

Applying the Values of Modesty and *Aurat* in the Childbirth Experience

Siti Khatijah Ismail^{*1}, Malini Mat Napes²

¹Faculty of Islamic Contemporary Studies, University of Sultan Zainal Abidin (UniSZA), Terengganu, Malaysia

²Faculty of Medicine, University of Sultan Zainal Abidin (UniSZA), Terengganu, Malaysia

*Corresponding Author

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ABSTRACT

Childbirth is a deeply embodied experience in which clinical care intersects with women's cultural, spiritual, and personal values. For Muslim women, modesty (*haya'*) and *aurat* are important in shaping perceptions of bodily privacy, dignity, autonomy, and psychological safety during labour and delivery. Despite growing attention to respectful maternity care, these dimensions remain insufficiently operationalised within institutional maternity practices. This study examines how modesty and *aurat* influence women's physical, emotional, and psychological childbirth experiences; identifies environmental, institutional, and interpersonal factors affecting bodily privacy; and develops clinically oriented principles for faith-sensitive maternity care. A qualitative, library-based document analysis was conducted within an interpretive paradigm using peer-reviewed literature on childbirth, bodily privacy, gender preferences, respectful maternity care, and faith-sensitive healthcare. The documentary corpus was analysed thematically using Braun and Clarke's framework. Three interrelated themes emerged: embodied modesty and relational autonomy; institutional and interpersonal negotiation of *aurat*; and operationalisation of modesty within faith-sensitive maternity care. The synthesis indicates that compromised privacy may intensify embarrassment, vulnerability, distress, and loss of control, whereas respectful practices can strengthen dignity, trust, emotional comfort, and participation in decision-making. Protection of *aurat* is therefore not solely an individual provider responsibility but an organisational issue shaped by maternity-unit design, staffing, communication, consent processes, and workflow. The article proposes an Aurat-Sensitive Respectful Maternity Care approach grounded in clinical necessity, minimum necessary exposure, relational consent, and institutional accountability. As a secondary document analysis, the study offers conceptual and practice-oriented synthesis rather than prevalence estimates or causal inference, and its propositions require empirical validation in maternity settings.

Keywords: *Aurat*, Modesty, Respectful Maternity Care, Childbirth, Faith-Sensitive Maternity Care

INTRODUCTION

Childbirth is a profound and transformative event in a woman's life, marked by significant physical, emotional, and psychological changes. The experience is shaped not only by medical factors but also by deeply held cultural, spiritual, and personal values. Among these, the values of modesty and *aurat* (the concept of bodily privacy and covering, particularly in Islamic contexts) play a crucial role in influencing women's perceptions and experiences during childbirth, especially in societies where these values are strongly emphasized (Mostafa et al., 2026; Gagnon & Marcotte, 2023).

Background of the Study

Modesty and the concept of *aurat* play a significant role in shaping women's experiences during childbirth. Pregnancy and childbirth often require multiple medical examinations, which can trigger feelings of modesty

and embarrassment, especially when these procedures involve nudity or exposure of private body parts. Such feelings are deeply rooted in the desire to maintain privacy and avoid situations perceived as strictly private being exposed to others, which, if breached, can lead to shame and discomfort for the individual (Le Breton, 2018).

The hospital environment, where childbirth typically occurs, often challenges these notions of modesty. Women may feel vulnerable due to the lack of privacy and the presence of multiple healthcare providers, which can intensify feelings of exposure and embarrassment. This is particularly relevant in cultures where the concept of *aurat* is strongly emphasized, and maintaining body coverage is a core value (Walburg et al., 2014).

Furthermore, the childbirth experience is not only a physical event but also an emotional and psychological one. The need for physical and emotional privacy during labour and delivery is frequently highlighted by women, who desire a friendly and comfortable environment that respects their modesty and personal boundaries (Kuo, 2005). When these needs are not met, it can negatively impact their overall childbirth experience, potentially affecting their psychological well-being and their perception of the healthcare system (Le Breton, 2018).

In summary, respecting modesty and *aurat* during childbirth is crucial for ensuring a positive and dignified experience for women. Healthcare providers should be aware of these cultural and personal sensitivities to support women effectively and promote their well-being during this transformative life event (Kuo, 2005).

Research Objectives

The study was guided by the following objectives.

1. To explore how modesty and *aurat* shape women's physical, emotional, and psychological experiences during childbirth.
2. To identify the hospital environmental, institutional, and interpersonal factors that impact women's bodily privacy during labour.
3. To propose actionable, culturally sensitive maternity care practice framework that safeguard modesty and enhance psychological safety.

