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The Determinants of Perceived Experiences of Respectful Maternal Care During Labor and Delivery in a Sample of Iranian Women: A Cross-sectional Study

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Abstract

Objectives: This study investigates mothers' perceptions of respectful maternity care (RMC) during childbirth in Urmia, Iran, focusing on experiences of disrespect and service satisfaction.

Materials and Methods: A cross-sectional analytical design was employed, involving 400 mothers who experienced either vaginal deliveries or unplanned cesarean sections. Data were collected one month postpartum using tailored questionnaires that assessed RMC, experiences of disrespect and abuse, and service satisfaction based on the SERVQUAL model.

Results: The findings revealed that 61.25% of mothers rated their RMC as good, with a mean score of 76.12 ± 12.99. Among the dimensions of respectful care, participatory care received the lowest score (76.15 ± 6.67), whereas avoidance of violence scored the highest (86.22 ± 12.59). Alarmingly, 97.2% of mothers reported experiencing at least one form of disrespect, predominantly related to inadequate pain relief during labor (61%). Furthermore, 90% expressed dissatisfaction with service quality, particularly in responsiveness (-1.98). Key predictors of perceived respectful care included the type of hospital, lack of basic insurance, maternal assessment of service quality, and types of violence encountered.

Conclusions: The results underscore an urgent need for reforms in monitoring mechanisms to improve the quality of maternal care, ensuring that dignity and respect are upheld during childbirth. Addressing these issues is crucial for enhancing the overall maternal healthcare experience in Iran.

Keywords: Human dignity, Violence, Obstetrics, Quality of health care, Respectful maternity care, Disrespect

Introduction

The principle of human dignity is emphasized as the most important foundational principle of the international human rights system in numerous international documents. These documents highlight the inherent and inviolable dignity of all human beings, regardless of any conditions or distinctions (1). Pregnancy and childbirth, due to specific physiological and psychological conditions, are significant events in women's lives that require the provision of respectful and dignified care (2). Respectful maternity care (RMC), focusing on the fundamental rights of women, newborns, and families, not only promotes equitable access to evidence-based care but also addresses the individual needs and preferences of mothers (3).

Globally, alongside extensive efforts to reduce maternal and neonatal mortality and morbidity within the framework of the Millennium Development Goals, access to medical facilities has increased. However, these advancements have not always been accompanied by improvements in childbirth experiences and the promotion of respectful care (4). Disrespect and Abuse during labor and childbirth—sometimes referred to as "Obstetric Violence"—have multiple definitions in the scientific literature. According to Friedman's definition, this term refers to interactions or actions that are considered disrespectful, humiliating, or a violation of dignity, depending on cultural and local contexts (5). The International Confederation of Midwives (ICM) and the United Nations Population Fund (UNFPA) have identified the main forms of disrespect and abuse as "physical abuse, care without consent, non-confidential care, undignified care (including verbal abuse), discrimination based on specific characteristics, abandonment or deprivation of care, and involuntary detention in the ward" (6). Global evidence indicates that these behaviors are prevalent in many countries and can have significant negative effects on the experiences and outcomes of childbirth (4).

Receiving respectful care during pregnancy and

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childbirth facilitates a confident transition to motherhood and promotes faster recovery. In contrast, experiences of disrespect and violence can lead to the development of post-traumatic stress disorder (PTSD), anxiety, insomnia, nightmares, and difficulties in caring for the newborn (7). Additionally, negative interactions with maternity care providers may result in both physical and psychological harm to mothers (8), leading to consequences such as decreased satisfaction, distrust in the healthcare system, delays in seeking services, avoidance of prenatal care, preference for home births, and elective cesarean deliveries (9-11). The World Health Organization (WHO) has also identified disrespectful care as a significant barrier to mothers' use of healthcare services, emphasizing that this issue can jeopardize the achievement of the fifth Millennium Development Goal, improving maternal health (12). Given that the childbirth experience is a multidimensional, complex, and unique process (13), it is essential that the concepts of "safe motherhood" and "respectful maternity care" align with one another, extending beyond the scope of preventing complications and mortality to include respect for the fundamental rights of women (9).

Although Iran has achieved the fifth Millennium Development Goal in maternal health indicators (3,14) and accepted the Mothers' Rights Bill in 2003, along with issuing guidelines for the respectful treatment of pregnant women to medical universities across the country, evidence indicates that the full implementation of these standards faces challenges. Results from domestic studies (such as research conducted in Urmia) show dissatisfaction among mothers regarding the preservation of privacy, the provision of adequate explanations during interventions, support in breastfeeding, attention to educational needs, and insufficient training at inappropriate times (15). All these issues represent violations of respectful care (3), which can lead to preferences for cesarean sections in future pregnancies, breastfeeding difficulties, and tokophobia (fear of future pregnancies) (16-18). All these factors contradict the general policies of the country and the "Youth Population Law", which is a binding law aimed at promoting childbearing and natural childbirth. Today, respectful maternal care is widely acknowledged as essential, and efforts to promote natural childbirth without ensuring it may lead to distrust in the healthcare system and heightened risks of physical and psychological complications for mothers (19).

This study was designed to address the following questions:

1. What are the perceptions and experiences of mothers regarding respectful care during labor and childbirth?
2. How satisfied are women with the care received during labor and childbirth based on their expectations and perceptions?
3. What factors predict mothers' experiences of respectful care during labor and childbirth?

