Restoring Dignity at Birth: Integrating Gender Sensitivity, Bioethics, and Religious Values to Eliminate Obstetric Violence

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ABSTRACT

Obstetric violence remains a pervasive public health and human rights issue that quietly strips women of their autonomy and dignity during childbirth. Rooted deeply in biomedical power imbalances and institutional paternalism, this mistreatment persists across health systems particularly in under-resourced settings where standard guidelines fail to protect bodily integrity. Despite international efforts to promote respectful maternity care, women routinely endure non-consensual medical interventions, verbal abuse, and non-dignified clinical practices. Systemic resource shortages, provider biases, and a lack of standardized definitions continue to normalize these non-dignified childbirth experiences. To address these challenges, this study examines how synthesizing gender sensitivity, bioethical principles, and religious values can dismantle clinical hierarchies, restore patient rights, and eliminate obstetric violence. Employing a qualitative, library-based document research design grounded in an interpretive paradigm, the study systematically retrieved academic literature, global health policies, and socio-religious texts, focusing particularly on multicultural and Muslim-majority contexts. The collected data were analyzed through thematic analysis using Braun and Clarke's six-phase framework to identify recurring operational patterns and systemic mechanisms. The analysis reveals that lasting reform depends on a synergistic three-pillar approach: gender awareness dismantles traditional clinical hierarchies, bioethical standards enforce informed consent and autonomy, and spiritual values such as *Karamah Insaniyyah* (human dignity) and *Ihsan* (benevolence) cultivate intrinsic moral accountability and empathy among care providers. While implementation is hindered by severe staffing shortages, inadequate ethical training, and entrenched systemic biases, adoption of woman-centered care models, continuous ethics education, and strong policy frameworks serve as primary facilitators. Ultimately, bridging global bioethical standards with local faith values establishes a meaningful sense of moral responsibility, transforming clinical guidelines into compassionate, dignified, and violence-free birth experiences for every woman.

Key words: Obstetric Violence, Bioethics, Respectful Maternity Care

INTRODUCTION

Obstetric violence, defined as the mistreatment, disrespect, and abuse of women during childbirth, has emerged as a critical human rights and public health issue worldwide. This form of gender-based violence undermines women's dignity, autonomy, and right to respectful care, often manifesting through dehumanizing and non-consensual medical practices, lack of information, and disregard for women's autonomy and self-determination during childbirth (Olajide & Duma, 2026; S. Yildirim & Mert-Karadas, 2025). Despite global efforts to promote respectful maternity care (RMC), many women, particularly in low- and middle-income countries, continue to experience mistreatment and disrespect during childbirth, highlighting the urgent need for systemic change (Michaels et al., 2020; Fares et al., 2026).

Background of the Study

Obstetric violence is deeply rooted in structural and cultural factors, including gender norms within biomedical models of birth, systemic deficiencies in healthcare facilities, and historically constructed power relations that devalue women's bodies and experiences (Fares et al., 2026; Iparraguirre et al., 2023). The phenomenon is not only a violation of sexual and reproductive rights but also a philosophical and ethical problem, symbolizing the exercise of power over the female body and the erosion of women's rights to health, safety, and psychological integrity (Rusu et al., 2025).

The principle of human dignity is central to ethical maternity care and is recognized as both an obligation and a human right within the midwifery profession (Haseli et al., 2024; Ferreira et al., 2021). Ensuring women's rights during childbirth, based on humanized and bioethical principles, leads to better quality of care, patient safety, and positive childbirth experiences 13. However, the lack of consensus on the terminology and definition of obstetric violence, as well as limited attention to the enabling factors for respectful care, hinders effective policy and practice (Olajide & Duma, 2026; Ferrão et al., 2022).

Integrating gender sensitivity, bioethics, and religious values offers a holistic approach to eliminating obstetric violence. Gender sensitivity addresses the specific needs and vulnerabilities of women, while bioethical principles such as autonomy, beneficence, non-maleficence, and justice provide a framework for ethical decision-making in obstetric care (Ferrão et al., 2022) G. Yildirim, 2020). Religious and spiritual values have historically shaped childbirth practices and can play a transformative role in restoring trust, empowerment, and dignity for women during birth (Strazzeri & Spagnolo, 2025).

