

Experience of Respectful Maternity Care during Labor and Childbirth among Women Admitted in Postnatal Ward of a Hospital of Siddharthanagar Municipality

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Abstract

Introduction: Respectful Maternity Care (RMC) involves upholding dignity, privacy, informed decision-making, and emotional support for women during childbirth process. However, many women in the world, including in Nepal, continue to experience mistreatment such as neglect, verbal abuse, and inadequate privacy, which undermines their trust in healthcare. This study explores postnatal mothers' experiences with RMC during labor and delivery.

Methods: The qualitative phenomenological study was conducted among 13 mothers who had normal vaginal deliveries and non-probability purposive sampling technique was used to select the samples for study. Self-developed interview schedule based on RMC framework was used for the data collection. Interviews were transcribed, translated, and thematically analyzed. Field notes were coded, and transcripts reviewed to identify key concerns. Deductive approach was used for thematic analysis which was done manually.

Results: The results of the study are outlined in seven key themes: informed consent, right to information, privacy & confidentiality, freedom from abuse, freedom from discrimination, neglect & abandonment and dignity & respect. Interpretation of the data showed that women reported positive experiences when informed about procedures. However, issues regarding pain relief options and privacy were noted, where some women expressed their privacy was not maintained during clinical check-up, which is a crucial aspect of respectful maternity care.

Conclusion: This study reveals strengths and gaps in RMC. While verbal consent and non-discriminatory care were noted, key aspects like informed decision-making, communication, privacy, and emotional support were often missing. Neglect and mistreatment highlight systemic issues, calling for better training, staffing, and a respectful, accountable care environment.

Keywords: experience, mothers, postnatal, respectful maternity care

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Introduction

Respectful Maternity Care (RMC) involves treating women with dignity throughout pregnancy, labor, and childbirth.¹ It emphasizes preserving their privacy, protecting them from harm or mistreatment, and supporting their right to make informed decisions while providing continuous care.²

Every woman is entitled to respectful and dignified

maternity care as a basic human right³, women who feel secured, valued, supported, and able to be involved in decision-making are likely to have more positive childbirth experiences.⁴ Ignored or shouted throughout labor would hesitate to inform danger signs for fear of further maltreatment,⁵ and commonly experienced during the second stage of labor.⁶

Globally, disrespect and abuse are existing problems which often act as strong barrier to utilization of services.⁷

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The prevalence of disrespectful maternity care was 71.31%, with 23.51% of women reporting experiencing at least one form of mistreatment during labor or childbirth.^{8,9} Participants expressed their privacy was protected (83%), consent was obtained for examinations (77%), but not given information before any medical procedure (11%),¹⁰ 33.7% were not advised to eat or drink during labor at least once and 58.2% experienced lack of visual and auditory privacy.¹¹ Eighteen percent women reported non-dignified care, 14.3% expressed neglect or abandonment¹², 12.4% of the participants expressed not treated with dignity and respect,¹³ verbal abuse (25.75%) and discrimination (14.79%),⁸ physical abuse (35.7%),¹⁴ and not talking about pain and its relief in a positive way (28.0%).¹⁵

In Nepal, many women face disrespect and mistreatment during childbirth in healthcare settings, which compromises their dignity and personal autonomy.¹⁶ The aim of the study was to explore the experience of respectful maternity care during labor and childbirth among postnatal mothers.

Methods

The qualitative phenomenological study was carried out in the postnatal ward of Universal College of Medical Sciences-Teaching Hospital (UCMS-TH). The study population included of 13 postnatal mothers who had undergone normal vaginal delivery, admitted in postnatal ward and who were about to discharge. Sample were selected using a non-probability purposive sampling technique, and data collection was carried out through in-depth interview sessions which was developed by the researchers on the basis RMC framework and pretested among two participants who were not included in the study. Ethical clearance was granted from Institutional Review Committee of UCMS and before preceding data collection administrative approval was obtained from UCMS-TH. Each participant was fully informed about the objective of

the study, and their written consent was obtained before participation. Participants were assured for confidentiality of information provided by them will only be used for research purpose. Privacy was maintained by interviewing the participants in separate place. Verbal and non-verbal expression were observed and noted while interviewing. Researchers themselves interviewed the respondents from 1st to 28th February 2021. Data analysis was started along with data collection.

