initiate immediately necessary measures while communicating in brief, direct language; where the woman has decision-making capacity and time permits, consent remains necessary. If the woman cannot participate, clinicians should follow relevant

law and emergency policy, seek an authorised surrogate when feasible, and document why delay was unsafe. Respectful care neither promotes refusal of evidence-based treatment nor allows convenience to be mislabelled as emergency.

A woman's preference is not automatically irrational because it differs from a clinician's recommendation. The care team should explain the expected benefits, material risks, alternatives and likely consequences of declining treatment. The woman should be given an opportunity to ask questions and express concerns. If a decision creates substantial risk, the team can seek senior review or a second opinion without threats, punishment or abandonment. Respect includes continuing to provide appropriate care even when a woman refuses a proposed intervention. This distinction is central to ethical obstetric practice and helps separate valid informed consent from a signature obtained under pressure.

4. Patterns and Consequences of Disrespect and Mistreatment:

4.1. Common forms of mistreatment:

The literature uses several overlapping categories to describe mistreatment during childbirth. Bowser and Hill's landscape analysis grouped commonly reported experiences into physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment or neglect, and detention related to inability to pay (Bowser and Hill, 2010). A later mixed-methods systematic review identified physical and verbal abuse, sexual abuse, stigma and discrimination, failures to meet professional standards, poor rapport between women and providers, and health-system constraints (Bohren et al., 2015; Kassa et al., 2020). These frameworks are not perfectly interchangeable, but both show that mistreatment can arise through overt acts, omissions, coercive practices and institutional arrangements.

Physical abuse includes slapping, pinching, forceful restraint without justification or other unnecessary physical acts. Verbal abuse includes insults, shouting intended to humiliate, threats, blame or comments that shame a woman for her pain, sexual history, parity or behaviour. Non-consented care includes vaginal examinations, episiotomy, augmentation, sterilisation, operative procedures or other interventions undertaken without meaningful explanation and valid consent. Non-confidential care occurs when bodies or personal information are exposed to people who do not need access. Neglect may involve leaving a woman without clinically appropriate monitoring, failing to respond to requests for assistance, or delaying assessment of warning signs. These behaviours should not be normalised as routine consequences of a busy labour ward.

Some harmful practices are more subtle. Staff may speak about a woman as though she were absent, refer to her by bed number rather than name, dismiss her reports of pain, or discuss intimate findings in a corridor. A facility may permit companions in policy but exclude them without a clear safety or privacy reason. A woman who cannot pay may be delayed, embarrassed or discharged before a safe plan is in place. Staff may pressure a woman to accept a procedure by implying that refusal makes her a bad mother. Such practices can undermine autonomy even if no physical assault occurs. The nurse should recognise the full spectrum of behaviours and use reporting and improvement processes that address both direct mistreatment and system conditions.

4.2. How common is mistreatment? Interpreting prevalence carefully:

Prevalence estimates vary widely because studies differ in setting, timing of interviews, sampling, definitions, question wording and willingness to disclose negative experiences. A 2025 global systematic review and meta-analysis included 117 studies and more than 209,000 participants across 37 countries and reported a pooled estimate of 54.5% for mistreatment or disrespect, with very high heterogeneity (Mirzania et al., 2025). The estimate is a signal of widespread concern, not a universal probability that can be applied unchanged to every maternity unit. A single pooled figure combines experiences and environments that are not equivalent. Specific forms of mistreatment can also vary substantially by facility and population, and women may report more than one form of disrespect.

An earlier four-country study using labour observations and community surveys documented a range of mistreatment, including physical and verbal abuse, stigma or discrimination and failure to meet professional standards (Bohren et al., 2019). In India, Ansari and Yeravdekar's 2020 systematic review included seven studies and reported high, variable estimates of disrespectful care; the authors noted non-consent, verbal abuse, threats, physical abuse and discrimination among reported forms (Ansari and Yeravdekar, 2020). The included studies were few and highly heterogeneous, and confidence intervals around pooled estimates were very wide. These figures should not be presented as a current national rate for all Indian facilities. They instead support the case for regular local measurement, qualitative listening and reporting that is sensitive to context.

Under-reporting is possible when women fear retaliation, depend on the facility for follow-up, do not know that the behaviour was unacceptable, or have limited privacy during interviews. Reports can also differ depending on whether questions are asked immediately after birth or later. Staff observations may miss verbal humiliation occurring outside sampled periods, while self-reports may be affected by recall or social desirability. A robust facility assessment should therefore use several sources: anonymous patient surveys, confidential interviews, observation where ethically appropriate, complaint review, staff feedback and audits of clinical documentation. No single indicator should be treated as a complete picture of respectful care.

4.3. Consequences for women, newborns and health services:

Mistreatment can cause immediate distress, shame, anger, fear and loss of trust. Some women describe memories of childbirth as traumatic, particularly when pain, helplessness and lack of control occur together. Negative experiences can affect how women interpret later symptoms, whether they seek postnatal care and whether they feel safe discussing concerns in subsequent pregnancies. Reviews have linked disrespect and abuse with barriers to postnatal service use and adverse well-being, although causal pathways differ across studies and should not be oversimplified (Minckas et al., 2021; Mira-Catalá et al., 2024). A respectful approach does not guarantee an uncomplicated birth or eliminate grief after adverse outcomes, but it can reduce avoidable distress and support recovery.

At service level, a pattern of disrespect can reduce trust in professional advice, generate complaints and contribute to avoidance of future facility birth. Women may share negative experiences within families and communities, shaping the reputation of a maternity service. Staff can also be affected by moral distress when workload and institutional routines prevent care that they regard as ethical. Repeated conflict, blame and lack of psychological safety can damage teamwork. RMC programmes should therefore protect women and also create environments where staff can speak up about unsafe conditions without fear of humiliation. Accountability should focus on preventing harm, responding fairly to individual misconduct and fixing structural conditions that repeatedly create risk.

5. Nursing Strategies across the Maternity Continuum:

5.1. Antenatal care: establish trust before labour:

Antenatal encounters provide an opportunity to learn how a woman wishes to communicate, identify practical and emotional needs, discuss birth preferences and prepare for possible complications. Nurses should ask open questions such as, "What would help you feel safe during labour?" and "Is there anything about examinations or touch that you would like us to know?" These questions should not force disclosure of trauma or intimate history. The woman should understand that she can choose what to share and that information will be treated confidentially. Antenatal education should explain common procedures, warning signs, available pain relief, referral pathways, companionship policies and how to request help. Information should be accessible in the preferred language and adapted for literacy, disability and age.