LITERATURE REVIEW

The synthesis prioritises recent scholarship published between 2021 and 2026 where available, while retaining older foundational studies that remain influential in understanding privacy, dignity, and culturally appropriate maternity care. Across this literature, modesty and *aurat* emerge not as marginal religious preferences but as recurring determinants of women's comfort, trust, disclosure, and engagement with care. The evidence clusters around three linked themes: embodied privacy needs, institutional negotiation of gender and service delivery, and the transition from cultural sensitivity to operational models of faith-sensitive maternity care.

Embodied Modesty and Relational Privacy

The strongest theme is that modesty and *aurat* are experienced materially through bodily exposure, examinations, movement between spaces, and who is present during labour. Muslim women commonly want female providers and the least possible exposure before, during, and immediately after birth (Al-Mubarak et al., 2025; Hassan, 2022; Khan, 2021). Qualitative work from Iran extends this beyond physical covering, showing that privacy in childbirth also includes spiritual-mental, informational, and social privacy, with failures in consent, confidentiality, empathy, and communication all contributing to negative birth experiences (Valizadeh et al., 2022).

This broadening of privacy is a major strength in the recent literature because it prevents *aurat* from being reduced to dress alone. Australian Muslim women similarly linked religious insensitivity to diminished safety, dignity, and mental well-being, while respectful, listening-based interactions improved trust and psychological safety (Jemai et al., 2026). Studies from Jordan and Oman add that privacy concerns shape views on companions

as well as clinicians: many women value support during labour, but this preference is often conditional on avoiding embarrassment, exposure, and conflict with understandings of *awrah* (Maabreh et al., 2025; Al-Aufi et al., 2026).

Critically, however, most studies are qualitative and context-bound, so they illuminate meaning better than prevalence. Small samples, such as interviews with four immigrant Muslim women in Canada, offer depth on modesty but limit transferability across Muslim populations that are internally diverse by ethnicity, migration history, and doctrinal practice (Hassan, 2022; Khan, 2021).

Gendered Care Delivery

A second theme concerns the friction between women's modesty-related preferences and the realities of maternity systems. The 2025 qualitative systematic review is especially important here because it synthesizes 24 studies and shows that negative maternity experiences often arise from cultural insensitivity, stereotyping, rigid care models, and communication failures rather than religion alone (Al-Mubarak et al., 2025). It also shows the practical dilemma around provider gender: requests for female staff can interfere with care delivery, and when female providers are unavailable, delays can occur (Al-Mubarak et al., 2025).

The literature does not treat this as a simple opposition between religion and safety. Several sources argue that when beliefs are respectfully acknowledged, women are more willing to accept necessary care from male professionals (Al-Mubarak et al., 2025; Halim & Ismail, 2024; Suryani et al., 2023). This is analytically important because it suggests that refusal of male care is often contingent, not absolute. Yet the evidence also shows persistent institutional unpreparedness. Women report lack of confidence in expressing religious needs, while professionals sometimes avoid asking about sensitive practices such as fasting for fear of causing offence (Hassan, 2022; Al-Mubarak et al., 2025).

A limitation of this theme is that many studies diagnose barriers but provide limited evaluation of outcomes after service changes. The evidence is stronger on what women want than on which staffing, triage, or communication interventions most reliably reconcile modesty with urgent obstetric care.

Operationalizing Faith-Based Care

The third theme is a shift from describing needs to proposing Islamically informed care frameworks. Hassan's UK recommendations are among the most practice-ready, advising extra sheets, flexible gowning, retention of headscarves until necessary removal, and awareness that male students or interpreters may also compromise modesty (Hassan, 2022). Indonesian and Malaysian papers move further by calling for sharia-compliant maternity systems, clearer procedural limits for exposing *aurat* across pre-, intra-, and post-partum phases, privacy-protective facilities, and formal guidance for staff (Ismail & Mutalib, 2022; Suryani et al., 2023).

These frameworks are conceptually rich because they integrate dignity, spirituality, and woman-centred care rather than treating Islamic values as oppositional to evidence-based practice (Kalla et al., 2025). Some studies also report benefits from spiritual support, prayer, *dhikr*, or Qur'anic recitation for trust, calmness, and preparedness (Suryaningsih et al., 2026; Siregar et al., 2025). Yet this literature is also the least mature. Several papers are exploratory, normative, or based on student and provider perspectives, and they frequently acknowledge weak implementation, absent guidelines, and limited formal training (Suryani et al., 2023).