Discovering the answers to these questions will be beneficial for care providers and maternal health program planners, providing them with insights into the perspectives of those receiving care during labor and childbirth. This understanding can assist in enhancing the coverage of respectful care and delivering high-quality services.

Materials and Methods

Study Design

This cross-sectional-analytical study was conducted in health centers in the city of Urmia, Iran. Urmia county is characterized by ethnic, religious, and cultural diversity, which may influence the way services are provided and the perceptions of respectful care received. Sampling was carried out from June to October 2024 among mothers who had given birth (either vaginal delivery or unplanned cesarean section) within the past month and visited comprehensive health service centers and health posts in Urmia. The urban areas were divided into five regions, and one center with the highest number of births in the past two months was selected from each region to participate in the study. The number of participants from each center was determined using a quota sampling method, and sampling in the centers was conducted using a convenient sampling approach. This methodology allows researchers to effectively and comprehensively explore the experiences and perspectives of mothers regarding respectful care during childbirth.

Sample Size and Participants

To estimate the sample size for the research, the variables of interest were assessed quantitatively, and means were calculated and utilized. The minimum required sample size was determined to be 385 participants, calculated using the following formula:

$$n \geq \frac{z_{1-\alpha/2}^2 \ \sigma^2}{d^2}$$

$$\alpha = 0.05 \Rightarrow z_{1-\alpha/2} = 1.96$$

$$EffectSize = \frac{d}{\sigma} = 0.10$$

The minimum required sample size, taking into account a potential dropout rate of 10% (20), was determined to be 400 samples for this study.

The participants in this study included 400 mothers who visited health centers in the city and had experienced either vaginal delivery or unplanned cesarean section within the past month at one of the city hospitals. Participants were required to be able to communicate in Persian. Women who reported a history of encountering serious crises, such as a tragic incident or the loss of family members within the last six months during the researcher's inquiry, or whose pregnancy records indicated the presence of a debilitating physical illness or a known psychological disorder, were excluded from the study.

The questionnaires used for data collection were prepared in both electronic and paper formats and were provided to the eligible participants. In this phase, the link to the electronic questionnaires was sent via email or through accessible messaging applications that could be easily installed and used on smartphones. Participants could complete the electronic questionnaire self-reportedly without needing to provide their full names, using only a code assigned to each participant. If participants preferred the paper format, the questionnaires were completed in a separate room at the sampling site, either self-reportedly or through an interview conducted by the researcher if the mother was illiterate or had low literacy skills. Due to factors such as poor internet connectivity and the lack of access to smartphones for some mothers in underprivileged areas of the city, all questionnaires were ultimately completed in paper format. In cases where questionnaires were incomplete or if a mother was unwilling to publish her responses after completion, those questionnaires were excluded from the data analysis.

Data Collection Tools

The data for the study were collected using the "Demographic Questionnaire", the "WP-RMC (Dignity-Based Care Questionnaire for Mothers)", the "Disrespect and Abuse during Childbirth Questionnaire (D&A)" and the "SERVQUAL-based Service Recipient Satisfaction Scale".

Demographic Questionnaire

The demographic questionnaire was developed to assess individual factors influencing mothers' perceptions of the respectful nature of care. Drawing on findings from previous studies (21,22), as well as insights from experts and caregivers, the questionnaire was designed by the researchers to include demographic and reproductive information. It consisted of 15 questions aimed at capturing relevant data to better understand the factors that may affect mothers' experiences and perceptions of care during childbirth.

The WP-RMC (Respectful Care Questionnaire for Mothers)

The WP-RMC is a tool designed and psychometrically validated by Ayubi and colleagues in Iran (23). It consists of 19 items rated on a 5-point Likert scale (1 to 5), with reverse scoring applied to items 15 to 19. The questionnaire encompasses three domains: Providing Comfort (7 questions), Participatory Care (7 questions), and Avoidance of Violence and Discrimination (5 questions). Scores are converted to a scale of 0 to 100, and the total score is categorized into three levels based on percentage scores: Poor (less than 33.3%), Average (33.3% to 66.6%), and Good (above 66.6%) regarding the receipt of respectful maternal care. The reliability of the questionnaire was confirmed with a Cronbach's alpha coefficient of 0.9, indicating high internal consistency. Additionally, the intraclass correlation coefficient (ICC) was calculated by having 30 eligible participants complete the questionnaire and retake it two weeks later, yielding an ICC of 0.9, which demonstrates excellent stability and test-retest reliability of the instrument.

The Disrespect and Abuse During Childbirth Questionnaire (D&A)

D&A was translated and psychometrically validated by Hajizadeh and colleagues in Iran in 2023. This questionnaire consists of 23 items that measure disrespect and abuse during labor and childbirth, organized into seven domains: Protection of the mother from physical harm (6 items), Maintenance of the mother's rights regarding awareness of her condition/informed consent/choice of delivery method (8 items), Preservation of the mother's privacy and confidentiality (1 item), Upholding the dignity and respect of the pregnant woman (2 items), Receipt of care and attention without abandonment (3 items), and Delayed discharge or restrictions on the pregnant woman (1 item). If a response to any item within a domain is positive, it is considered an experience of mistreatment (24). The reliability of this instrument was assessed using the test-retest method, and internal consistency was established with a Cronbach's alpha coefficient of 0.84 and an ICC of 0.8.