Birth planning is a conversation rather than a contract that must be followed regardless of changing circumstances. A useful plan may record preferred name and pronouns, language support, chosen companion, mobility and position preferences, sensory or cultural needs, pain-management preferences, previous traumatic experiences and how the woman would like staff to explain urgent

changes. The nurse should document preferences in a visible but confidential way, ensure the relevant team knows about them and revisit the plan when circumstances change. Women should be told that safety needs may require options to change and that decisions will be explained as fully as possible. This approach supports autonomy without creating unrealistic guarantees.

Antenatal care is also a setting for equity-focused assessment. Nurses can ask about transport, financial barriers, food insecurity, family support, intimate partner violence, housing, mental health and access to follow-up in a private, non-judgemental manner. Screening for violence or coercion must follow local safeguarding protocols, ensure safe confidentiality and avoid exposing the woman to greater risk if an accompanying person is controlling. Adolescents and unmarried women should receive evidence-based care without moral judgement. Women with disabilities may require accessible facilities, additional time or supported decision-making, but disability alone does not remove capacity. Nurses should distinguish a woman's own preferences from assumptions made by family members or staff.

5.2. Admission and first assessment in labour:

The first minutes in a labour unit can establish whether the woman feels welcomed or treated as an interruption. Staff should introduce themselves, confirm the woman's preferred name, explain immediate assessment, obtain permission before touching and make clear how to call for help. Clinical assessment should proceed promptly, but not as a silent series of actions performed around the woman. A concise explanation—what will be checked, why it matters and what the woman may feel—often takes only seconds. The nurse should ask about contractions, membrane rupture, bleeding, fetal movement, pain, prior complications, allergies, medications, support person and any urgent concerns, while observing privacy and using a professional interpreter when required.

Triage requires a balance of respectful engagement and rapid identification of risk. Women with major bleeding, seizures, severe hypertension symptoms, suspected cord prolapse, collapse, imminent birth or other emergency signs need urgent assessment. The team should avoid using urgency as a reason to shout, insult or ignore the woman. Staff can assign one team member to communicate while other members prepare equipment and treatment. If a woman is temporarily separated from her support person, staff should explain why, how long the separation is expected to last and what support remains available. Reassessment should occur when the immediate threat has been addressed.

Privacy during admission includes curtains or screens, doors where possible, limiting unnecessary people in the examination area and ensuring that educational observers introduce themselves and seek permission. A woman should not have to repeat her most sensitive history in a crowded corridor. If a transfer or handover requires sharing information, it should be limited to what is necessary for safe care and made in a way that protects confidentiality. When bed pressure makes ideal privacy difficult, the team should use available screens and explain the limitation without treating exposure as inconsequential. Simple environmental actions communicate respect more effectively than posters that are not reflected in practice.

5.3. Informed consent and shared decision-making:

Valid consent is a process of communication, not merely a signature. It requires adequate information, understanding, voluntariness and decision-making capacity for the decision at hand. For significant interventions, the explanation should include the reason for the procedure, expected benefits, material risks, reasonable alternatives, what may happen if the procedure is delayed or declined, and the opportunity to ask questions. Language should be plain and specific. A nurse should avoid asking "You agree, don't you?" or presenting a proposed intervention as compulsory when alternatives exist. Teach-back can help establish understanding: "Just so I know I explained this clearly, can you tell me what you understand about the plan?"

Consent should be sought for vaginal examinations, membrane rupture, episiotomy, urinary catheterisation, exposure of the body, students' participation, photography and sharing of identifiable information, according to local law and policy. Consent for one procedure is not blanket consent for all later procedures. The woman may withdraw consent, and refusal should trigger further discussion rather than punishment. When the woman chooses not to have a particular student or staff member

present, the preference should be respected unless a specific and defensible safety concern exists. Documentation should record the discussion, questions, decision and any clinically relevant reason why the ideal process could not be completed.

During labour, pain, fatigue, anxiety and medication can affect how much information a woman can process, but they do not automatically invalidate her decisions. Nurses should use short explanations, repeat information when appropriate and involve the woman's chosen support person only with her permission. When decisions are urgent, communication may need to be concise: state the problem, the recommended action and the immediate reason, then answer questions as feasible. If the woman lacks capacity, follow applicable emergency and substitute-decision-making rules. After a difficult emergency, a debrief can help the woman understand what occurred and ask questions once the clinical situation is stable.

5.4. Communication techniques that support dignity and safety:

Effective communication is an active clinical skill. It includes listening without interruption, acknowledging emotion, using non-stigmatising language, providing information in manageable parts, checking understanding and keeping promises about follow-up. Staff should describe what they are doing before touching the woman, narrate unexpected changes, and avoid discussing a case as if she were an object. Acknowledging pain does not require promising that pain can be removed: "I can see that this is difficult; let us look at the options available now" validates the experience while moving towards care. The nurse should tell the woman when they need to leave, who will remain responsible and how she can summon assistance.

A calm tone matters, but verbal respect must be accompanied by responsive action. Reassurance without assessment can become dismissive if a woman reports a severe or unusual symptom. Statements such as "This is normal, stop worrying" should be replaced with acknowledgement followed by clinical evaluation. Similarly, explanations should not be delivered in a patronising tone or as a test of the woman's intelligence. Ask how much information the woman wants, clarify uncertainty and explain the difference between what is known and what is being monitored. These communication habits preserve trust even when the team cannot give the answer the woman would prefer.

Language access is essential to informed participation. When a professional interpreter is available, use that service for significant clinical decisions rather than relying on a child or an untrained companion. Speak directly to the woman, pause for interpretation and use short, clear sentences. If there is no interpreter during an urgent event, use approved backup procedures, pictorial aids or bilingual staff as appropriate and revisit the explanation when an interpreter becomes available. Digital translation tools may assist with simple logistics but should not be the sole mechanism for consent to complex procedures unless local policy and safety validation support their use. Record the method of interpretation and any limitations.

5.5. Pain relief, comfort and continuous support:

Pain management is a core part of respectful care because the woman's perception of pain and her preferred coping methods deserve serious attention. Nurses should ask about pain regularly, provide accurate information on pharmacological and non-pharmacological options, and avoid suggesting that a woman is weak or failing when she requests analgesia. Depending on clinical status and facility resources, options may include breathing and relaxation, mobility, upright or lateral positioning, massage, warm showers or compresses, nitrous oxide, systemic analgesics, regional analgesia and other locally approved methods. No single option is suitable for everyone. The nurse should explain likely benefits and limitations and monitor efficacy and adverse effects according to protocol.

