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Original Article

The Parturient Women's Privacy Preservation in the Delivery Rooms: A Qualitative Study

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Abstract

Introduction: Parturient women's privacy preservation and respectful maternity care (RMC) in delivery room is an important principle in the high quality of midwifery care to achieve maternal satisfaction and positive childbirth experience. Hence, it is essential to make natural vaginal delivery (NVD) a positive experience and increase the mothers' satisfaction. This study aimed to investigate the privacy preservation of parturient women's in the delivery room.
Methods: Using conventional content analysis, this qualitative study was conducted from June 2018 to December 2020 at two hospitals and three health centers in Shahroud, Iran. Purposeful sampling was employed and it was continued till data saturation through in-depth interviews with 37 participants.
Results: The results of interviews with 21 women with NVD experience and 16 maternity health service providers resulted in the extraction of four themes including physical, spiritual-mental, informational, and social privacy.
Conclusion: Various mechanisms were found to promote the privacy and satisfaction of parturient women in the delivery room. They included the necessity continuous education, monitoring about mother's privacy preservation and intervention to improve effective communication skills among staff in delivery rooms.

Introduction

Privacy is defined as a feeling that every adult has towards his/her identity, dignity, independence, and personal space.[1] Price defines it as a selective control of access to oneself or a group.[2] Koskimies et al divided this concept into physical, psychological, social, and informational dimensions.[3] As mentioned in the 1994 Declaration of Patients' Rights, preserving privacy is one of the fundamental human needs and an important concept in the field of health, treatment, and medical ethics.[4,5] Privacy is considered one of the important 5-fold articles in the Iranian Patients' Rights Charter, in which it is emphasized that providing health must be based on respect for privacy and meeting the confidentiality principles.[6,7] Preserving patients' privacy is considered one of the main indices of quality of care and a basic goal of health services by international organizations and associations.[8-10] However, the results of national and international studies demonstrate that respect for the patient's privacy is dissatisfying.[11-13]

Accordingly, preserving parturient women's privacy, which is one of the subcategories of the patient's rights, is of great value in their health conditions. The recommendations by World Health Organization (WHO) in 2018 emphasized the quality of interaction between women and their healthcare providers and considered good interactions as a prerequisite for positive outcomes of childbirth.[14,15] Additionally, respecting parturient women's rights is one of the important aspects of medical care in which midwives, as the core of midwifery care, play the role of a spiritual and emotional catalyst to promote the capabilities and self-confidence of parturient women. Creating an effective relationship with the parturient women increases their self-confidence. Studies have shown that communicating with mothers during childbirth can reduce pain, anxiety, and sense of guilt; it also increases satisfaction, acceptance, and adapting to the conditions, participation, cooperation with the treatment team, stabilizing blood pressure, increasing the effectiveness of training, and prevention of medical errors.[16,17] Providing care by concerning the mothers' beliefs and values and respecting their dignity and privacy is a fundamental issue that leads to an increase in their satisfaction with natural vaginal delivery (NVD) and makes the procedure pleasing.

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Lack of privacy leads to an increase in one's anxiety, stress, and arousal of aggressive behaviors.[18,19] Studies conducted on natural childbirth in Iran showed that the main reasons for women's unpleasant experience in natural childbirth include various interventions, frequent vaginal examinations, and lack of emotional support during labor and delivery.[20] The results of a study by Janssen et al showed that using a single room for maternity care significantly improved satisfaction in parturient women because of the relaxing physical setting, preservation of dignity, privacy, and information, avoidance of transfers, and improved continuity of midwifery-nursing care.[21] According to recommendations by the WHO, respectful maternity care (RMC) is a care that maintains dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth.[22] RMC leads to mothers' satisfaction during childbirth, including the quality of both physical interactions and inter-personal relations between care providers and parturient women.[23] Despite these efforts, there is evidence of parturient mothers' perceptions about the lack of effective communication with them during delivery by clinicians with adverse consequences.[24,25]

Most studies have focused on delivery services and no research has been conducted on meeting and conceptualizing parturient women attitudes towards privacy and RMC. As far as the researchers investigated, few studies have been conducted to investigate parturient women's views in Iran. Hence, we decided to investigate and conceptualize the view of parturient women and maternity health services providers towards preserving mothers' privacy and RMC in delivery rooms. Accordingly, this study aimed to explain the experiences of mothers and midwives about privacy preservation and RMC in the delivery room. These findings could be valuable for education, research, and practice in the field of obstetrics and help present resolutions for existing problems and increase mothers' satisfaction consistent with the promotion of the natural childbirth program.