The Service Recipient Satisfaction Scale Based on SERVQUAL

The SERVQUAL Service Recipient Satisfaction Scale, was designed by Parasuraman et al to measure service quality from the perspective of service recipients (25). This multidimensional tool assesses customers' expectations and perceptions of the goods or services received. Given the study's objective to determine women's perceptions of care during labor, utilizing this scale could objectively estimate the gap between perceptions and expectations. The tool comprises five domains: Tangibles (physical environment conditions, 4 items), Reliability (ability to perform the service dependably and accurately, 5 items), Responsiveness (willingness to help and provide prompt service, 4 items), Empathy (providing special attention to each service recipient based on their needs, 5 items), and Assurance (employees' competence and ability to instill confidence and trust in service recipients, 4 items). The scale includes 22 pairs of items (44 items) rated on a Likert scale, with the first 22 items assessing clients' expectations and the subsequent 22 items measuring the perceived level of received services. Service quality is evaluated by calculating the difference between the scores of each paired item (the difference between expectation scores and perception scores). A negative difference indicates poor quality and satisfaction, while a positive difference signifies acceptable satisfaction (26). Following the designers' recommendations, necessary modifications were made to each item while maintaining the factorial

structure of the questionnaire, resulting in a reevaluation of its qualitative and quantitative face validity, content validity, and reliability. For qualitative face validity, the questionnaire was first provided to experts and 10 eligible women for feedback, leading to necessary adjustments and subsequent approval. For quantitative face validity, item impact coefficients were calculated based on feedback from 10 specialists, and since all items scored above 1.5, none were removed. Content validity was assessed by relevant experts, and their feedback was incorporated. For quantitative content validity, the content validity index (CVI) and content validity ratio (CVR) were calculated, with all items achieving minimum scores, and based on the CVI index, all questions received scores above 0.79, indicating none required removal. The reliability of the questionnaire was confirmed through Cronbach's alpha calculations, yielding coefficients of 0.97 for expectations and 0.96 for performance. Additionally, the ICC of this tool was recalculated using test-retest methodology with 30 eligible participants completing the questionnaire twice, two weeks apart, resulting in an ICC of 0.9, demonstrating high stability and repeatability of the questionnaire.

Statistical Analysis

In this study, the determinants of women's experiences, the variables influencing mothers' perceptions of respectful care, satisfaction with the type of services provided, the frequency and types of violence and mistreatment encountered by mothers during labor and childbirth, and certain individual variables were considered. The outcome variable was the average overall score of mothers' perceptions of respectful care, which was measured using the WP-RMC questionnaire across three different domains. Given that the level of women's satisfaction with the services provided to them during labor and childbirth appears to play a decisive role in shaping their experiences of respectful care, this variable was examined independently. Additionally, the violence and disrespect that mothers faced during labor and childbirth were also likely to influence their perceptions of respectful care; therefore, this variable was investigated separately using appropriate tools. Quantitative data analysis was conducted using SPSS software, version 23. Descriptive statistics were utilized to summarize the demographic and reproductive variables, the average overall score of mothers' perceptions of received care as the study's outcome variable, as well as the frequency and number of instances of violence encountered by mothers as independent variables influencing the outcome. Furthermore, the level of satisfaction of women with the type of services provided to them during labor and childbirth was independently extracted by examining the scores of various domains of expectations and perceptions, as well as the overall satisfaction scores of participants. In accordance with the research questions, to identify the variables under investigation in the model, the correlations of the variables with the respectful care score were assessed using Pearson and Spearman correlation tests, depending on the normality of the data distribution. The differences in mean scores were analyzed using the independent t-test and analysis of variance (ANOVA). To examine the simultaneous effects of individual and reproductive variables based on the type of variable on women's perceptions of respectful care, multiple linear regression analysis was employed. A P value of less than 0.05 was considered statistically significant.

Results

Initially, a two-step control process was implemented to ensure the completeness of the questionnaires. In the first step, after the questionnaire was completed and before the mother exited, the questionnaire was reviewed, and any incomplete items were filled in. In the second step, at the end of the day, the completed questionnaires were reviewed by the team leader to ensure that there were no distorted data or incomplete information. Therefore, by implementing a rigorous quality control process, all 400 questionnaires were fully completed, with no missing data or invalid responses.

In this study, the average age of the participating mothers was 28.71 ± 6.05 years. 70% of them had a maximum of two children. Most of them were housewives, had education below diploma level, and lived in urban areas. 95% of them had health insurance, and 40 % of the mothers gave birth in a public hospital. The demographic characteristics of the mothers are presented in Table 1.

In response to the first research question, the results showed that the score for respectful care during labor and delivery (rated out of 100), based on the mothers' evaluations, was 0.5% in the poor category, 31.25% in the average category, and 61.25% in the good category. From the mothers' perspective, the domain of "avoiding violence and discrimination" had the highest average score of 86.22 ± 12.59 out of 100, while the domain of "participatory care" had the lowest average score of 67.76 ± 15.76. The overall score of the questionnaire, based on a score out of 100, was 73.99 ± 12.76, which is categorized as good (above 66.6) in terms of receiving respectful maternal care (Table 2).