After interview all field notes were labeled with code numbers. The verbatim information given by participants was transcribed and translated into English for reporting. Theme based analysis as described by Braun and Clarke (2006) was done manually and deductive approach was used for thematic analysis which was done manually. The preliminary assessment of the transcripts was conducted to familiarize with the content. The transcripts were then coded by segmenting text into smaller units of meaning. The data was categorized into broader themes, within these categories, specific subthemes were identified.

During the analysis, some contradictory responses emerged that enrich the understanding of women's experiences with respectful maternity care. For instance, while several participants reported discomfort and dissatisfaction regarding lack of privacy during examinations, others appeared to normalize privacy violations, often attributing it to cultural norms or the inevitability of labor conditions.

Results

Regarding socio-demographic variables among the 13 participants, 6 were of age 21-25 years, 5 participants were Aadibasi Janajati. All the participants belonged to Hindu religion, 7 participants were educated up to secondary level and 8 participants were home maker. (Table 1)

Table 1: Socio-demographic Variables of the Participants n=13

Case No.	Age in year	Caste	Religion	Education	Occupation
1.	24	Harijan	Hindu	No education	Home maker
2.	22	Prajapati	Hindu	11 grade	Home maker
3.	27	Chaudhary	Hindu	11grade	Teaching
4.	30	Yadav	Hindu	12 grade	Home maker
5.	35	Magar	Hindu	Bachelor	Teaching
6.	25	Neupane	Hindu	12 grade	Business
7.	33	Bhattarai	Hindu	Master	Teaching
8.	22	Chaudhary	Hindu	10 grade	Home maker
9.	24	Gupta	Hindu	12 grade	Home maker
10.	27	Tiwari	Hindu	Bachelor	Home maker
11.	29	Chaudhary	Hindu	Master	Service holder
12.	35	Chhetri	Hindu	Bachelor	Home maker
13.	25	Chaudhary	Hindu	10 grade	Home maker

Regarding age at marriage, 7 participants got married at the age of 18-20 years and 8 participants

had first pregnancy at the age of 20-26 years. Seven participants were multi, 7 had female baby (current) and 8 participants had 8-12 hours of labor (recent delivery) (Table 2).

The key findings are highlighted in seven key themes: (1) informed consent, (2) right to information, (3) privacy & confidentiality, (4) freedom from abuse (5) freedom from discrimination, (6) neglect & abandonment and (7) dignity & respect. (Table 3)

Table 2: Age at Marriage and Obstetric Variables of the Participants n=13

Case No.	Age at Marriage (in year)	Age at first pregnancy	Gravida	Sex of baby (current)	Duration of labor in hour (recent delivery)
1.	18	19	3	Female	18
2.	19	21	1	Female	12
3.	22	23	2	Female	10
4.	18	25	2	Female	9
5.	27	34	1	Male	9
6.	18	19	4	Female	14
7.	23	25	2	Male	13
8.	19	21	1	Male	12
9.	20	23	1	Male	18
10.	22	26	1	Female	8
11.	24	26	3	Female	8
12.	19	21	2	Female	9
13.	24	24	1	Male	12

Table 3: Experiences of Participants

Theme	Subtheme	Description / Participant Insights
Informed Consent	Verbal consent before procedures	Participants were verbally informed before procedures like vaginal exams, catheterization, episiotomy, and perineal repair.
	Lack of information on pain medication	Many women were unaware about availability or use of pain medications during perineal repair.
Right to Information	Information provided on request	Women received updates on labor progress, fetal condition, and instructions when they asked.
	Inadequate information on pain management	Many reported not receiving sufficient information about pain relief options.
Privacy and Confidentiality	Lack of privacy during examinations	Physical exams, including vaginal exams and catheterizations, were done without adequate screening, often in open spaces.
	Lack of awareness about privacy rights	Some women did not feel bad due to cultural normalization, while others expressed discomfort.
Freedom from Abuse	Verbal abuse	A few women experienced scolding or angry remarks during labor pain.
	No physical abuse reported	None of the participants reported physical mistreatment.
Freedom from Discrimination	Equal treatment	All participants felt they were treated equally, with no bias based on caste, religion, or economic status.
Neglect and Abandonment	Responsiveness when approached	Some women reported positive experiences when they sought help.
	Lack of proactive care	In some cases, staff were not attentive unless called upon. One woman had to manage alone until very late in labor.
Dignity and Respect	Respectful communication by some staff	Some nurses were kind and informative.
	Rude or indifferent behavior by others	Several participants noted rude behavior, lack of counseling, and disrespect. Procedures were performed without privacy or removal of visitors.