Overall, the past five years of literature supports the research title by showing that modesty and *aurat* are central to childbirth experience, but the field remains stronger in documenting unmet needs than in testing scalable solutions. The clearest implication is that respectful maternity care for Muslim women requires not only cultural awareness, but concrete protocols, environmental privacy, communication training, and ethically flexible responses to gender preferences.

Conceptual Framework

This conceptual framework positions childbirth at the intersection of religious observance and clinical care. It proposes that modesty (*haya'*) and protection of *aurat* shape how women interpret bodily exposure, provider

interactions, consent, and dignity during labour and delivery. These values operate through mediating clinical conditions—including provider gender where feasible, privacy-conscious draping, control over unnecessary room entry, clear explanation of procedures, and respectful communication—which may influence perceived safety, trust, autonomy, and birth satisfaction. The framework does not assume that religious preferences override clinical necessity; rather, it treats safety and modesty as values to be reconciled through proportionality, minimum necessary exposure, and shared decision-making.

METHODOLOGY

The methodology of this study was designed to systematically examine how the values of modesty (*haya* ') and *aurat* shape women's childbirth experiences and can be translated into culturally sensitive maternity care. Accordingly, the methodological approach comprises three key components: research design, study area, and data collection methods, followed by thematic analysis of the retrieved literature.

Research Design

This study employed a qualitative research design using library-based document analysis, situated within an interpretive approach. This design was appropriate because the study sought to understand how the Islamic values of modesty (*haya* ') and *aurat* are represented and operationalised within women's childbirth experiences rather than to measure their prevalence statistically. The analysis focused on interpreting existing scholarly evidence concerning women's physical, emotional, and psychological experiences, factors affecting bodily privacy during labour, and approaches to culturally and faith-sensitive maternity care. These areas correspond directly with the three research objectives of the study. The qualitative approach enabled evidence from different sociocultural and healthcare contexts to be synthesised conceptually, particularly in relation to privacy, dignity, autonomy, psychological safety, and respectful maternity care.

Study Area

As a library-based study, the research did not involve a geographically bounded field site, hospital, or direct recruitment of participants. Instead, the study area was conceptualised as the body of scholarly literature concerning childbirth, maternity care, bodily privacy, modesty, *aurat*, and culturally or religiously sensitive healthcare, with particular attention to Muslim women and healthcare settings in which Islamic values influence maternity experiences. The analytical scope covered childbirth within institutional healthcare environments, including labour and delivery rooms, where women's privacy may be affected by environmental design, institutional policies, staffing practices, and interactions with healthcare professionals. This approach permitted consideration of evidence from different geographical settings while maintaining a specific conceptual focus on the application of modesty and *aurat* in maternity care.

Data Collection Methods

Data were collected through structured documentary retrieval and review of secondary sources relevant to the research objectives. This study was designed as an interpretive document analysis rather than a systematic review or meta-analysis; therefore, the purpose was conceptual and thematic synthesis, not exhaustive coverage or quantitative estimation. The documentary corpus comprised primarily peer-reviewed academic literature addressing modesty and bodily privacy during pregnancy and childbirth, women's emotional and psychological responses to bodily exposure, gender preferences for healthcare providers, maternity-unit environments, institutional policies, healthcare professional–patient relationships, respectful maternity care, and culturally or faith-sensitive maternity practices. Particular attention was given to environmental factors such as private spaces and delivery-room arrangements; institutional factors including policies, protocols, staffing and professional training; and interpersonal factors such as communication, informed consent, emotional support, and provider–patient relationships.

The retrieved documents were subsequently screened for their relevance to the study objectives and their contribution to understanding the relationship between Islamic modesty values and childbirth care. Evidence concerning practical strategies including minimising bodily exposure, providing private examination spaces,

accommodating provider-gender preferences where feasible, respecting religious dress and practices, strengthening communication, and involving women in decision-making was specifically extracted to inform the development of culturally sensitive maternity-care recommendations. The resulting documentary dataset provided the basis for the thematic analysis and the development of the study's three principal themes.

Ethical Considerations

Although this study did not involve direct human participants, clinical interventions, experimental procedures, or the collection of identifiable or sensitive personal data, ethical principles were carefully observed throughout the research process. As a library-based document analysis, ethical considerations primarily focused on academic integrity, accuracy of interpretation, transparency, and the responsible use of published sources. All academic literature, policy documents, and relevant religious sources were appropriately acknowledged to prevent plagiarism, misrepresentation, selective reporting, or distortion of evidence. Particular attention was given to the sensitive nature of childbirth, women's bodily privacy, modesty (*haya*'), and *aurat*. Accordingly, the literature was analysed objectively and respectfully, without generalising women's religious preferences or portraying Islamic values as barriers to appropriate clinical care. Cultural and religious perspectives were contextualised within principles of dignity, autonomy, privacy, and clinical necessity. Since the study relied exclusively on publicly available secondary sources and involved no human participants or identifiable data, formal institutional ethical approval was not required.