In completing the response to the first question, the types of violence that mothers might face during labor and delivery, which could affect their understanding and perception of respectful care, were examined using the D&A. According to the results, among the various domains investigated, the highest incidence of receiving care accompanied by mistreatment and disrespect was related to the domain of "Preserving the Rights of the Mother" (91.8%). This indicates that mothers complained about the anonymity of caregivers, lack of sufficient explanations regarding the labor process and necessary interventions, not obtaining permission for certain interventions during labor and delivery, being deprived of the right to choose

Table 1. Demographic Characteristics of Participating Mothers in the Study (N=400)

Variable	Frequency	Percent
Number of children		
1	140	35
2	140	35
3	90	22.5
4	24	6
5	4	1
6	2	0.5
Education level		
Illiterate	15	3.8
Primary	75	18.8
Guidance school (First cycle of high school)	81	20.3
High school (Second cycle of high school)	44	11
Diploma	110	27.5
University	75	18.8
Spouse's education level		
Illiterate	5	1.3
Primary	43	10.8
Guidance school (First cycle of high school)	74	18.5
High school (Second cycle of high school)	25	6.3
Diploma	137	34.3
University	116	29
Marital satisfaction		
Very dissatisfied	1	0.3
Somewhat dissatisfied	15	3.8
Somewhat satisfied	132	33
Very satisfied	252	63
Place of residence		
Village	54	13.5
City	346	86.5
Ethnicity		
Azeri language	209	52.3
Kurdish language	191	47.8
Occupation		
Housewife	303	75.8
Employed	73	18.3
Student	23	5.8
Employed student	1	0.3
Spouse's occupation		
Unemployed	3	0.8
Employee	89	22.3
Specialist/Senior Manager	14	3.5
Worker	81	20.3
Self-employed	213	53.3
Personal assessment of income		
Insufficient	86	21.5
Average	266	66.5
Sufficient (able to save)	43	12
Health insurance		
Yes	380	95
No	20	5
Supplementary insurance		
Yes	127	31.8
No	273	68.3
Individual perception of spousal support		
Very Low	15	3.8
Low	11	2.8
Average	110	27.5
High	172	43
Very high	92	23
Hospital of delivery		
Public	161	40.3
Private	90	22.5
Social security	115	28.7
Armed forces	34	8.5

their preferred position during labor and delivery, and being restricted in their movement during pain. The least reported instance of mistreatment among the domains was related to the domain of "Restricting the Mother" (hospitalization without medical justification and against the mother's wishes) (0.8%). Among the items, the statement "I did not receive as much pain relief and analgesia as I needed" (61%) was the most frequently reported by mothers in terms of perceived mistreatment. In contrast, the statements "The caregiver left me alone or without supervision" and "I was restricted to stay only in my hospital bed" were not reported by any mothers (Table 3).

Among the 23 different types of violence identified in the questionnaire, 389 mothers (97.2%) reported experiencing one or more forms of violence. Only 11 mothers (2.8%) reported not facing any type of violence (Figure 1).

In examining the second research question, the results of the SERVQUAL questionnaire indicated that the average score of mothers' perceptions (after dividing the average of each dimension by the number of questions in that dimension, each dimension score was converted to a number between 1 and 7) regarding respectful care had the highest average in the empathy dimension (5.45 ± 1.14) and the lowest average in the responsiveness dimension (4.18 ± 0.59). The average score of expectations was also highest in the assurance dimension (6.38 ± 0.62) and lowest in the responsiveness dimension (6.13 ± 0.52). The average scores for all five dimensions of the questionnaire in the perception section decreased compared to expectations, with the greatest difference between the average scores of perception and expectations occurring in the responsiveness dimension (-1.98). The services

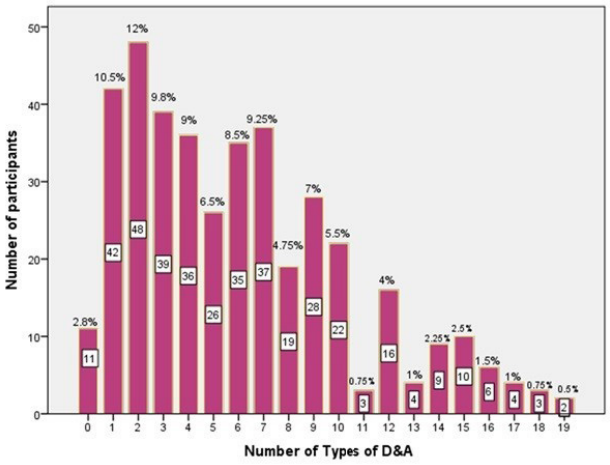

Figure 1. Number of Types of Violence and Misconduct. A histogram depicting the number of participants experiencing various types of disrespect and abuse (D&A) during childbirth. The graph illustrates the frequency distribution, with the highest number of participants reporting 1 type of D&A, and the frequency gradually decreasing as the number of D&A types increases, with very few participants reporting 18 or 19 types.

Table 2. Frequency, Mean, and Standard Deviation of the WP-RMC Scores and Their Related Domains (N=400)

Domains	Minimum	Maximum	Domain score (Mean ±SD)	Score based on 0 to 100 (Mean ±SD)
Providing comfort (7 items)	7	35	25.29 ± 5.69	72.26 ± 16.25
Participatory care (7 items)	7	35	23.45 ± 5.51	67 ± 15.76
Avoiding violence and discrimination (5 items)	10	25	21.55 ± 3.14	86.22 ± 12.59
Total score	24	95	70.29 ± 12.12	73.99 ± 12.76
Degree	**Weak**		**Average**	**Good**
Score	< 33.3		33.3–66.6	> 66.6
Count (%)	2 (0.5%)		125 (31.25%)	273 (61.25%)

SD: standard deviation.