Continuous emotional and practical support may include reassurance, helping with position changes, offering fluids when clinically appropriate, assisting with toileting, maintaining a quiet environment, providing touch with permission and communicating the woman's preferences to the team. A Cochrane review found that continuous labour support may improve several birth-related outcomes and women's reported experiences, with no evidence of harm in the included studies, although effects varied by setting and support provider (Bohren et al., 2017). The evidence supports making a chosen

companion accessible where feasible and consistent with the woman's wishes. Companion policies should include clear infection prevention and safety arrangements rather than default exclusion.

Comfort strategies should be individualised and reassessed. Some women find touch soothing; others find it intrusive during contractions. Some prefer coaching; others prefer quiet. Ask before providing massage or physical assistance, and stop if the woman changes her mind. Repositioning and mobility should be supported when clinically appropriate, with safe monitoring and equipment management. If maternal or fetal conditions require restricted movement, explain the reason and offer the greatest safe choice possible. Nurses should also attend to environmental comfort—temperature, lighting, noise, access to water and toileting, clean bedding and culturally acceptable clothing or coverings. Small practical measures can reduce distress without delaying evidence-based care.

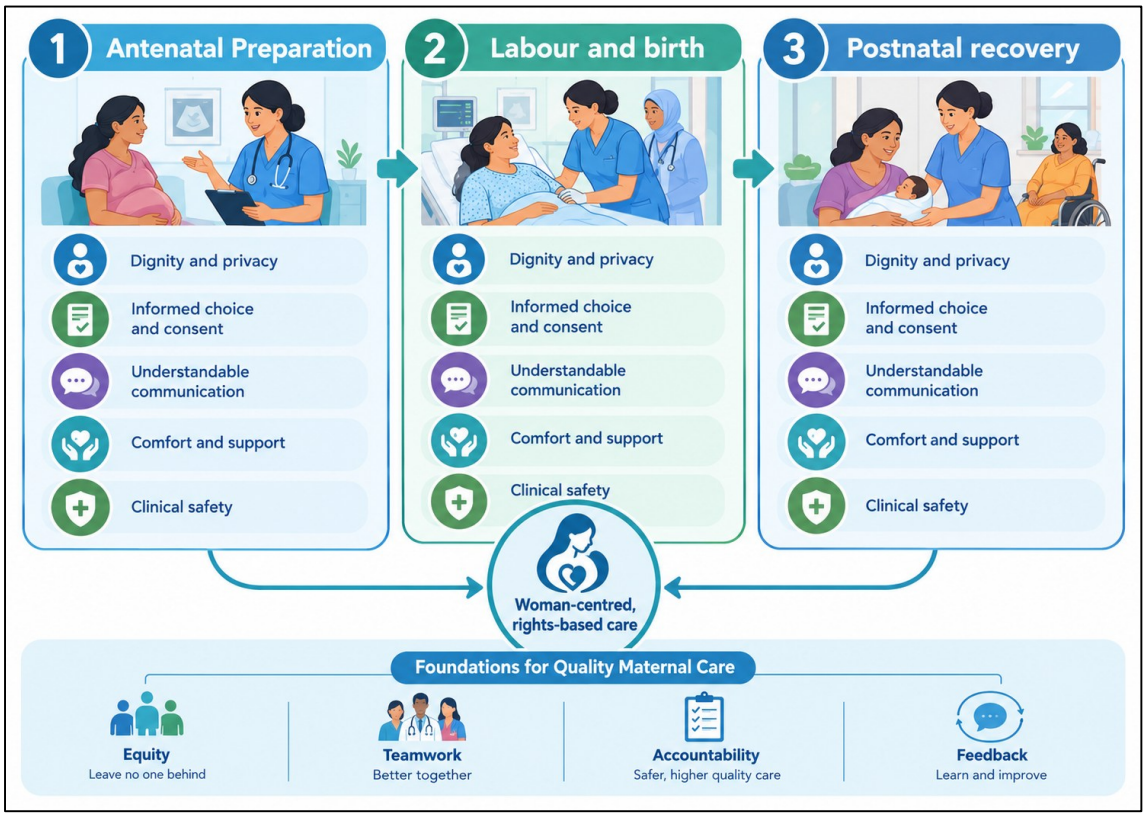


Figure. 1: The Respectful Maternity Care Pathway Across Antenatal, Intrapartum and Postnatal Care

5.6. Privacy, confidentiality and respectful examinations:

Maternity care involves intimate assessment and a level of bodily exposure that would be unacceptable in many other settings. The nurse should explain the purpose of an examination, obtain permission, offer a chaperone consistent with policy and the woman's preference, provide adequate draping, and expose only the area required. The number of people in the room should be limited to those necessary for care or explicitly permitted by the woman. Staff should avoid casual conversation during intimate examinations and never make jokes or comments about body shape, genital appearance, sexual activity or hygiene. If a woman experiences pain or asks to pause, the clinician should respond, reassess and explain whether continuing is urgent.

Confidentiality extends beyond closed curtains. Personal information should not be discussed in lifts, public corridors, staff social media or informal messages. Photographs, recordings or educational case examples require appropriate consent and compliance with institutional policy, with special care for identifiable images. Records should be accessed only by authorised personnel and shared with other services as needed for continuity and safety. Family members are not automatically entitled to details about pregnancy, HIV status, mental health, reproductive choices or complications. Nurses should ask the woman whom she wants involved and what information can be shared. If safeguarding laws require disclosure, the nurse should explain the limits of confidentiality as far as it is safe and lawful to do so.

5.7. Supporting physiological birth without imposing a preferred birth model:

Respectful care supports physiological processes when safe but does not define one type of birth as morally superior. A woman who chooses or needs caesarean birth, operative vaginal birth, induction, augmentation or analgesia should not be shamed. Likewise, a woman who prefers fewer interventions should receive honest explanations and clinical monitoring appropriate to her risk. The role of the nurse is to provide balanced information, notice changes, help the woman understand options and communicate evolving clinical needs. WHO's intrapartum guideline promotes positive childbirth experience through care that combines evidence-based practice with attention to women's values, preferences and support (WHO, 2018).

Position and mobility decisions should reflect clinical circumstances and woman preference. If the woman is low risk and there is no contraindication, staff should support movement and positions that feel comfortable rather than enforcing a routine position for staff convenience. If continuous monitoring, regional analgesia or a complication changes what is feasible, explain the reason and offer alternatives. The same approach applies to oral intake, toileting, pushing, skin-to-skin contact and early breastfeeding: follow evidence and protocols, explain when exceptions are needed and avoid using a routine as a substitute for clinical judgement. Respect does not mean every preference can be fulfilled; it means preferences are heard and addressed honestly.