Research Objectives

The study was guided by the following objectives.

1. To analyze the integration of gender sensitivity, bioethical principles, and religious values in restoring dignity and eliminating obstetric violence during childbirth.

2. To identify key barriers and facilitators in implementing gender-sensitive, ethical, and culturally respectful maternity care practices across healthcare settings.

3. To develop actionable recommendations for healthcare providers and policymakers to advance respectful, dignified, and violence-free perinatal care.

LITERATURE REVIEW

Restoring dignity at birth requires attention to three linked dimensions: manifestations of obstetric violence, the operational use of gender-sensitive bioethics, and the integration of religious and spiritual values into compassionate maternity care.

Manifestations and Implications of Obstetric Violence on Women's Dignity

Obstetric violence is widely described as a violation of women's dignity, autonomy, and fundamental rights during childbirth (Yalley et al., 2024; Pickles, 2025). Across settings, its manifestations include physical and verbal abuse, humiliation, coercion, non-consented procedures, neglect, denial of companionship, privacy breaches, unnecessary interventions, and abandonment in care (Van der Waal & Mayra, 2023). Reviews from India, the Eastern Mediterranean, and global datasets show that these practices are not isolated incidents but are often normalized within patriarchal, hierarchical, and institutionally violent systems ((Khalil et al., 2022; Faheem, 2021; Perrotte et al., 2020).

The implications extend beyond childbirth itself. Obstetric violence is associated with birth trauma, postpartum depression, post-traumatic stress, worsened trust in health systems, and avoidance or delay of future facility-based care (Reyes-Amargant et al., 2025; Khalil et al., 2022). Women from marginalized groups, including

those who are poor, socially excluded, from minority communities, or illiterate, appear especially vulnerable (Faheem, 2021; Collins et al., 2025). Underreporting is also substantial because many women normalize mistreatment or do not recognize routine abusive practices as violence (Khalil et al., 2022).

Non-dignified care often overlaps with other abuses because gender and power norms shape how women are treated (S. Yildirim & Mert-Karadas, 2025). Overmedicalization can itself function as violence when routine interventions are unnecessary, coerced, or poorly explained (Khalil et al., 2022; Reyes-Amargant et al., 2025). Women consistently identify respectful communication, privacy, timely care, consent, and companion support as markers of dignified birth (Mayra et al., 2022; Collins et al., 2025).

Operationalizing Gender Sensitivity and Bioethics in Obstetric Care

Operationalizing gender sensitivity and bioethics in obstetric care means translating dignity into routine clinical practice. The literature frames respectful maternity care as broader than simply avoiding abuse: it includes freedom from harm, privacy, confidentiality, informed consent, equitable treatment, effective communication, family support, continuity, and respect for women's choices (Moridi et al., 2020; Collins et al., 2025). Bioethically, the core principles are autonomy, informed consent, non-maleficence, justice, and person-centred care (S. Yildirim & Mert-Karadas, 2025).

Studies of providers and interventions suggest that implementation depends on both interpersonal and structural change. Communication training, privacy measures, birth companionship, and rights-based information reduce mistreatment and improve perceptions of respectful care (Yalley et al., 2024). Midwives describe respectful care through empathy, women-centred decision making, equal care, safe evidence-based practice, and an appropriate environment (Moridi et al., 2020). Recent work also argues that gender sensitivity must explicitly challenge paternalism, defensive medicine, and the subordination of maternal autonomy to foetal interests (Reyes-Amargant et al., 2025).

Training reforms should include respectful birth, human rights, consent, communication, and ethical reflection. Institutional accountability requires complaint systems, legal frameworks, monitoring, and infrastructure that protects privacy and dignity (Pickles, 2025; Collins et al., 2025). Inclusive gender sensitivity should also extend to transgender and non-binary patients through affirming language, education, and policy change (Chauhan & Sivan, 2025).

Integrating Religious and Spiritual Values as Catalysts for Compassionate Care

Religious and spiritual values can act as catalysts for compassionate obstetric care when they are integrated respectfully rather than imposed. Across diverse contexts, spirituality appears central to many women's experiences of pregnancy and childbirth, functioning as a source of meaning, emotional support, coping, confidence, and resilience (Trisiani et al., 2024); (Showkat, 2025). Women report practices such as prayer, singing, fellowship, thanksgiving, use of religious artefacts, and spiritual consultation as part of their birth experience (Aziato et al., 2016).