Table 3. Frequency and Percentage of the Disrespect and Abuse during Childbirth Questionnaire (D&A) and Its Related Domains Among Participating Mothers in the Study(N = 400)

Domain	Item No.	Statement	Yes (%)	No (%)	Negative Domain (No Disrespect)	Positive Domain (Disrespect)
Physical Harm	1	My caregivers pushed me or slapped/beaten me	3 (0.8%)	397 (99.2%)	105 (26.3%)	295 (73.8%)
	2	I was restricted to stay only in my room	0 (0%)	400		
	3	My newborn was separated from me without any medical issue	13 (3.3%)	387 (97.7%)		
	4	Despite having a low-risk delivery, I was not allowed to drink water or fluids	42 (10.5%)	358 (89.5%)		
	5	I did not receive enough pain relief and anesthesia as I needed	244 (61%)	156 (39%)		
	6	I felt that my caregivers did not respect my cultural values and beliefs	75 (18.8%)	325 (81.2%)		
Protecting Mother's Rights	7	My caregivers did not introduce themselves to me	(56%) 224	176 (44%)	33 (8.3%)	367 (91.8%)
	8	My caregivers did not encourage me to ask my questions	222 (55.5%)	178 (44.5%)		
	9	My caregivers did not respond to my questions politely, promptly, and honestly	127 (31.8%)	273 (68.2%)		
	10	My caregivers did not explain to me what was to be done and what to expect during my delivery	195 (48.8%)	205 (51.2%)		
	11	My caregivers did not periodically inform me about my status and the progress of my labor	151 (37.7%)	249 (62.3%)		
	12	My caregivers did not allow me to move during labor pains	113 (28.2%)	287 (71.8%)		
	13	My caregivers did not allow me to be in the position I wanted during labor	114 (8.5%)	286 (71.5%)		
	14	My caregivers did not ask for my permission or consent before doing anything	172 (43%)	228 (57%)		
Privacy Protection	15	During examinations, my caregivers did not draw the curtain by the bed or close the door	112 (28%)	288 (72%)	288 (72%)	112 (28%)
Dignity Preservation	16	My caregivers did not speak to me politely	71 (17.8%)	329 (82.2%)	315 (78.8%)	85 (21.3%)
	17	My caregivers insulted me and coerced me to do what they wanted through threats	43 (10.7%)	357 (89.3%)		
Fair Care	18	My caregivers spoke to me in a language that was either foreign or beyond my comprehension (using technical terms)	96 (24%)	304 (76%)	290 (72.5%)	110 (27.5%)
	19	My caregivers disrespected me based on some of my physical characteristics (unkempt appearance, being rural, etc.)	28 (7%)	372 (93%)		
Continuity of Care	20	My caregivers did not inform me that I could call for them if needed	96 (24%)	304 (76%)	198 (49.5%)	202 (50.5%)
	21	My caregivers did not arrive in a timely manner when I called them	183 (45.7%)	217 (54.3%)		
	22	My caregivers left me alone or unsupervised	0 (0%)	400 (100%)		
Limitation	23	I was kept in the delivery hospital against my will (without medical reason)	3 (0.8%)	397 (99.2%)	397 (99.2%)	3 (0.8%)

received by mothers in the empathy dimension showed the greatest alignment with their expectations, with the smallest difference in the average scores of perception and expectations in the empathy dimension (-0.7). The results showed that 90% of participating mothers rated the quality of services received as lower than their expectations, and only 6.25% of the participating mothers evaluated the quality of the services received as higher than their expectations. In this study, only 3.75% of mothers received services that matched their expectations (Table 4).

To address the third research question, the simultaneous effects of the independent variables under investigation on women's scores regarding the perceived respectfulness of care were examined using multiple linear regression with the Enter method. The adjusted coefficient of determination (R^2) for the model was 0.58, indicating that 58% of the variance in the dependent variable is explained by the independent variables included in the linear regression model. The results of this model showed that the experiences of the participants influenced their satisfaction with care during labor by up to 58%, including the number of types of violence experienced, the place of delivery, and access to health insurance. The remaining 42% of variance was influenced by factors outside the

Table 4. Mean and Standard Deviation of Women's Scores in the Domains of Expectations and Perceptions of Care as Measured by the SERVQUAL Questionnaire and Their Differences (N=400)

Minimum Score of Expectation-Perception Difference	Maximum Score of Expectation-Perception Difference	Frequency of Score < 0	Score of 0	Frequency of Score > 0	
100	55	360 (90%)	15 (3.75%)	25 (6.25%)	
Domain	**Item**		**Mean ±SD (Expectations)**	**Mean ±SD (Perceptions)**	**MD (Perception - Expectation)**
1 Tangibles (4 items)	Equipment and facilities (building, ward ventilation, beds, restrooms…) should be clean and new		6.18 ± 0.46	5.33 ± 0.67	-0.845
	The delivery room should seem like a reliable environment				
	The appearance of staff should be neat and tidy				
	The physical space of the delivery room should be appropriate for the care provided to me				
2 Confidence (5 items)	The center and its services should be trustworthy		6.38 ± 0.62	5.16 ± 0.91	-1.22
	Timely and routine services should be provided to patients/clients (referrals/deliveries) in the hospital				
	Records and information should be accurately retrievable and confidentially maintained				
	There should be appropriate communication and mutual trust between staff and clients (patients)				
	The behavior of caregivers and staff should create a sense of security and calm in clients/patients				
3 Responsiveness (4 items)	Services should be provided to clients/patients quickly and without delay		6.13 ± 0.52	4.18 ± 0.59	-1.98
	Whenever I have a request, staff and caregivers should respond promptly				
	There should always be a suitable person to answer clients'/patients' scientific questions				
	Responses and training from caregivers/staff should be sufficient and understandable for clients/patients				
4 Empathy (5 items)	Each client/patient should receive special and individual attention		6.16 ± 0.63	5.45 ± 1.14	-0.71
	My specific needs during delivery should be understood by my caregivers				
	Caregivers should consider the interests of clients/patients in any actions and responses				
	Staff should be interested and motivated to address problems and care for clients/patients				
	Staff should be flexible in dealing with clients/patients				
5 Guarantee (4 items)	The behavior of the care staff, especially in the delivery room, should be acceptable and respectful		6.27 ± 0.47	4.52 ± 0.78	-1.75
	A sense of security and calm should be created in interactions with staff for clients/patients				
	Staff and caregivers should have the necessary skills to provide care and services				
	After discharge, there should be a possibility to contact and access healthcare providers in case of problems				