5.8. Care during operative birth and obstetric emergencies:

Respectful practice is particularly important when the birth plan changes suddenly. Women may feel frightened when urgent caesarean birth, operative vaginal birth, haemorrhage management, hypertensive emergencies or neonatal resuscitation becomes necessary. The team should communicate a concise explanation of the situation and the reason for intervention, maintain privacy during transfer, and avoid blame or frightening statements. Where feasible, a named staff member should stay with the woman and provide updates while the team prepares. Even in the operating theatre, staff should introduce themselves, explain sensations and sounds, ask about comfort and protect the woman from unnecessary exposure. Her companion's presence should be considered within clinical and operational policy.

The emergency response should include a clear leader, role allocation and closed-loop communication. RMC should not delay haemorrhage protocols, seizure management, fetal resuscitation or timely surgery. Rather, it shapes how the response is delivered: the team avoids humiliating commands, gives information when possible, and does not abandon the woman emotionally because attention is directed to technical tasks. If the woman is conscious, staff should speak to her even when she cannot participate fully. If she is unconscious, staff should maintain privacy and dignity and communicate with her support person in accordance with consent and policy. After the event, a structured debrief can explain interventions, acknowledge distress, answer questions and identify follow-up needs.

Debriefing should be offered, not imposed. Some women want a detailed timeline soon after birth; others need time before discussing what happened. A useful debrief includes the woman's account, an explanation of clinical decisions in understandable language, an opportunity to correct misunderstandings and a plan for questions that need further review. It should avoid defensive language or pressuring the woman to feel grateful that mother or baby survived. If the woman reports mistreatment, staff should listen without arguing, explain how feedback can be reviewed and offer an independent complaint route where available. Clinical success does not erase a poor experience of care.

5.9. Cultural safety, inclusion and equitable care:

A respectful maternity service recognises that culture influences expectations about modesty, family roles, food, prayer, birth position, pain expression and postpartum practices. Cultural responsiveness begins by asking rather than assuming. A woman may welcome traditional support practices that are safe and compatible with clinical care; another may not wish to follow the preferences of her family or community. The nurse should support the woman's own choices and explain any safety concern with respect. Where cultural practices carry risk, discuss safer alternatives rather than ridiculing the

practice or the people who value it. Cultural safety also requires reflection on the power held by the clinician and how institutional norms can disadvantage people whose language or customs differ from the majority.

Equity requires more than treating every woman identically. Women with disabilities may need accessible examination equipment, communication aids, extra time or adapted positioning. Adolescents may need confidential, non-judgemental discussion and clear safeguarding boundaries. Women with low literacy may benefit from diagrams and teach-back. Migrants and refugees may face language barriers, unfamiliar health systems and trauma histories. Women from marginalised caste, ethnic or racial groups may experience stereotyping or poorer responses to pain. Transgender and gender-diverse people who need maternity care should be addressed respectfully, with privacy and clinically relevant language. Staff should use the terms and names a person requests while ensuring the clinical record accurately captures information needed for safe care.

Trauma-informed practice is particularly valuable when women have a history of sexual violence, previous traumatic birth, coercive medical experiences or loss. It emphasises emotional and physical safety, transparency, collaboration, empowerment and choice. Nurses should not demand a detailed trauma narrative to provide respectful care. Instead, ask what would make examination or labour safer, warn before touch, obtain permission at each step and offer a signal to pause if feasible. A person may become distressed, freeze, dissociate or appear unusually compliant; the response should be calm, non-judgemental and clinically appropriate. Trauma-informed care is not a substitute for specialist mental-health treatment, but it can reduce avoidable triggers and support a sense of control.

5.10. Family involvement, companionship and newborn-related decisions:

The woman determines who should accompany or support her unless a defined legal or immediate clinical constraint applies. A partner, relative, friend, doula or another trusted person may provide reassurance, comfort and advocacy. The nurse should clarify the role of the companion, emphasise that the woman's wishes remain central and address infection prevention or privacy concerns in a proportionate way. A companion should never be used as a replacement for skilled nursing care, professional interpretation or clinical monitoring. The woman may ask for a companion to leave, decline family involvement or change her preferred support person at any time. Staff should avoid allowing relatives to override her decisions simply because they are more vocal or socially powerful.

After birth, respectful care includes supporting safe skin-to-skin contact and breastfeeding when clinically appropriate and desired, while avoiding judgement of women who cannot or choose not to breastfeed. If mother or newborn needs urgent treatment or separation, explain the reason, how contact will be maintained when possible and when the situation will be reassessed. Parents should be informed about newborn observations, medicines, feeding support and signs that require attention.

When a newborn is critically ill or dies, compassionate communication becomes especially important. Staff should explain events honestly, avoid blame and offer culturally and personally appropriate support, including bereavement care and referral pathways.

5.11. Postnatal care and continuity after discharge:

The postnatal period is not an administrative phase after the "main event." Women may experience pain, bleeding, fatigue, breastfeeding difficulty, anxiety, changes in identity and uncertainty about infant care. Respectful postnatal nursing includes asking about physical comfort, emotional well-being, sleep, feeding goals, family support, concerns about the birth and understanding of discharge instructions. WHO guidance emphasises information, reassurance and consistent support for women and newborns during the first six weeks after birth (WHO, 2022). Nurses should not assume that a woman who has delivered safely feels well or has no questions. Information should be delivered in manageable sections, supported by written or visual resources and checked through teach-back.

Before discharge, the woman should know which symptoms require urgent care and how to reach assistance. Guidance should be tailored to the actual birth and clinical risk, including bleeding, fever, severe headache, visual symptoms, chest pain, breathlessness, unilateral leg swelling, wound changes, severe abdominal pain and thoughts of self-harm or harm to the baby. The nurse should explain local referral arrangements and avoid vague instructions such as "come back if unwell." Respectful

discharge planning also considers transport, affordability, access to telephone services, language and safe home circumstances. Where follow-up barriers are likely, the team should arrange a realistic plan rather than transferring responsibility to the woman without support.

Continuity matters when a woman has experienced emergency birth, major complications, neonatal intensive care, stillbirth, neonatal death or a distressing interaction with staff. Where possible, the team should coordinate follow-up with obstetric, primary-care, mental-health, lactation and social services. The woman should have access to a conversation about the birth and a route to raise unresolved concerns. Referral must be presented as support rather than evidence that the woman has failed to cope. Respectful maternity care continues after discharge through accessible communication, accurate records, safe transfer of information and attention to the woman's account of what happened.

6. Nursing Communication in Challenging Situations:

6.1. Responding to anger, fear or refusal:

A woman's anger or refusal may reflect pain, fear, previous mistreatment, cultural misunderstanding, and loss of control or a genuine disagreement about the proposed intervention. Nurses should first assess immediate clinical risk, then listen to the concern without labelling the woman as difficult. A useful sequence is to acknowledge emotion, ask what worries her most, explain the clinical issue, discuss options and agree on the next step. Avoid threats, sarcasm or statements that invoke the baby to shame the woman. If disagreement persists around a high-stakes decision, seek a senior clinician, interpreter or ethics support as appropriate. Maintain care while the disagreement is resolved, and document the decision-making process factually.