The literature does not present spirituality as a substitute for evidence-based care. Instead, it supports holistic care that attends to physical, emotional, social, and spiritual needs while respecting women's beliefs and preferences (Trisiani et al., 2024; Ohaja et al., 2019). Providers' own assumptions can either support or hinder meaningful maternity care, which makes reflexivity and cultural humility important (S. Yildirim & Mert-Karadas, 2025). The growing maternity-spirituality literature increasingly calls for clinical strategies that integrate spiritual care into maternal services, especially in underrepresented regions (Dilmen et al., 2025).

Spiritual care can strengthen autonomy, comfort, security, and maternal-foetal attachment (Backes et al., 2023). Respecting women's faith practices supports holistic and culturally responsive childbirth care (Aziato et al., 2016; Showkat, 2025; Trisiani et al., 2024. Compassionate integration requires support for women's beliefs, not religious coercion or replacement of clinical standards (Moridi et al., 2019; Dilmen et al., 2025). Eliminating obstetric violence therefore requires a three-part shift: naming its violations of dignity, embedding gender-sensitive bioethics into routine obstetric practice, and honouring women's religious and spiritual worlds

as part of respectful, compassionate care.

Conceptual Framework

Dismantling systemic obstetric violence driven by medical paternalism, unconsented interventions, and gendered power imbalances requires an integrative three-pillar model that unites gender sensitivity, bioethical principles, and religious values. By operationalizing gender responsiveness to challenge clinical hierarchies, bioethics (*autonomy*, *non-maleficence*, *justice*) to enforce continuous informed consent, and faith-informed imperatives (*Karamah Insaniyyah*, *Amanah*, *Ihsan*) to cultivate cultural humility and spiritual comfort, healthcare systems can implement actionable institutional enablers. Supported by provider reflexivity training, privacy-preserving infrastructure, and robust accountability mechanisms, this synergistic integration transforms perinatal care into a respectful, autonomy-affirming, and dignity-centered experience for every birthing individual.

METHODOLOGY

This section outlines the research design, data collection techniques, and data analysis procedures employed to explore the integration of gender sensitivity, bioethics, and religious values in addressing and eliminating obstetric violence.

Research Design

This study adopts a qualitative research methodology. A qualitative design is particularly suited for this inquiry as it enables an in-depth exploration of complex social, ethical, and human rights issues such as obstetric violence which are deeply entangled with emotional, cultural, and systemic dimensions of maternal healthcare. Grounded in an interpretive paradigm, this design facilitates a comprehensive understanding of how gender sensitivity, bioethical frameworks, and religious values can be harmoniously integrated to restore dignity, respect, and autonomy to women during childbirth.

Study Area

The study area for this research is conceptual and literature-based, operating at the intersection of maternal healthcare, bioethics, gender studies, and religious ethics. Contextually, the study examines global frameworks on obstetric violence such as World Health Organization guidelines while focusing on multicultural and Muslim-majority settings, particularly Malaysia and Southeast Asia. By analysing global human rights standards alongside localized academic literature, health policies, and religious ethical frameworks, the study area bridges global medical ethics with local socio-religious contexts to establish a culturally sensitive approach to respectful childbirth.

Data Collection Methods

Data was collected through document analysis (a library-based qualitative research approach) focusing on gathering primary frameworks and secondary academic literature, including peer-reviewed journal articles from databases such as Scopus, Web of Science, PubMed, and Google Scholar covering obstetric violence, gender-sensitive care, maternal health rights, and medical humanities. The collection also encompassed bioethical and global health policy documents from organizations like the World Health Organization, scholarly religious and cultural texts articulating moral imperatives and compassionate treatment during labor, as well as legal and human rights reports addressing mistreatment during childbirth, with all documents screened using clear inclusion and exclusion criteria to ensure authority and direct alignment with the research objectives.