SD: standard deviation.

model that were not examined in this study. The type of hospital where the delivery took place was the strongest predictor of the level of respectful care. Women who delivered in private hospitals had a score of 5.4 units higher, those who delivered in Social Security hospitals had a score of 4.9 units higher, and those who delivered in Armed Forces hospitals had a score of 5.4 units higher for respectful care compared to those who delivered in public hospitals ($P < 0.001$).

Additionally, the score for respectful care among women without basic health insurance was 4 units higher than that of mothers with basic health insurance ($P= 0.037$). Mothers who rated the services they received as appropriate had a score of 5.3 units higher for respectful care compared to mothers who rated the quality of services as low, and this relationship was statistically significant ($P < 0.001$). For each additional type of violence experienced, the mother's score for respectful care decreased by 1.7 points. The effects of variables such as the spouse's education level, ethnicity, occupation, spouse's occupation, marital satisfaction, income level, supplementary insurance, and spousal support on women's perceptions of respectful care were not statistically significant (Table 5).

Table 5. Examining the Simultaneous Effects of Demographic Variables, Number of Types of Violence, and Quality Assessment of Services on the RMC Scores of Mothers Participating in the Study (N=400)

Variable	B	SE	β	*P* value
Education level*				
Illiterate & primary	-0.567	1.788	-0.020	0.752
High school (first/second level)	-1.116	1.613	-0.043	0.490
Diploma	-0.481	1.403	-0.018	0.732
University (R)				
Spouse's education level*				
Illiterate & primary	-2.966	1.998	-0.080	0.139
High school (first/second level)	0.755	1.539	0.027	0.624
Diploma	0.475	1.276	-0.019	0.710
University (R)				
Marital satisfaction				
Dissatisfied	1.096	2.723	0.018	0.688
Average satisfaction	-1.484	1.168	-0.058	0.205
Satisfied (R)				
Ethnicity				
Kurdish	-0.062	0.891	-1.496	0.094
Occupation*				
Employed	0.064	1.187	1.803	0.130
Spouse's occupation*				
Unemployed/laborer	-0.128	1.497	-0.004	0.932
Employee/specialist/top manager	0.420	1.583	0.15	0.787
Self-employed (R)				
Personal assessment of income				
Insufficient	2.454	1.641	0.066	0.136
Average	0.965	1.150	0.038	0.402
Sufficient (able to save) (R)				
Health insurance				
No	4.06	1.941	0.073	0.037
Supplementary insurance				
No	-0.559	1.055	-0.021	0.596
Individual perception of spousal support				
Low	-2.311	2.255	-0.047	0.306
Average	-1.759	1.337	0.065	0.189
High (R)				
Hospital of delivery				
Public (R)				
Private	5.423	1.301	0.187	<0.001
Social security	4.854	1.066	0.181	<0.001
Armed forces	5.438	1.576	0.125	0.001
Quality of services	5.315	1.400	0.135	<0.001
Number of types of violence faced	-1.663	0.113	-0.596	<0.001

*To perform the regression model coefficients test, the response options for some items in the demographic questionnaire (due to low sample size in the responses) have been merged with adjacent options.
R: Reference.

Discussion

The results of this study, although showing that more than half of the participants rated the level of care during labor as good and respectful, indicate that the experience of at least one type of violence and mistreatment by most participants suggests that the care provided to mothers still falls short of the desired standards of respectful care. On the other hand, the significant gap between the expected care and the received care demonstrates that the level of satisfaction with these services was weak, to the extent that only 10% of women rated the quality of this care as satisfactory. The type of delivery hospital, access to insurance, the number of types of violence experienced, and the mother's evaluation of service quality were identified as the most important predictors of mothers' assessments of the respectfulness of the care received.

In studies conducted on the informational support for pregnant mothers, involving them in decision-making, obtaining informed consent for interventions, and overseeing the performance of healthcare providers are factors that influence the understanding of respectful care (27-29). In the present study, mothers reported the lowest satisfaction regarding participatory care. It seems that care is provided based on the usual regulations of labor wards and a paternalistic physician-centered care model, as some providers believe that mothers have limited knowledge about the childbirth process and emphasize the medical aspects of labor (30). As a result, this leads to mothers having a passive role in decisions regarding their own care. Meanwhile, mothers should receive all relevant information about their care and feel that they are involved in all decisions made regarding their treatment (31-32).