Refusal should prompt clarification, not coercion. The nurse should confirm whether the woman understands what is proposed, whether her decision is voluntary and whether a modifiable concern exists, such as fear of pain, cost, prior trauma or lack of explanation. The team can offer alternative options and explain the likely consequences of each. Repeated questioning by multiple staff members can become pressure; a coordinated approach with one lead communicator is preferable. A competent adult may decline recommended care within applicable law, even when the team considers the decision unwise. Nurses should neither abandon the woman nor misrepresent risks to obtain agreement.

6.2. Handling mistakes and complaints:

When a communication failure or disrespectful incident occurs, the first response should be to address immediate safety and acknowledge the woman's experience. A sincere apology for an identifiable wrong, given within organisational policy, can be more constructive than defensiveness. Staff should not make unsupported promises about investigations or outcomes. Explain the route by which concerns will be reviewed and how the woman can access an independent advocate or complaint service where available. Clinical records should be factual and complete, and staff should not alter documentation to protect themselves. Serious allegations should be handled through appropriate safeguarding, professional and legal processes, with attention to the woman's safety and confidentiality.

Learning systems should distinguish between a one-off lapse, repeated harmful behaviour and system conditions that make errors likely. A staff member who uses degrading language requires accountability and support to change behaviour; a unit where staff are routinely unable to respond to call bells because of unsafe staffing requires organisational correction. These problems can coexist. Just-culture principles should not be used to excuse abuse, but punitive approaches alone can suppress reporting of near misses and operational hazards. Review should examine what happened, who was affected, what immediate remedy is appropriate, and what changes will reduce recurrence. Women and families should be informed about how their feedback contributed to improvement, while respecting confidentiality.

7. Organisational and System-Level Enablers:

7.1. Leadership, staffing and workplace culture

RMC is easier to sustain when leaders consistently model respectful behaviour, respond to concerns fairly and include women's experience in quality discussions. Staff should receive induction and continuing education on consent, communication, trauma-informed care, cultural safety, anti-discrimination and conflict management. Training is necessary but not sufficient. Workers must have reasonable workloads, clear responsibilities, functioning equipment, adequate supplies, access to interpreters and a way to request assistance. Understaffed units may experience rushed communication and missed care, while hierarchical cultures can discourage junior nurses from questioning inappropriate orders. Leaders should create a psychologically safe environment where anyone can raise an urgent concern without ridicule or retaliation.

Workforce well-being is a legitimate part of quality improvement, not an excuse for mistreatment. Chronic fatigue, moral distress, workplace bullying and poor supervision can reduce empathy and increase errors. Managers should monitor staff workload, shift patterns, exposure to traumatic events and access to debriefing. Supportive supervision can help staff discuss difficult interactions, recognise implicit bias and practise alternative communication. A compassionate team culture must apply to staff as well as patients: humiliation of nurses by senior colleagues reproduces the same power dynamics that respectful maternity initiatives are trying to change. Accountability and support should work together to protect both women and workers.

7.2. Facility design, privacy and basic resources:

The physical environment communicates whether women are considered active participants or passive recipients. Practical improvements include functioning curtains or screens, doors that close, clear signage, clean toilets, accessible handwashing, and safe spaces for companions, comfortable seating, call bells, appropriate lighting and clear visual information about rights and available services. Facilities should plan space for private consent discussions and sensitive assessments. Where architectural changes are not immediately possible, movable screens, defined quiet zones and protocols limiting unnecessary traffic can reduce exposure. Staff should explain unavoidable limitations and actively protect privacy rather than treating crowded conditions as permission to disregard it.

Equipment and supply availability also affect whether choices are real. A facility that advertises multiple pain-relief options but lacks the staff or medicines to provide them creates unrealistic expectations. Quality teams should assess availability of medicines, monitoring equipment, newborn resuscitation supplies, clean linen, interpretation services and referral transport alongside patient experience measures. Procurement and maintenance systems should incorporate frontline nursing feedback. When a service cannot provide a desired option, the woman should receive an honest explanation and a discussion of feasible alternatives. Transparent constraints are more respectful than silence, false reassurance or blaming the woman for requesting care.

7.3. Policies, protocols and accountability mechanisms:

Written policy is valuable when it specifies expected actions and is incorporated into daily work. A respectful care policy should address introductions, communication, consent, privacy, and companionship, dignity during examinations, non-discrimination, emergency exceptions, documentation, complaints, staff conduct and escalation of concerns. It should be translated into local languages and introduced through scenarios and practice rather than distributed as a document alone. Checklists and prompts can help staff remember key steps during busy periods, but excessive forms can become burdensome if they duplicate existing records without improving care. The aim is to make the respectful action the easy and expected action.

India's LaQshya Labour Room Quality Improvement Initiative explicitly includes respectful maternity care within improvement of labour-room and maternity-operation-theatre quality (Ministry of Health and Family Welfare, Government of India, 2017). Its relevance lies in linking women's

experience with facility processes, staff roles, infrastructure and monitoring rather than treating RMC as a purely interpersonal matter. Implementation should align with current national and state guidance and local legal requirements. Facilities can incorporate RMC into existing quality committees, patient-safety rounds, staff appraisal, onboarding, morbidity review and accreditation processes. Leaders should avoid measuring compliance only by the presence of posters or signed forms; they should ask women about their actual experience and observe whether processes protect autonomy.

7.4. Training that changes behavior:

RMC training is most useful when it is practical, reflective and repeated. Effective sessions may combine short teaching modules, role-play, simulation, case discussion, review of complaints and feedback from women. Scenarios should include routine vaginal examinations, refusal of an intervention, urgent caesarean birth, language barriers, adolescent care, grief after loss and conflict between staff and family members. Staff need to practise brief explanations under time pressure, obtain consent without coercion, use interpreters, respond to emotional distress and debrief after emergencies. Training should include both clinical and non-clinical staff because security personnel, registration staff, cleaning teams and attendants can influence a woman's first and last impressions of the facility.

The intervention literature is promising but limited. (Mira-Catalá et al., 2024) identified ten intervention studies and noted that provider training was the most frequent component, with several studies suggesting improved experiences; additional strategies included checklists, posters, open maternity days and ongoing feedback. (Downe et al., 2018) found that multicomponent respectful-care policies could improve women's reported experiences and reduce some forms of mistreatment, while noting limitations in the evidence and uncertainty about sustainability. (Smith et al., 2022) reported that a behavioural-design intervention package in Zambia was associated with lower reported disrespect and abuse and greater requests for pain management in intervention facilities than in comparison facilities. Together, these studies support implementation with evaluation, rather than an assumption that one-off training will solve structural problems.