Ethical Considerations

Although this research does not involve direct human participants, medical interventions, clinical trials, or sensitive personal data and is therefore exempt from institutional review board (IRB) ethical approval ethical integrity was strictly maintained throughout the research process. As a library-based document analysis, ethical

considerations centred on academic integrity, objective interpretation, and responsible handling of published literature. The study ensured absolute avoidance of plagiarism, falsification, or cherry-picking of data by providing full, accurate citations and references for all retrieved academic journals, policy documents, and religious texts. Furthermore, because the topic addresses sensitive issues such as obstetric violence and women's healthcare experiences, the analysis was conducted with professional objectivity, academic neutrality, and respect for cultural and religious sensitivities, ensuring that secondary sources were contextualized accurately without distortion or bias.

Data Analysis

The collected document data was analyzed using thematic analysis following Braun and Clarke's (2006) six-phase framework to systematically identify, analyze, and organize recurring patterns directly aligned with the research objectives. This analytical process involved familiarizing with the data through repeated readings, generating initial codes for key concepts such as obstetric violence manifestations, gender dynamics, bioethics, and religious imperatives, clustering these codes into themes, reviewing them for coherence, and defining clear master themes specifically: Manifestations and Implications of Obstetric Violence on Women's Dignity, Operationalizing Gender Sensitivity and Bioethics in Obstetric Care, and Integrating Religious and Spiritual Values as Catalysts for Compassionate Care before synthesizing the findings into a critical narrative supported by existing literature.

RESULTS

The Integration of Gender Sensitivity, Bioethical Principles, and Religious Values in Restoring Dignity and Eliminating Obstetric Violence

Applying bioethical principles, particularly autonomy and human dignity, is crucial in combating obstetric violence. Studies highlight that when healthcare providers respect women's autonomy and intrinsic dignity, it strengthens their rights and counters dehumanizing practices during childbirth. This approach is recognized as both an ethical obligation and a human right, leading to improved quality of care and positive childbirth experiences for women (Vargas-Machado & Roncancio Bedoya, 2025). Respectful care, grounded in bioethics, not only boosts mothers' self-esteem and confidence in the medical system but also encourages future pregnancies and trust in healthcare providers (Raesi et al., 2023).

On the other hand, gender sensitivity, defined as awareness and active endorsement of gender equality, is identified as a key factor in shaping attitudes toward respectful maternity care. When healthcare professionals and students are educated about gender equality and the impact of patriarchal structures, they are better equipped to recognize and prevent obstetric violence (Sharon & Alnabilsy, 2025). The normalization of obstetric violence is often rooted in gender and moral injustices. Addressing these through gender-sensitive training and feminist perspectives helps challenge harmful norms and empowers women to advocate for their rights during childbirth (Shabot, 2026).

Integrating religious values and cultural sensitivity into maternity care addresses the diverse needs of women and supports their dignity. Studies involving women from different religious backgrounds (e.g., Jewish and Arab women in Israel) reveal that acknowledging spiritual beliefs and cultural practices can help mitigate the effects of obstetric violence and promote healing (Sharon & Alnabilsy, 2025). Culturally and religiously sensitive care also enhances psychosocial support, which is critical in contexts where systemic inequalities and underfunded health systems persist. This approach ensures that care is not only clinically effective but also emotionally and spiritually supportive, contributing to the overall well-being of mothers (Mengesha et al., 2025).

In Muslim-majority and multicultural settings, such as public maternity hospitals across Malaysia and Indonesia, operationalizing faith-based values like *Karamah Insaniyyah* (human dignity) and *Ihsan* (benevolence and excellence in care) translates into specific clinical protocols. For instance, providing routine birth companion access to spouses or female relatives aligns directly with religious principles of spiritual comfort and emotional safety during labor. Furthermore, ensuring modesty protection such as using full-body

privacy drapes during examinations, assigning female care teams upon request when available, and allowing time for quiet prayer or religious rituals (*doa* and recitations) prior to clinical procedures bridges abstract bioethical mandates of autonomy with deeply held local cultural values. Grounding provider training in *Ihsan* elevates clinical duties from simple regulatory compliance to a deeply internalized moral obligation, directly reducing instance of harsh verbal reprimands or unconsented interventions during delivery.