Material and Methods

This qualitative study with a conventional content analysis method was conducted on 21 women aged 18–43 years with NVD experiences at delivery rooms of Bahar and Khatam hospitals in Shahroud, Iran, and 16 maternity health services providers including midwifery students, obstetricians, and reproductive health specialists. Data were collected from June 2018 to December 2020. Content analysis is an analytical approach and scientific method to provide new cognition, improve researchers' perception of phenomena, and determine operational strategies in processes.[25] Participation in the study was voluntary for the women. After gaining the approval of the authorities, face-to-face semi-structured and in-depth interviews were conducted with mothers who came for post-partum care and care of their babies in a counseling room with calm atmosphere. The sampling process was purposeful. The inclusion criteria were mothers with the experience of NVD at Bahar and Khatam hospitals in Shahroud, the ability to talk and express emotions and feelings, and the willingness to participate in the study. All maternity health services providers included in the study had worked for at least one year in the delivery rooms of Bahar and Khatam hospitals in Shahroud. Interviews with caregivers were done in the staff break rooms of the hospitals. The duration of each interview varied from 30 to 40 minutes. After conducting 40 interviews (21 women with NVD experience and 19 maternity health service providers), the data were saturated and no new data were obtained. At first, the following general questions were asked: 1- How was your experience of NVD in the delivery room? Was it respectful? Please describe it, 2- What made you embarrassed in the delivery room? 3- Were you uncomfortable or embarrassed at the delivery room? Please describe it. The process of data analysis was also conducted based on content analysis described by Graneheim and Lundman as follows: (I) transcribing the recorded interviews, (II) reviewing the transcripts to come up with a general understanding of the content, (III) identifying meaningful units and primary codes, (IV) classifying the primary codes into broader categories, and (V) specifying the latent concepts.[26] In the first step, the interviews were audio recorded and then transcribed and reviewed for several times to obtain a general understanding. In the second step, words and sentences containing information about the research question were considered as semantic units. In the third step, the meaningful units were abstracted and labeled with codes. In the fourth step, the codes were compared with each other in terms of similarities and differences and grouped into categories. Finally, the themes were determined based on the categories.

To increase the scientific accuracy and validity of the data, the four criteria of Guba and Lincoln including credibility, confirmability, dependability, and transferability were assessed. Some factors including long-term engagement, insight into data collection, review by the supervisor, and continuous comparison of data were used to validate the data. Dependency indicated the consistency and reliability of the data and the participants on the categories, definitions, and interpretation of the data and the supportive quotes.

The transferability of the study was provided by rich data descriptions.[27] To achieve the maximum variation, women of different parities, age groups, and education levels were selected.

Results

Table 1 illustrates the demographic information of all 40 participants. Participants included 21 women with NVD experience and 16 maternity health service providers.

Table 1. Demographic data of participants

Demographic data	Range	
Mothers with the experience of having NVD (n=21)		
Age (year), Mean (SD)	18-41	28.2 (1.5)
Education, No. (%)		
Primary school		0 (0)
High school		3 (14.4)
Diploma		7 (33.3)
University education (year)		11 (52.3)
Parity (number), No. (%)		
1		11 (52.3)
2-3		7 (33.3)
3>		3 (14.4)
Employment status		
Positive :1	0-1	6 (28.5)
Negative: 0		15 (71.5)
Care providers and specialists in labor delivery units (n=19)		
Age (year), Mean (SD)	20-45	32.2 (1.7)
Education, No. (%)	13-23	
BSC	13-16	4 (25)
MSC	17-18	3 (18.75)
PHD or specialist	19-23	3 (18.75)
Student of Midwifery	17-23	6(37.5)
MSc	17-18	4 (25)
PhD	19-23	2 (125)
Duration of work experience in the delivery room (year)	1-16	6.8 (0.5)

Care providers consisted of 6 midwifery students (MSc, PhD), seven midwives, and three faculty members (gynecologists and reproductive health specialists). Data were collected through individual interviews.

The findings of the study extracted from the experiences of all the participants were arranged based on their similarities and differences. The extracted key concepts consisted of 22 codes, eight categories, and four themes (Table 2).

The results of this study revealed that although it is necessary to impose some physical limitations on the mothers, observing some points by the delivery room staff can prevent the violation of mothers' privacy rights and make delivery a positive experience for them. Results of interviews were divided into four categories including physical, spiritual-mental, informational, and social privacy.