According to Bohren and colleagues' study, cultural, racial, ethnic, and religious differences are among the main factors contributing to discrimination in the provision of care (33). Despite these differences among participants in this study, the domain of avoiding violence and discrimination received the highest score for respectful care. Similar results were found in the studies by Mousa and Turingan in Ethiopia (34) and Hajizadeh in Iran (21). These results indicate an improvement in this area, reflecting an increase in awareness and sensitivity among service providers regarding this aspect of violence. Although pregnant women may not be aware of the more subtle and complex dimensions of respectful care, they perceive verbal and physical violence as unethical due to its objective and overt nature and do not accept it (35). On the other hand, guidelines and increased attention to respectful care in recent years may have contributed to reducing the use of physical and verbal violence in labor wards. Despite the improvements in this area, several women in this study still reported experiencing varying degrees of physical, verbal violence, and discrimination (Table 2). Other studies conducted in Iran (21,22,36-38) also confirm the use of physical and verbal violence, which is sometimes due to various factors such as lack of oversight, follow-up and reporting mechanisms, insufficient awareness of providers and recipients about respectful care, caregiver disengagement, and the normalization and justification of using violence to encourage women to expedite childbirth (20,39). Despite the improvements in the area of avoiding violence and discrimination, the results of the violence and mistreatment scale indicated that the majority of women (97.2%) had encountered at least one form of various types of violence (Table 3). These results are consistent with previous findings in Iran (38,40) and Ethiopia (41). The reason for this issue may be the healthcare system's excessive focus on technical aspects and the healthy delivery of a newborn, which causes caregivers to be unaware of the impact of their actions on mothers and to overlook their rights. Additionally, the lack of support and effective communication with women, especially in emergencies, leads them to have negative perceptions of the efforts and performance of staff (32).

The status of respectful care in this study was rated positively by more than half of the mothers. Since studies using similar tools to assess mothers' perceptions of respectful care have been very limited up to the time of writing this article, a direct comparison of results with similar studies was not feasible. In the NHS report of 2024, 87% of English women stated that their dignity was always preserved and they were treated with respect during their previous experiences of labor and delivery care (42). However, in studies from Indonesia (44%), Ethiopia (66%), and Iran (42.63%), the proportion of mothers reporting positive experiences regarding RMC was similar to the current study (20,43,44). The contradictions and alignments in these findings may stem from similar barriers to accessing respectful care in developing countries compared to developed countries (45). These barriers include limitations in infrastructure and resources, lack of appropriate policy and legal frameworks, deficiencies in evaluation systems, insufficient awareness among mothers and service providers, and cultural differences (46). Therefore, although some mothers reported positive experiences, the existence of these barriers does not negate the necessity for attention to and improvement in the quality of maternal care.

One of the notable aspects of this study is the simultaneous positive perception of most participants regarding the respectfulness of care and their experience of violent behaviors. This phenomenon may indicate a lack of sufficient awareness among mothers about their rights and the manifestations of violence and respect, as well as being influenced by the prevailing social conditions in the community, the normalization of mistreatment during childbirth, and the low expectations mothers have from the healthcare system.

Despite the emphasis of maternal dignity guidelines and the Population Youth Law on the enhancement of childbirth experiences and the use of non-pharmacological pain relief methods as a way to improve labor and delivery

(47), the lack of pain relief was reported as the most common type of mistreatment (61%) by participants in this study. In contrast, the rate of non-use of pain relief in a study conducted in Jordan was 23%, and in another study in Iran, it was 41.9% (30,40). The neglect and failure to implement national protocols due to a shortage of human resources in hospitals for utilizing these methods, or the lack of willingness and motivation among maternity care providers to employ them, may be reasons for the non-implementation of these regulations (48,49).

The results of the present study, consistent with other studies conducted in the country Iran, indicated that the quality of services provided has not met the expected level of women, and there is a noticeable gap between mothers' expectations and their perceptions of the services received across all domains. The most significant decrease in perceived quality of services compared to the expectations of service recipients was observed in the area of responsiveness, indicating the dissatisfaction of service recipients with the sensitivity and responsiveness of providers to their requests and questions. Weakness in system responsiveness has also been noted in other studies (50-52). A study in Poland reported a positive score difference in four domains, with only the tangibles being perceived as below the expectations of recipients (53), which contradicts the findings of the current study and may be attributed to different economic, social, cultural conditions, and healthcare systems compared to Iran. Among the main reasons for the weakness in responsiveness are overcrowding and a high number of patients, lack of suitable physical space, and inadequacies in equipment. While effective interaction between recipients and service providers can significantly improve the responsiveness of the healthcare system, unfortunately, the receiver-provider communication is a concept that has received less attention in health sector reforms in Iran (54). Inadequate documentation practices, sometimes excessive emphasis on documentation at the expense of care quality, lack of awareness and motivation among providers, insufficient training in communication skills and patient-centered care, and structural and physical space issues are reasons for the decline in quality and satisfaction with service delivery (33,55).