The core dimensions of the proposed framework and their respective contributions to eradicating systemic mistreatment during childbirth are summarized below:

Table 1: Integration of Gender Sensitivity, Bioethics, and Religious Values in Eliminating Obstetric Violence

Dimension	Contribution to Restoring Dignity & Eliminating Violence
Gender Sensitivity	Challenges power imbalances, centres women's experiences, addresses systemic gender norms
Bioethical Principles	Ensures autonomy, informed consent, justice, and non-maleficence
Religious Values	Promotes respect, trust, and dignity through cultural/spiritual frameworks

Integrating gender sensitivity, bioethics, and religious values in maternity care is effective in eliminating obstetric violence and restoring dignity at birth. This multidimensional approach addresses ethical, social, and cultural factors, leading to more respectful, empowering, and holistic care for women

Key Barriers and Facilitators in Implementing Gender-Sensitive, Ethical, and Culturally Respectful Maternity Care

There is substantial evidence highlighting both barriers and facilitators in implementing gender-sensitive, ethical, and culturally respectful maternity care. Key barriers include systemic and organizational challenges such as inadequate staffing, lack of resources, and insufficient training for healthcare providers, which hinder the consistent delivery of respectful and culturally competent care (Ng et al., 2026). Additionally, cultural and language differences between providers and women, as well as entrenched social norms and biases, can impede the provision of care that is sensitive to gender and cultural needs. Disrespectful care, which violates women's rights and autonomy, remains a significant obstacle, particularly in least-developed countries, and is associated with delayed care-seeking and adverse birth outcomes (Ng et al., 2026; Mohammadrezayi et al., 2026). Healthcare providers often report difficulties in balancing clinical demands with the need for interpersonal and culturally sensitive communication, and women from ethnic minority backgrounds frequently encounter systemic barriers that limit their access to appropriate antepartum and intrapartum care (Tajvar et al., 2022). Furthermore, the lack of opportunities for women from diverse backgrounds to share their birth experiences can prevent the identification and resolution of care gaps, especially for those who have had unexpected or negative childbirth experiences. In some contexts, the implementation of respectful maternity care is further challenged by unsatisfactory organizational support and limited integration of human rights-based approaches into routine practice (Chinkam et al., 2023) Amenah et al., 2026) .

On the other hand, facilitators for implementing gender-sensitive and culturally respectful maternity care include the adoption of women-centred care models, ongoing training and education for healthcare providers in cultural competence and respectful communication, and the integration of human rights principles into maternity care policies and practices. The involvement of midwives and other frontline providers in the design and delivery of care, as well as the creation of supportive organizational environments, are also crucial. When healthcare systems actively seek to understand and address the unique needs of women from diverse backgrounds, including sexual and gender minorities, and provide opportunities for women to share their experiences, the quality and accessibility of maternity care improve. These facilitators help ensure that care is not only clinically effective but also respectful of women's dignity, autonomy, and cultural identity (Tajvar et

al., 2022)**.** The primary challenges and supporting factors associated with delivering humanized maternal healthcare across clinical environments are outlined below:

Table 2: Key Barriers and Facilitators in Implementing Respectful and Dignified Maternity Care

Barriers	**Facilitators**
Systemic inequalities and power imbalances	Institutionalizing RMC and policy support
Cultural and language barriers	Culturally tailored interventions
Lack of provider training	Provider education and training
Disrespectful, non-ethical care	Emphasis on rights, dignity, and autonomy
Barriers for SGM and diverse groups	Community engagement and feedback

Addressing the core obstacles through targeted enabling strategies is essential for transforming clinical practices and protecting maternal rights. While systemic inequities, cultural disconnects, and educational gaps continue to compromise patient care, institutionalizing respectful maternity practices provides a direct pathway toward meaningful reform. Ultimately, prioritizing rights-based frameworks, continuous provider education, and community feedback ensures that every woman receives dignified, safe, and culturally responsive care during childbirth.