1. Physical Privacy

Physical privacy is the degree of personal privacy in which the individual becomes physically accessible. A mother may feel a lack of physical privacy due to several reasons. We extracted two subcategories and five codes from the interviews (Table 2). The identified subcategories included 'ignoring the scientific principles of examination and care for parturient women and Ignoring the nakedness of the parturient women.

1.1. Ignoring the Scientific Principles of Examination and Care for Parturient Women

The results of interviews with the participants demonstrated that ignoring some scientific principles of examination and care by the medical staff such as noticing the mothers' covering in the delivery room can be important for preserving the mothers' privacy.

Mothers' interviews expressed that frequent and unnecessary examinations caused their dissatisfaction

"*To check the cervix dilation, midwives frequently examine the mother without using folding screens in the delivery room*" (M. V., 23 years old, first delivery experience, housewife, high school dropout).

Also, some participants mentioned frequent and violent examinations in the delivery rooms.

"*Midwives always put their hands into the vagina and mothers feel as if they have been raped, or even gang-raped. It is immoral and violent*" (F. S., 31 years old, second delivery, employed).

1.2. Ignoring Nakedness of the Parturient Women

Respecting privacy issues related to gender, as one of the religious principles, is very important and may occur in emergency and mother-infant cardiopulmonary resuscitation units. Ignoring these issues can be annoying for the mothers.

Among the cases of not preservation physical privacy in delivery rooms, it was mentioned nakedness in parts of the body unrelated to examination.

"*They don't notice that there should be a sheet over the mother, or while injecting drugs, only the site of injection should be exposed*" (M. A., 30 years old, third delivery experience, teacher).

One of the important points, some participants mentioned ignoring gender concordance in the delivery rooms.

"*Once a baby was born with low Apgar and cyanosis. They called a code and all male anesthesiology specialists and assistants, as well as several nurses and midwives entered the LDR [labor, delivery, and recovery] room, while the mother was naked*" (S. Z., Midwife).

One of things that may happen in the delivery room was inappropriate covering of mothers in delivery rooms.

"*During the delivery procedure, everything may happen. It is inevitable that the anesthesiology team may enter the delivery room in emergency. However, sometimes the mothers' covering is not appropriate. It should be noticed*" (F. K., Midwife).

2. Spiritual-Mental Privacy

The spiritual-mental privacy preservation of the pregnant mothers means respecting the mothers' values and identity, particularly in the critical conditions

Table 2. Extracted concepts from the participants' interviews

Themes	Categories	Codes
1. Lack of physical privacy	1.1. Ignoring the scientific principles of examination and care for parturient mother	1.1.1. frequent and unnecessary examinations 1.1.2. frequent and violent examinations
	1.2. Ignoring the nakedness of parturient women	1.2.1. nakedness in parts of the body unrelated to examination 1.2.2. ignoring of gender-concordance 1.2.3. inappropriate covering for mothers
2. Lack of spiritual-mental privacy	2.1. Lack of effective communication with the mother	2.1.1. not being empathetic to the mother 2.1.2. staff-mother interaction quality 2.1.3. lack of training of staff
	2.2. Ignoring parturient women feelings	2.2.1. lack of the human dignity preservation 2.2.2. ignoring of the mother's respect and dignity 2.2.3. inappropriate behavior towards her companion
3. Lack of informational privacy	3.1. Lack of medical informational privacy preservation	3.1.1. lack of confidentiality 3.1.2. disclosing the mothers' medical information 3.1.3 ignoring of her information needs
	3.2. Lack of personal informational privacy preservation	3.2.1. disclosing the mothers' personal information 3.2.2. searching the mothers' personal affairs
4. Lack of social privacy	4.1. Doing the examination in front of others (non-medical staff)	4.1.1. simultaneous examination of several parturient mothers at the labor room 4.1.2. examination of the parturient mother in front of her companion 4.1.3. examination of the parturient mother in front of non-medical staff
	4.2. Lack of right to autonomous decision-making	4.2.1. lack of the right to choose the type of care 4.2.2. lack of the right to make decision 4.2.3. lack of the right to choose the bed or the room

after delivery. This will make the mother feel calm and encouraged to cooperate. In the delivery room, fear and anxiety are some natural reactions. We extracted two subcategories and five codes from the interviews (Table 2) including 'the lack of effective communication with the mother' and 'ignoring parturient women's feelings.