8. Measurement, Audit and Quality Improvement:

8.1. Choosing meaningful indicators:

Measurement should cover both experience of care and the systems that enable it. Potential experience indicators include whether the woman felt treated with dignity, understood explanations, gave consent before examinations, had privacy, was free from discriminatory comments, received timely responses to requests, had access to a companion when desired and could express preferences. Process indicators may include documented consent conversations, interpreter use when required, birth-plan review, privacy checks, companion availability, staff training coverage and timely complaint response. Balancing measures should examine whether new processes create unintended delays, documentation burden or exclusion of women with complex clinical needs. Each indicator needs a clear definition, numerator, denominator, data source, sampling plan and assigned owner.

A patient survey should be confidential, understandable and available in the languages used locally. It should ask about specific behaviours as well as overall satisfaction, because women may report being satisfied despite experiencing non-consented care or may hesitate to complain when they depend on the facility. Satisfaction is influenced by expectations, outcomes and social desirability and should not be used as the only measure. Interviews should occur in a private setting without staff who directly provided care present. Women should be told that feedback will not affect access to services. Where feasible, an independent interviewer or anonymous survey can help reduce pressure to provide positive responses.

Tools can support consistency, but no single measure should be treated as universally definitive. (Bohren et al., 2018) demonstrated the value of combining structured labour observations with community surveys to capture experiences that may be missed by one method alone. (Afulani et al., 2017) developed a person-centred maternity care scale with domains covering dignity and respect,

communication and autonomy, and supportive care, initially validated in Kenyan settings. (Afulani et al., 2018) validated a 27-item adaptation in India and reported good reliability in the Uttar Pradesh study population. (Cantor et al., 2024), in a systematic review, identified multiple RMC frameworks and measurement tools but found no clear gold standard and noted evidence gaps about the effects of implementation on maternal or infant outcomes. Facilities should select a tool suited to the population and language, test comprehension locally and avoid comparing scores across settings without considering differences in case mix and administration.

8.2. Using a practical improvement cycle:

A useful quality-improvement cycle begins with listening to women and staff, mapping the care pathway, identifying a small number of high-priority problems and testing feasible changes. For example, if women report repeated examinations without explanation, the team may introduce a standard pre-examination consent prompt, a designated lead examiner and a documentation field. The team should establish a baseline, train staff, test the change in a limited area, review feedback and refine it before wider adoption. Measurement should be frequent enough to detect change but not so burdensome that it takes staff away from care. A monthly dashboard can combine a few experience indicators, complaints, process measures and balancing measures, with narrative comments used to interpret patterns.

Feedback should lead to visible action. If women repeatedly report that companions are excluded without explanation, leadership should review policy, infection-control concerns, space and staffing, then report what changed. If privacy scores remain low, the team should inspect the layout and patient flow rather than instructing staff to “be more respectful” without environmental changes. If staff report that informed consent is difficult because of language barriers, interpreter access and clinical workflow need attention. Improvement should be owned by a multidisciplinary team that includes nursing, midwifery, obstetrics, anaesthesia, neonatology, administration, cleaning and support staff, with meaningful representation of women or community advocates.

8.3. Learning from complaints and patient narratives:

Complaints and personal narratives reveal aspects of care that routine clinical indicators may miss. A complaint may describe a series of small interactions being ignored, not being told who was examining her, hearing staff discuss her body, and being scolded for crying that together created an experience of humiliation. The review should look beyond whether a single sentence can be proven and examine the broader care process. Narrative data can identify recurrent patterns, such as dismissing pain in adolescents or inadequate interpretation for migrant women. They should be collected ethically, de-identified and reported in ways that do not expose women or staff to unnecessary risk.

A facility can also conduct respectful-care rounds, where trained reviewers observe whether staff introduce themselves, ask permission before touch, explain procedures and protect privacy. Observation should be transparent, authorised and designed to avoid disrupting clinical care. Observers need training and a defined approach to intervening if serious harm is imminent. Results should be aggregated for learning rather than used as an uncontextualised league table. The strongest quality systems combine structured data with stories and staff reflection, because numbers can show that a problem exists while narratives explain how and why it occurs.



Figure. 2: A Nursing-Led Quality Improvement Cycle for Respectful Maternity Care

9. Implementation Framework for Nursing Teams:

9.1. At the level of the individual nurse:

At the bedside, respectful care can be translated into a short, repeatable sequence: introduce yourself; ask how the woman wishes to be addressed; explain what is planned; seek permission before touch; protect privacy; listen to questions; check understanding; document important preferences and decisions; and reassess comfort and safety. This sequence is intentionally simple so that it can be used during routine care without creating an impractical parallel workflow. It should not become a scripted performance that replaces listening. The woman may need a detailed conversation, very little conversation, an interpreter, a pause or support with a decision. The nurse should adapt the sequence to the person and the clinical situation.

Self-reflection is also important. Nurses should examine assumptions about how women "should" behave during labour, what constitutes a good mother, which pain responses are genuine and whether a woman's background affects the credibility given to her concerns. Bias can influence the interpretation of pain, compliance, emotional distress and requests for analgesia. The goal is not to claim that any individual is free of bias but to build practices that reduce the effect of assumptions: structured assessment, open questions, clear documentation, second opinions and consistent policies. When an interaction becomes tense, a brief pause and a colleague's support may prevent escalation.

9.2. At the level of the ward:

The ward can establish a small set of non-negotiable practices, including privacy before intimate examinations, explanation and permission before touch, clear response to call bells, no tolerance of abusive language, reliable access to interpretation, and review of consent for procedures. Shift huddles can identify women with communication needs, known preferences, high anxiety or possible safeguarding concerns while sharing only necessary information. Handover should include patient-defined priorities, not just clinical observations. A named nurse or midwife can help provide continuity and ensure that the woman knows whom to approach. When staffing is insufficient, the

team should escalate the risk and prioritise essential care transparently rather than silently normalising neglect.

Ward leaders should review everyday routines that may undermine autonomy, such as automatic restrictions on movement, blanket companion bans, repeated examinations by multiple clinicians, loud discussions of confidential information or rules that make women ask repeatedly for basic comfort items. Some restrictions may be clinically justified in defined circumstances, but they should be reviewed for proportionality and communicated clearly. Staff should be empowered to adapt unnecessary routines while maintaining safety standards. Handover, shift changes and transfers between labour room, operating theatre and postnatal ward are important moments for loss of information; a short respectful-care handover prompt can preserve preferences across those transitions.