Informed Consent

Obtaining informed consent is a basic human right and a vital aspect of RMC. All participants confirmed that they were verbally informed prior to per vaginal examinations, catheterization, episiotomy and perineal repair. However, most of the women were not aware that whether they received pain medicines before episiotomy and/or perineal tear.

"They performed vaginal examination twice and each time they informed me" (P1)

"During labor, I could not void and they remove urine through catheter (pipe) two times, one time before delivery and 1 time at the time of delivery. Each time they informed me that they are inserting catheter to remove urine". (P5)

"She said that she is going to make incision on my perineum in order to increase the way baby come out. She again informed me before repairing the perineum"(P3)

"They informed me that they will repair the perineum in three layers. Initially, I didn't feel any pain but at last there was more pain. I was not informed the pain medicines before repair. I was not aware that pain medicines are also available so, I did not ask them" (P9)

Right to information

RMC ensures that women are entitled to receive information. Most women were informed about the progress of labor and fetal condition when they asked to the health personnel. They were informed about when to bear down, dietary intake and rest. Many participants reported a lack of information on pain management.

"After first vaginal examination, when I asked about the progress they told me 3 cm dilatation and in the second examination, they again told me 7 cm dilatation has occurred." They also informed me to take rest and lie down in left lateral position"(P2)

"They informed the fetal condition, cervical dilatation, when to bear down, everything they informed me when I asked any questions." (P6)

"They informed me to take warm liquid and I took black tea and lentil soup." (P4)

"They told me when you feel urge to urinate and defecate then only bear down otherwise do not bear down" (P1)

Privacy and Confidentiality

Upholding privacy and dignity of a woman is a core principle of RMC, yet it was one of the most commonly violated areas. All the participants mentioned that their privacy was violated during physical examinations and catheterization. Physical barriers like curtains were often absent or not used properly during labor. However, delivery was conducted in separate room.

"They did vaginal examination in front of other mothers and their visitors." (P4)

Most of the women did not feel bad when privacy was not maintained. Most of them were unaware that invasion of privacy during childbirth is a disrespectful care. However, some women feel very bad just because of invasion of privacy.

"They examined my private part without using screen. I did not feel bad at that time because of labor pain. Why to be shy, it's normal during childbirth." (P9)

"They examined in the open space, may be due to hospital rules. It would be better if they examined in closed area." (P6)

"They examined me in the open space, no one used screen, they came and remove our clothes and examined in the open space which I did not feel good." (P5)

"There was no screen in the room, examining in front of everyone was not good. I saw two deliveries happening in labor room before taking them to delivery room. Everything was open and everyone present there saw it. I did not feel good about that part." (P7)

Freedom from Abuse

Physical abuse was not reported by any participant. However, few mothers recounted an episode of verbal abuse but they took it normally.

"When I shouted because of labor pain, they told me with angry faces that don't shout; otherwise we will send you home." (P2)

"When I shouted loudly because of labor pain, they told me do not make loud noise." (P8)

"When blood came out we went to call them in hurry and they scold with angry face and said why you are anxious" (P12)

Freedom from Discrimination

On a positive note, all participants expressed that they were treated equally, non-discriminatory care based on caste, religion, or economic status.

"I did not feel any discrimination based on my background." (P12)

Neglect and Abandonment

Most of the women stated that healthcare staff were responsive when approached, but proactive support was lacking in some cases. Several women shared positive experiences where their needs were promptly addressed.

"Even the senior doctor came when I asked. I felt very supported." (P4)

"I asked them to check if the baby's head was coming, and they came quickly. That was a relief." (P2)

"I don't know what may be the reason, maybe I was in high risk. They provided good care to me. When I called them, they came immediately." (P10)

"They did not come to see me from time to time. When the baby was about to come out I pushed my baby up and support the baby's head with my both leg and by holding with my gown. They took me to the delivery room very late." (P12)

Dignity and Respect

Few participants reported consistently respectful communication from healthcare providers. Several participants appreciated the kind behavior of some staff, while others expressed disappointment in the attitudes of nurses and even non-clinical staff such as security personnel.

"The nurses were very polite and answered our questions." (P9)

"Some were good, but many were rude. I expected more from this big hospital. They did not counsel properly in my case, everyone gets angry. Every procedure was done in open room even without removing visitors. I did not feel any respect according to my expectation." (P12)

Discussion

The qualitative phenomenological study was conducted 13 postnatal mothers. The study aimed to explore postnatal mothers' experiences with RMC during labor and childbirth.