2.1. Lack of Effective Communication with the Mother

In this study, midwives reported that the most important factor for evaluating the quality of care and satisfaction is the type of communication and behavior of the staff towards mothers. During labor, mothers need understanding, empathy, care, reassurance, comfort, as well as appropriate verbal and nonverbal communication:

"Keeping effective communication with the mother during the labor lessens the pain, shortens the duration of labor, facilitates the delivery, decreases the need for analgesics, and finally makes her have a positive experience" (S. J., MSc in Midwifery).

In interviews, participants expressed dissatisfaction of not being empathetic to the parturient women and lack of staff-mother interaction quality.

"*I was terribly suffering from pain; but they were talking loudly on cellphone and getting on my nerves instead of comforting me*!" (P. N., 30 years old, second delivery experience, diploma, housewife).

"*Sometimes we forget the service receiver is not a robot. We shouldn't forget smiling facial expression and soothing statements in the ward because they are very important there*" (R. A., Midwifery).

One of the important points was communication skills training for staff which the participants mentioned.

"*It is essential that staff be trained in communication skills to protect mothers' privacy and satisfaction*" (M. A., 30 years old, third delivery experience, teacher).

2.2. Ignoring Parturient Women's Feelings

According to the interviews, respecting parturient women's dignity and feelings is a basic issue in midwifery care and a step to observe Patients' Rights Charter, which increases one's satisfaction with the services, but the parturient women's dignity ignored in some delivery rooms

"*There was a doctor in the delivery room that didn't let the mother speak a word. So where on earth is 'honoring the client'?*" (S. M., 33 years old, second delivery experience, BSc, housewife).

"I came from… [name of a village] for my third delivery. The midwife said loudly 'You have given birth to three children, that's enough. Have you thought about their future? God gives 3 children to one and no child to another!' She continued, 'You don't understand anything and you are a hillbilly'" (S. A., 32 years old, third delivery experience, housewife).

"*I gave birth to my child in a private hospital. They behaved well and asked for permission before examining*" (M. R., 28 years old, first delivery experience, employed).

Women expressed dissatisfaction of inappropriate behavior towards mother's companion.

"*One of the staff working in the labor room shouted at my companion saying 'go out' while they had already told that I could have one companion with me. I was scared and wanted my mom to be with me because it was my first delivery experience. But they didn't think about me*" (A. M., 25 years old, first delivery experience).

3. Informational Privacy

Preserving the informational privacy of pregnant mothers in the maternal ward is feasible through keeping their private medical and familial information confidential.

3.1. Lack of Preserving the Privacy of Medical Informational

Our results indicated that one of the most important

problems in delivery room was the lack of confidentiality of the medical information and not preserving the personal privacy as a part of the secrets of a mother, as well as her personal and familial relationship.

"*My fetus had a cleft lip which was detected in the ultrasound… they showed the sonography to each other… maybe I didn't like others knew about my baby's defect*" (M. H., 27 years old, first delivery experience).

"A Parturient Woman *with HBsAg+was referred to the hospital from a health center. Everybody, from the guard to nurses knew that she was affected by hepatitis. She suffered a lot; there was no need to disclose it to so many people"* (F. S., Midwife).

Some mothers mentioned to ignoring mother's information needs.

"*In the labor room, they had my baby's ECG and showed it to each other. I asked them if there was a problem? And they didn't answer clearly"* (F. N., first delivery experience, 30 years old).

3.2. Lack of Preserving the Privacy of Personal Informational

Personal informational privacy is part of mothers' secrets and confidential personal and familial relationship and personal affairs. The following were mentioned in the interviews by the participants:

"*They murmured that this Parturient Woman was the second wife… it was none of their business at all…*" (M. S., first delivery experience, 24 years old).

"*They asked about something personal in front of others; it annoyed the mothers. They asked a woman with genital warts whether her sexual relationship with her husband was OK and if the man was willing to live with her or not? and….*" (N. G., Midwife).

4. Social Privacy

Preserving social privacy is culturally very important. If a person can control her interactions with others, she can preserve her social privacy too. Events such as being examined in front of others (non-medical staff) and not having the right to make a decision (the right to choose the type of care, treatment, bed, and room) can negatively affect social privacy of the patients. From the interviews, two themes and six codes were obtained (Table 2) including 'doing the examinations in front of others (non-medical staff)' and 'lack of right to autonomous decision-making'.

4.1. Doing the Examinations in Front of Others (Non-medical Staff)

Some women reported simultaneous examination of in front of several parturient women, their companion, non-medical staff at the labor room leading to dissatisfaction and general discomfort

"I objected when three of us were examined in the maternal ward. They said, 'spend money and go to private hospital. My way or the highway!" (S. J., 23 years old, first delivery experience, high school dropout, housewife).