In this study, the location of delivery (private hospital), lack of basic insurance coverage, the mother's evaluation of the quality of received services, and the number of types of violence experienced by the mother were identified as predictors of mothers' scores for respectful care (Table 5). The provision of free delivery services in public hospitals in Iran leads to a high influx of patients to these facilities. Additionally, due to the absence of competing counterparts and a lack of effective monitoring procedures for respectful care, there is little incentive for competition in service delivery. In contrast, private hospitals, as profit-driven healthcare systems, are mainly operated by self-employed physicians and provide their services with the expectation of receiving payments from patients. The presence of competition leads to more dynamic information exchange and improved performance in these centers. Furthermore, public hospitals serve as training centers for medical students, which results in overcrowding and a lack of familiarity among students with patient rights and respectful care, potentially compromising certain aspects of this type of care (30). Interestingly, women without basic health insurance reported receiving more respectful care. This finding is similar to a study in Rwanda, where mothers with private insurance received more respectful care than those with community-based health insurance. It appears that uninsured mothers, due to the high costs of care, tend to visit their chosen centers and are more assertive in demanding better care. This tendency leads to requests for higher quality and more respectful care from these mothers (56). Another reason for the lower scores of respectful care in public hospitals compared to private ones lies in the types of deliveries, as in private sectors, most mothers' delivery experiences are shaped by elective cesarean sections before the onset of labor phases (57). WHO has identified respectful care as one of the eight key dimensions of quality care and emphasizes its vital role, as RMC sets standards for enhancing the quality of maternal and neonatal services (32,58). In this study, the type of evaluation by mothers regarding the quality of care received, as well as the diversity and frequency of violence experienced by mothers, were significant variables related to this type of care.

Strengths and Limitations

In the present study, an effort was made to select the study population from various locations within the city, resulting in a diverse range of first-time and multiparous mothers with full-term, preterm, singleton, and twin deliveries, both through unplanned vaginal births and cesarean sections, who received care from different hospitals. Using standardized questionnaires, the study comprehensively assessed RMC, disrespect and abuse during childbirth, and mothers' satisfaction with the quality of services provided during labor and delivery in Urmia, a city with a diverse ethnic and religious population. This aspect can be considered one of the strengths of the current research.

The novelty and local relevance of the tools used to measure respectful care, while a strength of the study, also limited the ability to make comparisons with other studies. Additionally, under specific social conditions in the community and the nature of interviews conducted at healthcare facilities, some women may have refrained from accurately expressing their negative experiences due to the sensitivity of the subject matter. Furthermore, individuals' perceptions of a certain behavior in similar situations, even by the same healthcare provider, can vary, leading to different interpretations of whether the behavior was respectful or not. It is also important to note that the data used in this study were based on self-reports

from women collected within one month after childbirth, which may have been influenced by recall bias, a common limitation in cross-sectional studies.

Conclusions

High scores in the provision of respectful care and its various domains indicate that, despite relative improvements and reductions in violence and mistreatment, there are still aspects of disrespect and discrimination in service delivery, highlighting the gap that remains before achieving fully respectful care.

The inverse relationship between the number of experiences of violence and the score for respectful care confirms its detrimental effects on mothers' perceptions and experiences, which can threaten their mental health. Despite some positive evaluations of respectful care, serious challenges persist in delivering quality services. This study also emphasizes the need to change existing approaches within the maternity care system and to reform current monitoring and oversight mechanisms regarding how care is provided during labor in hospitals. This includes the necessity of increasing women's participation in the decision-making processes related to childbirth. Establishing effective communication between service providers and recipients, along with the implementation of standard protocols and necessary training for staff, can enhance the satisfaction of pregnant women and improve the quality of services. Ultimately, paying attention to the human and respectful dimensions of care as a fundamental priority within the healthcare system can lead to improved childbirth experiences and better health outcomes for mothers and infants. Given that the above results are based on self-reports from mothers who were proficient in Persian, future observational studies are recommended. Additionally, mothers' perceptions of the types of violence and their interpretations of mistreatment are influenced by the cultural and social factors of each region, which cannot be captured through cross-sectional studies alone. Therefore, conducting qualitative studies in this area could be beneficial.

Implications of Practice and Research

The findings of this study underscore the urgent need for healthcare providers and policymakers to prioritize the implementation of RMC practices in health centers. The high prevalence of disrespect and abuse reported by mothers indicates significant gaps in the delivery of maternal care that can adversely affect women's physical and mental well-being. Healthcare facilities should develop and enforce comprehensive guidelines that promote respectful interactions, informed consent, and the active participation of mothers in their care. Training programs for healthcare professionals must emphasize the importance of communication, empathy, and cultural sensitivity to enhance the quality of care provided to mothers during labor and delivery. From a research perspective, future studies should explore the long-term impacts of disrespectful care on maternal mental health and the quality of mother-infant interactions. Additionally, qualitative research could provide deeper insights into the lived experiences of mothers and identify specific barriers to respectful care in various healthcare settings. Expanding the scope of research to include diverse populations and settings will help to generalize findings and inform best practices that align with the rights and dignity of all women in maternity care. Overall, addressing the issues highlighted in this study is critical for improving maternal health outcomes and fostering a healthcare environment that respects and upholds women's rights during childbirth.

Authors' Contribution

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Conflict of Interests

Authors have no conflict of interest to declare.

Data Availability Statement

Data is available upon reasonable request from corresponding author.

Ethical Issues

The present research has been approved by the ethics committee of the School of Nursing and Midwifery at Shahid Beheshti University of Medical Sciences, with the ethical code IR.SBMU.PHARMACY.REC.1402.151. Informed written consent was obtained from the participating mothers. Throughout the study, all ethical considerations, including the confidentiality of information, respect for privacy, and the voluntary nature of participation, were upheld.

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