Informed Consent

Most women said they were verbally informed before procedures like vaginal exams, catheter insertion, episiotomies, and perineal repairs—suggesting that healthcare workers are aware of the need to obtain consent. However, the consent process often lacked depth, with many women unaware of pain relief options and receiving little to no information about managing discomfort. This indicates that while procedural consent is being obtained, essential details for true informed decision-making—especially regarding pain—are frequently missing. Similar patterns have been observed in other low-resource settings, where consent is more formal than participatory.¹⁷

Right to Information

Women have right to information on fetal condition, progress of labor and other information related to diet, rest, exercise, emptying bladder and pain medication before episiotomy and perineum repair. Although updates on labor progress and fetal condition were usually given, they were often shared only when specifically asked for. Most of the women were not informed about pain relief measures. This reactive communication does not align with RMC principles, which advocate for proactive, continuous information sharing. The limited attention

to pain management in particular suggests a broader neglect of women's emotional and sensory needs during childbirth.¹⁸

Privacy and Confidentiality

Women's medical information should be kept confidential and their privacy should be respected. Maintaining confidentiality and privacy is one component of RMC. A common issue highlighted was the lack of privacy during medical exams and procedures. Many women reported being examined in shared spaces without curtains or screens. While some accepted this due to labor pain or cultural norms, others clearly felt uncomfortable. These results are aligned with existing research, which reveals that breaches of privacy are common in crowded and poorly resourced healthcare settings.¹⁹

Protecting privacy is not just about physical barriers—it reflects the respect given to a woman's dignity and autonomy. When privacy is not upheld, it can undermine a woman's rights and potentially lead to long-lasting emotional distress and mistrust in the healthcare system.

Freedom from Abuse and Discrimination

Positively, no participants reported physical abuse or discrimination based on caste, religion, or economic status—suggesting that care was delivered fairly and in line with ethical standards. However, some women did report verbal abuse, often in response to expressing pain or requesting help. Such interactions can erode a woman's sense of safety and respect. These findings resemble other studies that note verbal mistreatment is often normalized in settings with overburdened or emotionally exhausted staff.²⁰

Neglect and Abandonment

Experiences with staff attentiveness were mixed. While some women received timely, supportive care, others faced delays or had to manage parts of labor alone before reaching the delivery room. These disparities point to issues with staffing, workload, or care prioritization. Situations where women are left to deliver without assistance clearly violate RMC standards and align with broader global reports of neglect in facility-based childbirth.²¹

Dignity and Respect

Women should always be approached with kindness and respect, and their dignity should be maintained throughout childbirth. This research findings highlights a substantial difference in patients' opinion of dignity and respect in healthcare settings, reflecting both positive and negative experiences. Some appreciated kind and courteous behavior from certain nurses, while others encountered rudeness or indifference from both clinical and support staff.

some participants reported feeling respected when staff communicated kindly and were willing to answer their questions. This aligns with previous studies suggesting that that dignity is closely tied to how patients are communicated with, including the need for clear, empathetic, and respectful interactions.²²

However, few participants expressed dissatisfaction, citing instances of rude behavior and a lack of professional conduct. Participant's experience, where procedures were performed in an open room without privacy and staff members appeared angry, points to a breach in patient dignity, particularly in terms of confidentiality and respect for personal space. Such practices are concerning because they not only affect Patients' emotional and mental well-being but also have broader implications for patient trust and utilization of healthcare services. In a study dignity was primarily defined by patients as being treated with respect and as human. Patients emphasized feeling respected, maintaining identity, and having personalized care. Dignity involves receiving care suited to the particular needs of the patient.²²

Limitation

The subjectivity might lead to inconsistent findings across different researchers or studies. Smaller and non-random samples were used in the study which might be difficult to generalize findings to a larger population.

Conclusion

This qualitative study highlights both strengths and limitations in the implementation of RMC. While verbal consent and non-discriminatory care were generally reported, critical elements such as comprehensive informed decision-making, consistent communication, privacy, emotional support, and dignified treatment were often lacking. Experiences of neglect, verbal mistreatment, and lack of privacy reflect systemic issues within facility-based maternity care. These gaps in care may harm women's physical and emotional health, weaken their trust in the healthcare services, and discourage them future health care-seeking behaviour. To address these issues, it is essential to enhance provider training, improve staffing levels, and promote a healthcare environment rooted in empathy, respect, and accountability.

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