"*In some delivery rooms, where the patient's companion is permitted in, they think they can examine the mother in front of her/him. They don't ask the mother for permission*" (S. M., Midwife).

"*The mother is left naked in front of the janitors without any sheets or folding screens*" (F. K., Midwife).

4.2. Lack of Right to Autonomous Decision-making

Participants commented more broadly on the importance of having choices in relation to their maternity care and kinds of painless childbirth.

"*I preferred to have painless childbirth, but it was only done in limited number of hospitals. Actually, I didn't have the right to choose"* (M.H, 26 years old, first delivery experience, employed).

Some Parturient women indicated that were limited right to make a decision.

"*I was hospitalized in one of the government hospitals for my first delivery. I was a midwife and the cervix was 8 cm open. Two midwives said, 'It is too late.' I said 'I am your colleague, and my physician has said that I can deliver without intervention; please don't hurry. However, without noticing my objection and the fact that I am a human being, they performed episiotomy …. Later on, I realized that it was a project during which they wanted to experience the procedure*" (M. K., Midwife, second delivery).

Some participants expressed that mothers didn't have right to choose the bed or room

in maternity ward or delivery rooms.

"*Once I was at work and the window of the labor room was broken. A Parturient woman told that inside the room could be seen from outside. There were no empty beds; so, we covered the window with a lot of difficulty*" (S. M., Midwife).

"*In labor, all the patients are in one labor room. In fact, their privacy is invaded"* (M. J., 23 years old, first delivery experience, employed).

Discussion

In the health system of every country, respect for a pregnant mother's privacy is one of the most important aspects of medical care. The findings of this study from the experiences of participants resulted in extracting 21 codes and eight categories four themes including physical, spiritual-mental, informational, and social types of privacy. These concepts included lack of effective communication and empathy, lack of protecting confidentiality, lack of interpersonal relationship training for the staff, not obtaining the women's consent before examination in the labor process, not providing information during labor process, violating patient privacy rules, and the lack of freedom of choice related to position for giving birth, and up to the end all such concepts in our study revealed dissatisfaction, lack of privacy, and low RMC in the labor process and delivery room; finally, these concepts were

affecting factors in the negative or positive childbirth experiences. Continued on this research, appears fully justified that training of communication skills for staff in labor for childbirth satisfaction. This issue can be an effective factor in maternal satisfaction as a step towards the policy of promoting natural childbirth in the country. The results of the present study showed that inadequate communication of some delivery room staff can cause maternal dissatisfaction. So, training communication skills could potentially support effective communication in labor room, and consequently enhance women's experiences and birth outcomes. The results of studies by Moridi et al, Faghani Aghoozi et al, Iravani et al, and Tabrizi et al were consistent with our results.[16,28-30] Also, the studies by Hosseini Tabaghdehi et al,[31] Abdollahpour and Motaghi[32] and Azimi et al[33] showed that one of the most important issues making the experience of childbirth positive is the interpersonal relationship and human dignity preservation.A study by Taghizadeh et al showed that using communication skills (verbal and non-verbal) by midwives was undesirable (68%). Moreover, the clients' satisfaction with verbal and non-verbal communication skills of midwives was 50% and 48.4%, respectively. In fact, clients' satisfaction had a significant relationship with the use of communication skills by midwives.[34] Some researchers found that in the LDR room, mothers were moderately satisfied with the respectful behavior of the staff, though privacy preservation was poor.[35,36] In spite of the recommendations and emphasis of Iran's National Guidelines to preserve mothers' privacy rights before, while, and after the delivery for normal childbirth, the strategies and indicators to implement RMC have not been addressed clearly in the hospitals and health centers.[37] According to the results of a study by Khadivzadeh et al there was no relationship between midwives' communication skills and work experience, childbirth experience, age or interest in midwifery (the midwives' score on communication skills was 67.9 out of 130, which was considered an average score).[24] Differences in the results could be due to small sample size, samples only from teaching hospitals, different physical and psychological conditions of midwives and midwifery at students, the time of performance evaluation, as well as timing of assessment in relation to the birth and probably due to the difference in midwives' working hours at labor setting. However, it is not easy because of the complicated nature of privacy preservation. In order to remove the doubts and ambiguities in the results of studies, a comprehensive measurement tool is necessary to determine the observance of maternal privacy and RMC. To that end, a study by Taavoni et al showed that a new and reliable instrument (59-item QRMCQI) can be used for evaluating respectful maternity RMC in Iran.[23]