DISCUSSION

Implementing gender-sensitive, ethical, and culturally respectful maternity care is a multifaceted challenge influenced by individual, organizational, and systemic factors. Several barriers hinder the realization of respectful maternity care (RMC). These include inadequate provider training in interpersonal and cultural competence, high workloads, lack of privacy, and insufficient resources, which collectively undermine the ability to deliver care that respects women's dignity and autonomy (Moridi et al., 2020; Çamlibel, 2025). Discriminatory attitudes, lack of awareness about patients' rights, and entrenched hierarchical structures within healthcare settings further exacerbate disrespectful practices and impede the adoption of RMC principles (Fares et al., 2026) . For women from ethnic minorities or with physical disabilities, additional barriers such as language differences, cultural misunderstandings, and physical inaccessibility of facilities are prominent, often resulting in delayed or inadequate care (Fares et al., 2026). Socioeconomic constraints, including affordability and accessibility, also play a significant role in limiting access to quality maternity services, especially in low-resource settings (Tuyisenge, 2021).

On the other hand, several facilitators can promote the implementation of gender-sensitive and culturally respectful maternity care. Key enablers include comprehensive provider education focused on communication, empathy, and cultural competence, as well as ongoing professional support and supervision (Tuyisenge, 2021). Organizational commitment to RMC, including the development of clear guidelines, supportive leadership, and the institutionalization of respectful care practices, is crucial for sustaining improvements. Community engagement and the inclusion of women's voices in care planning help ensure that services are responsive to diverse needs and expectations (Tuyisenge, 2021). Additionally, interventions that address structural barriers such as improving facility accessibility, ensuring affordability, and providing language support can significantly enhance equitable access to respectful maternity care (Yohannes et al., 2026).

In summary, overcoming barriers to gender-sensitive, ethical, and culturally respectful maternity care requires a holistic approach that addresses provider attitudes, organizational culture, and systemic inequities, while leveraging education, policy support, and community involvement as key facilitators

RECOMMENDATIONS

Based on the study's findings, here are four key recommendations to advance respectful, violence-free maternity care:

Institutionalize Respectful Maternity Care (RMC) Policies: Healthcare facilities must integrate RMC and bioethical standards into clinical guidelines, enforcing mandatory informed consent, bodily autonomy, physical privacy, and zero tolerance for obstetric violence.

1. Institutionalize Respectful Maternity Care (RMC) Policies: Healthcare facilities must integrate RMC and bioethical standards into clinical guidelines, enforcing mandatory informed consent, bodily autonomy, physical privacy, and zero tolerance for obstetric violence.
2. Enhance Gender and Cultural Competency Training: Medical and midwifery curricula should incorporate gender-sensitive education and bioethics to challenge clinical paternalism, reduce implicit bias, and equip providers with respectful communication skills.
3. Incorporate Faith-Informed Ethical Frameworks: Health systems in multicultural societies should embrace women's spiritual and religious needs—such as prayer and birth companions—by training providers in cultural humility and aligning care with values like human dignity (*Karamah Insaniyyah*) and benevolence (*Ihsan*).
4. Establish Accountability and Feedback Mechanisms: Organizations must institute transparent reporting systems, patient feedback channels, and rights-monitoring processes to address care gaps, protect vulnerable groups, and support overworked frontline staff.

CONCLUSION

This study demonstrates that eliminating obstetric violence and restoring dignity at birth requires an integrative framework uniting gender sensitivity, bioethics, and religious values. Obstetric violence remains a pervasive human rights violation rooted in institutional paternalism, structural power imbalances, and gender inequality. Grounding perinatal care in bioethical principles specifically autonomy, informed consent, non-maleficence, and justice protect birthing individuals from coerced medicalization and protects bodily integrity. Gender-sensitive approaches actively dismantle patriarchal clinical norms, while incorporating faith-informed ethics, such as human dignity (*Karamah Insaniyyah*) and benevolence (*Ihsan*), fosters intrinsic moral accountability and cultural humility among healthcare providers. Although systemic barriers like resource deficits and inadequate training persist, institutionalizing respectful maternity care policies, continuous ethics education, and robust accountability mechanisms are essential. Ultimately, synthesizing global bioethical standards with local socio-religious values bridges human rights and clinical practice, ensuring a humanized, compassionate, and violence-free childbirth experience for all women.

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Competing Interests

The authors declare that there are no competing interests associated with this study.

Authors' Contributions

Author A conceptualized the study, reviewed, drafted and edited the manuscript.

Author B analyzed qualitative data and contributed to the results section.

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Data Availability

All data generated and analyzed during this study are included in this manuscript. Additional information can be made available upon reasonable request.

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