9.3. At the level of hospital governance and policy:

Hospital governance should make RMC visible in the quality strategy, assign responsibility to a named leader and provide time and resources for implementation. Policies should include clear routes for immediate escalation of mistreatment, confidential reporting, fair investigation and support for affected women. Governance teams should examine patterns across shifts, clinical areas and demographic groups. Disaggregating outcomes by age, language, disability, socioeconomic group or other ethically and legally appropriate variables can reveal inequities hidden by average scores. Data collection should be proportionate, protect privacy and avoid labelling marginalised groups as the problem; the purpose is to identify which processes and systems are failing to serve them equitably.

External quality programmes and accreditation can sustain attention, but compliance should not be reduced to paperwork. A facility may have a signed policy and high training attendance while women continue to experience disrespect. Governance should therefore connect structural readiness, observed practice, women's reports and response to complaints. RMC review should be linked to clinical morbidity review and emergency drills, because the way teams communicate during a haemorrhage or fetal emergency can be practised just like technical skills. Audit results should be fed back to staff in a non-shaming but accountable format, with deadlines and responsible persons for corrective actions.

10. Special Considerations in Contemporary Obstetric Practice:

10. 1. Digital technology and documentation:

Electronic health records and digital monitoring tools can improve continuity when they make important information accessible to the right clinicians. They can also distract staff from face-to-face communication or expose sensitive data if access controls are weak. Nurses should explain the need for a device or recording, maintain eye contact when possible and check that documentation is accurate. Decision-support tools should inform, not replace, professional judgement or a woman's participation. Automated alerts, telehealth and messaging can improve access to advice, but services should consider language, disability, digital literacy, data costs and access to private devices. Women should not be disadvantaged because they cannot use a digital platform.

Documentation should support care rather than create a defensive narrative. Record the information provided, the woman's questions, the decision reached, the clinical assessment, changes in condition and the plan for reassessment. Use neutral, observable language rather than labels such as "uncooperative," "difficult" or "dramatic." If a woman refuses an intervention, document the discussion and alternatives offered, not a judgement about her character. Digital systems should include useful prompts for consent, interpreter use, pain assessment and patient preferences without forcing redundant data entry. Confidentiality should be preserved through access control, safe communication and compliance with applicable data-protection law.

10.2. Birth trauma, mental health and bereavement:

A distressing birth experience does not always lead to a psychiatric disorder, and a woman can have post-traumatic symptoms after an objectively uncomplicated birth. Nurses should be attentive to persistent fear, intrusive memories, avoidance, guilt, sleep disturbance, low mood or difficulty bonding, while avoiding premature diagnosis. A supportive initial response includes listening, validating the woman's account, explaining available help and arranging follow-up when symptoms or distress warrant it. The woman should not be told that she must feel happy because the baby is healthy. Respect includes space for ambivalent or difficult emotions and appropriate referral to mental-health or perinatal support services.

Following stillbirth, neonatal death or severe maternal morbidity, communication should be compassionate, clear and consistent. Staff should use the family's preferred terms, explain events without euphemisms that create confusion, check what information the woman wants at that moment and offer opportunities to ask questions later. Cultural and spiritual preferences should be explored rather than presumed. In the event of a possible error or adverse event, staff should not blame the woman or promise a predetermined investigation outcome. Bereavement care should include practical information, privacy, and support for family communication and a pathway for future clinical review. Respectful care is measured especially clearly in these situations, when technical recovery may not be possible but dignity remains essential.

10.3. Ethical tensions and difficult trade-offs:

Maternity teams face real tensions between individual preference, fetal considerations, institutional policy and emergency risk. The woman is the patient whose consent is required for procedures on her body, subject to applicable law. Clinicians may strongly recommend an intervention when maternal or fetal risk is high, but pressure, threats or deception do not become ethical merely because the clinicians believe their recommendation is beneficial. When disagreement continues, seek senior support, assess decision-making capacity where genuinely in doubt, discuss alternatives and document the reasoning. Avoid framing the decision as a moral test of motherhood. Where legal questions arise, consult institutional ethics or legal pathways promptly while maintaining supportive care.

A second tension arises when one woman's preferences conflict with the privacy or safety of others, such as in shared labour rooms. The solution is not to dismiss either woman's rights but to adapt space and processes: screens, limits on the number of companions, movement of sensitive discussions to a private area and clear agreements about photography or recording. A third tension arises when staff are overloaded and cannot immediately meet every request. Respectful communication requires acknowledgment, triage and an honest timeframe rather than silence or false promises. Systems should then track repeated unmet needs to determine whether staffing or workflow changes are required. These examples show that RMC is a practical decision-making discipline, not a slogan.

10.4. Evidence Gaps and Future Research Priorities:

The RMC evidence base has expanded, but important questions remain. Definitions and frameworks overlap without complete standardisation, while measurement tools vary in content, timing, language and validation. (Cantor et al., 2024) found well-described conceptual frameworks but no clear gold-standard measure and insufficient evidence to conclude that implementing RMC improves maternal or infant health outcomes. This does not diminish RMC as a rights-based obligation. It means researchers should avoid claiming that a specific training package is proven to reduce mortality or all forms of morbidity unless the study design supports that conclusion. Future trials and implementation studies should be transparent about the intervention components, context, fidelity, comparison condition and outcomes.

Research should prioritise outcomes meaningful to women, including agency, perceived dignity, ability to obtain information, confidence in care, emotional recovery, willingness to seek future care and the experience of people who are often under-represented in facility surveys. Studies should assess longer-term outcomes, not only immediate satisfaction or a single exit interview. Mixed-methods designs can help explain why a change worked in one facility but not another. More evidence

is needed from rural facilities, high-volume public maternity wards, conflict-affected settings, private hospitals and populations facing language or disability barriers. Evaluation should also examine potential unintended consequences, including increased documentation burden, exclusion of companions through over-restrictive safety rules or staff fatigue from poorly designed initiatives.
Implementation science can help distinguish the effects of education, workflow changes, supervision, environmental improvements, community participation and accountability mechanisms. Multicomponent programmes may be necessary because mistreatment can be caused by both individual behaviour and structural conditions. Researchers should report costs, resource requirements, staff acceptability, sustainability and transferability. Measurement instruments should be translated and culturally adapted with cognitive testing and psychometric assessment rather than simply word-for-word translation. Patient-reported experience measures should be triangulated with observation and system data while safeguarding confidentiality. The 2025 WHO compendium on respectful maternal and newborn care is a useful current resource for implementers, while emphasising that large-scale implementation and evidence on the most effective approaches remain ongoing challenges (WHO, 2025).