The studies by Orpin et al in Nigeria, Shimoda et al in Tanzania, and Oladapo et al in Uganda considered both respectful and disrespectful caregivers in two health facilities and reported several types of physical and psychological abuse problems. To promote respectful care of women, staff training measurements including skills for rapport building and counselling, improvement of working conditions, empowering parturient women to report disrespectful practices, and strengthening health policies are crucial and have equal value with the clinical and contextual environmental factors.[38-40] A systematic review on RMC was done by Shakibazadeh et al using the UNICEF/WHO RMC guidelines. It included 12 dimensions half of which were related to respecting mother's privacy. The results revealed that in low-income countries, the RMC rate was weak, while it was high in high-income countries.[41] According to the results of studies by McKinnon et al in Australian delivery rooms, Rosen et al in five countries of Eastern and Southern Africa, and Mannava et al quality of care (interpersonal and professional behavior), being involved in decision-making, responses to information needs were affecting factors in RMC.[42-44] A systematic review by Beake et al found very low quality evidence on the effectiveness of communication training of maternity care staff. Studies which are able to identify characteristics of interventions to support effective communication in maternity care are urgently needed.[45] Parturient women want effective communication in preterm labor from health professionals who offer clear advice in a sympathetic manner. They also need maternal health services with provision of effective communication to enable them to feel more confident.[46] However, establishing warm and friendly relationships with women has been reported in several studies from the UK, Norway, Sweden, New Zealand, and Australia.[47-51]

In addition to the cases mentioned, emphasizing duties and a sense of responsibility in midwifery care can make significant differences in the results. Sociocultural context and linguistic differences between midwives and mothers were a barrier to communication. Also, there are problems in labor settings, such as lack of midwife to mothers, lack of independence of midwives in professional decisions, disregard for the psychological needs of service providers, and injustice in the payment of maternity fees. As long as there is a superiority of critical and punitive policies over incentives, the possibility of effective communication will be difficult and often unattainable.

However, the lack of the patients' privacy preservation is not limited solely to the delivery room and parturient women's. Some study showed that the level of respecting patients' privacy ranged from moderate to weak. In conclusion, the patients' privacy preservation was overlooked.[52-54]

Like any other study, the findings of this report are subject to some limitations. First, since this is a qualitative study, the obtained results cannot be generalized to the entire women population. Second, lack of motivation among some of the participants to interview was another limitation of this study. Third, this study was done in a

small town without ethnic diversity.

Conclusion

The findings of this study come with the following recommendations. Firstly, it is essential to systematically train and evaluate the delivery room staff and medicine and midwifery students to preserve mothers' privacy rights before, while, and after the delivery. Furthermore, the medical team and students must be trained with continuous education regarding professional ethics charter. This will improve their accountability for the physical, mental, and spiritual health of the mothers.

Secondly, considering the inadequate communication skills of some delivery room staff, which could be the major cause of maternal dissatisfaction with delivery care, training communication skills could potentially support effective communication in labor room, and consequently enhance women's experiences and birth outcomes.

Thirdly, politicians and planners of the country should prioritize programs to create the needed infrastructure and institutionalize effective communication skills.

Fourthly, politicians and planners of the country should provide organizational support for intervention urgently to achieve and sustain effective communication by maternity care staff.

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Authors' Contribution

Conceptualization: Farzaneh Valizadeh, Zahra Motaghi.
Data collection; Farzaneh Valizadeh.
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Writing – review & editing: Zahra Motaghi.
Read and approved the final manuscript: Zahra Motaghi.

Competing Interests

The authors declare that they have no conflict of interests.

Data Accessibility

The datasets are available from the corresponding author on reasonable request.

Ethical Approval

Ethical approval was given by the Research Council and the Ethics Committee of Shahroud University of Medical Sciences (ethics code: IR.SHMU.REC.1397.103). All women participated in the study voluntarily. Before conducting the interviews, the researcher explained the purpose of the study, confidentiality of the responses, and the possibility to withdraw from the study at any time. In addition, informed written consent along with permission to record the interviews were obtained.

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Research Highlights

What is the current knowledge?

The parturient women's privacy preservation and respectful maternal care (RMC) is considered as one of the main indices of high quality of care and a basic goal of maternal health services.

What is new here?

Respecting parturient women's physical, spiritual-mental, informational, and social privacy in natural childbirth is essential for their satisfaction and making childbirth a positive experience.

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