10.5. Practical Recommendations for Nursing Practice:

The following recommendations translate the review into actions that can be adopted by individual nurses, ward leaders and health-system managers. They are intended to be adapted to local scope of practice, national guidelines, available resources and the woman's clinical condition. Respectful care should be integrated into routine workflows and emergency protocols, rather than added as a separate task that competes with clinical safety.

Table. 1: Practical Recommendations for Nursing Practice

Practice domain	Nursing action	How practice can be checked
Dignity and identity	Introduce yourself, use the woman's preferred name, explain each contact and avoid judgemental language.	Patient survey; direct observation; complaint themes.
Consent and autonomy	Explain purpose, benefits, risks and alternatives; seek permission before examinations and procedures; document decisions.	Record audit; patient interviews; review of refusals and urgent exceptions.
Privacy and confidentiality	Use screens, limit observers, drape appropriately and share information only with authorised people.	Privacy rounds; observation; incident reports.
Communication	Use plain language, professional interpreters when indicated and teach-back for important instructions.	Interpreter-use audit; patient-reported understanding.
Comfort and support	Assess pain, discuss feasible options, ask before touch and facilitate a chosen companion where possible.	Pain reassessment; companion access data; experience survey.
Equity	Identify access needs, adapt communication and examine differences in experience across groups.	Disaggregated indicators; community feedback.

Emergency care	Use clear team roles, explain urgent actions when feasible and offer post-event debriefing.	Simulation review; documentation audit; patient narratives.
Accountability	Offer a safe complaint route, respond fairly, learn from themes and report corrective action.	Response time; resolution and recurrence trends.
Workforce support	Provide regular training, supportive supervision, adequate resources and safe escalation routes.	Training coverage; staffing indicators; staff feedback.
Continuity	Include patient priorities in handover and provide understandable discharge and follow-up plans.	Handover audit; discharge comprehension; follow-up completion.

10.6. A brief bedside respectful-care checklist:

Before an examination or intervention, the nurse can pause for a short mental checklist: Have I explained who I am and what I plan to do? Has the woman had an opportunity to ask questions? Have I sought permission, protected privacy and offered support consistent with her wishes? Does she understand the reason for the intervention and its alternatives to the extent possible in the circumstances? Have I considered language, disability, trauma history or cultural needs without stereotyping? Is there a clinical reason for any restriction, and have I explained it? After the action, have I checked comfort and informed the woman of the next step? A checklist should support human interaction and should not replace clinical judgement or valid consent.

For team leaders, a brief shift-start check can cover staffing and role allocation, availability of interpreters, access to screens and comfort supplies, companion policy, emergency readiness, and unresolved patient-experience issues. During handover, include the woman's communication preferences and any concerns she has asked the team to address. At shift end, staff can identify one example of good respectful practice and one system barrier that needs escalation. These practices embed RMC into the rhythm of clinical work and reinforce that it belongs to every team member, not only the designated patient-experience officer.

11. Discussion:

The evidence and guidance reviewed converge on a clear point: respectful maternity care is both a moral and operational requirement for high-quality obstetric services. Its central elements dignity, consent, communication, privacy, support, equality and accountability are consistent across WHO guidance, rights-based frameworks and person-centred maternity care measures. At the same time, the literature shows that the concept is measured in different ways, and that interventions are often complex packages implemented in specific contexts. Recent evidence has improved understanding of the frequency and forms of mistreatment, but high heterogeneity and limited controlled data prevent simple conclusions about a universal prevalence rate or a single best intervention (Mirzania et al., 2025; Cantor et al., 2024).

Nurses are positioned to make the principles visible in ordinary moments: asking before touch, explaining examinations, acknowledging pain, facilitating companionship, protecting privacy and ensuring that concerns trigger assessment. These individual actions can be powerful because women interact with nurses repeatedly throughout labour and recovery. Yet a purely individual approach is insufficient. A nurse cannot consistently provide choice when staffing is unsafe, privacy is impossible, interpreters are unavailable or local policy blocks support people without justification. Facility leaders must therefore combine behaviour change with structural improvement, supervision, reliable supplies, confidential feedback and meaningful accountability. The review of interventions

by (Mira-Catalá et al., 2024) and the policy review by (Downe et al., 2018) support multicomponent approaches while also identifying the need for stronger evaluation and attention to sustainability.

The relationship between respectful care and clinical outcomes should be described with precision. Respectful care can support trust, cooperation, timely disclosure of symptoms and continued engagement with services, but these pathways do not justify claiming that any one respectful-care intervention will automatically reduce mortality. Research has identified promising improvements in reported experiences and reductions in certain forms of mistreatment, while downstream maternal and newborn outcomes remain insufficiently studied. RMC should therefore be implemented because it is ethically required and is a core domain of quality care, while clinical and service effects should be measured honestly. This approach avoids both extremes: dismissing experience as unimportant and overstating the causal evidence.

In the Indian context, the LaQshya initiative offers a policy platform for linking labour-room quality with respectful care. The evidence on mistreatment in India and validation of person-centred maternity care measurement in Uttar Pradesh suggest that locally adapted assessment is possible and needed (Ansari and Yeravdekar, 2020; Afulani et al., 2018). Implementation should pay close attention to language, caste and socioeconomic inequities, overcrowding, privacy, informed consent, availability of companions and responsiveness to complaints. National or state-level targets are most useful when they prompt facility-level listening and practical action rather than a narrow focus on certification. Experiences may differ substantially between large public hospitals, small facilities and private providers; local data must guide adaptation.

12. Conclusion:

Respectful maternity care is an essential component of contemporary obstetric nursing. It requires more than courteous language: it entails informed consent, meaningful participation, privacy, confidentiality, freedom from abuse and discrimination, emotional and physical support, culturally safe care and timely evidence-based clinical action. Nursing strategies should begin during antenatal care, continue through admission, labour, birth and postnatal recovery, and extend to discharge and follow-up. In emergencies, urgency may shorten communication but should not justify humiliation or avoidable disregard for autonomy. Staff should explain urgent actions when possible, preserve dignity and offer debriefing after difficult events.

Sustainable improvement depends on the combined efforts of individual nurses, midwives, obstetric teams, managers, policymakers and women's communities. Multicomponent training and quality-improvement programmes are promising, but they must be evaluated, adapted and supported by sufficient staffing, supplies, interpreters, privacy infrastructure, supervision and accountable feedback systems. Facilities should measure specific experiences as well as overall satisfaction, use validated tools where appropriate, disaggregate results to identify inequities and act visibly on the findings. Respectful care should be treated as a routine standard of safe maternity practice and an obligation owed to every woman, regardless of circumstance, clinical risk, background or birth outcome.

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