Data Analysis

The collected documentary data were analysed using thematic analysis following Braun and Clarke's (2019) six-phase framework to systematically identify, analyse, and organise recurring patterns in accordance with the research objectives. The analytical process involved familiarisation with the selected literature through repeated reading, generation of initial codes related to modesty (*haya*'), *aurat*, bodily privacy, emotional and psychological experiences, environmental conditions, institutional practices, interpersonal relationships, and culturally sensitive maternity care. Related codes were subsequently grouped into preliminary themes, which were reviewed, refined, and defined to ensure internal coherence and clear distinctions between themes. This process generated three overarching themes: *The Role of Modesty and Aurat in Shaping Women's Comfort and Autonomy During Childbirth*, *Institutional and Interpersonal Negotiation of Aurat*, and *Operationalising Modesty and Aurat into Faith-Sensitive Maternity Care*. The themes were then synthesised into an interpretive narrative to explain how modesty and *aurat* influence childbirth experiences and how these values can be translated into culturally responsive, dignity-centred, and psychologically safe maternity care. The analytical approach was also informed by Braun and Clarke's later clarification of reflexive thematic analysis (Braun & Clarke, 2019).

Methodological Boundaries

The analysis is bounded by the characteristics of the published literature available to the authors and by the interpretive nature of documentary synthesis. Because no primary interviews, observations, surveys, or clinical audit data were collected, the study cannot estimate the prevalence of modesty-related concerns, determine causal effects on clinical outcomes, or represent the full diversity of Muslim women's preferences across jurisdictions, ethnicities, schools of Islamic jurisprudence, and models of maternity care. In addition, the documentary approach does not permit direct evaluation of whether proposed privacy or gender-sensitive interventions are feasible under different staffing and emergency conditions. These boundaries are treated as limits on inference rather than as evidence against the clinical relevance of the themes.

RESULTS

Embodied Modesty, Relational Autonomy, and Psychological Safety

Across the documentary corpus, modesty and *aurat* were not experienced simply as requirements of dress or body covering. They appeared as embodied and relational concerns involving who could see or touch the body, how much of the body was exposed, whether exposure was anticipated and explained, and whether women

retained meaningful participation in decisions. The literature consistently links intimate examinations, repeated exposure, unannounced entry of personnel, and inadequate explanation with embarrassment, vulnerability, and loss of control. In contrast, privacy-conscious draping, advance explanation, permission before examination, and limiting the number of observers were associated with greater comfort, dignity, and trust (Walburg et al., 2014; Valizadeh et al., 2022; Hassan, 2022; Jemai et al., 2026).

The synthesis also indicates that the effects are differentiated across physical, emotional, and psychological domains. The physical pathway is mainly indirect: the literature does not establish that compromised *aurat* independently changes obstetric outcomes, but it suggests that stress, embarrassment, and discomfort may intensify pain perception or reduce willingness to participate in examinations and care. Emotional effects are more consistently described, particularly shame, distress, and vulnerability. Psychologically, repeated or poorly negotiated exposure can contribute to negative birth perceptions and a reduced sense of agency, whereas dignified treatment can strengthen satisfaction and empowerment (Kuo, 2005; Liddell & Johnson, 2018; Isik Ayan & Ejder Apay, 2026). Accordingly, *aurat*-sensitive care is best understood as a component of relational safety rather than as a purely visual or clothing-related concern. These interpretations are also consistent with studies linking compromised privacy and negative childbirth experiences with emotional distress and adverse postpartum psychological outcomes (Zinsser & Stone, 2026; Ismail et al., 2026; Van der Waal & Mayra, 2023).

Table 1: Analytical synthesis of the influence of modesty and *aurat* during childbirth

Dimension	Privacy-related mechanism	Potential experience	Clinical implication
Physical	Stress/discomfort associated with exposure or intimate procedures	Heightened pain perception or reluctance toward examinations; direct physiological effects remain insufficiently established	Minimise unnecessary exposure and explain the clinical need for each examination
Emotional	Embarrassment, shame, vulnerability, lack of privacy	Distress, discomfort, reduced trust	Use draping, private spaces and permission-based interaction
Psychological	Loss of control and reduced agency	Negative birth perception, reduced satisfaction, possible trauma-related distress	Support shared decision-making, relational consent and continuity of respectful communication

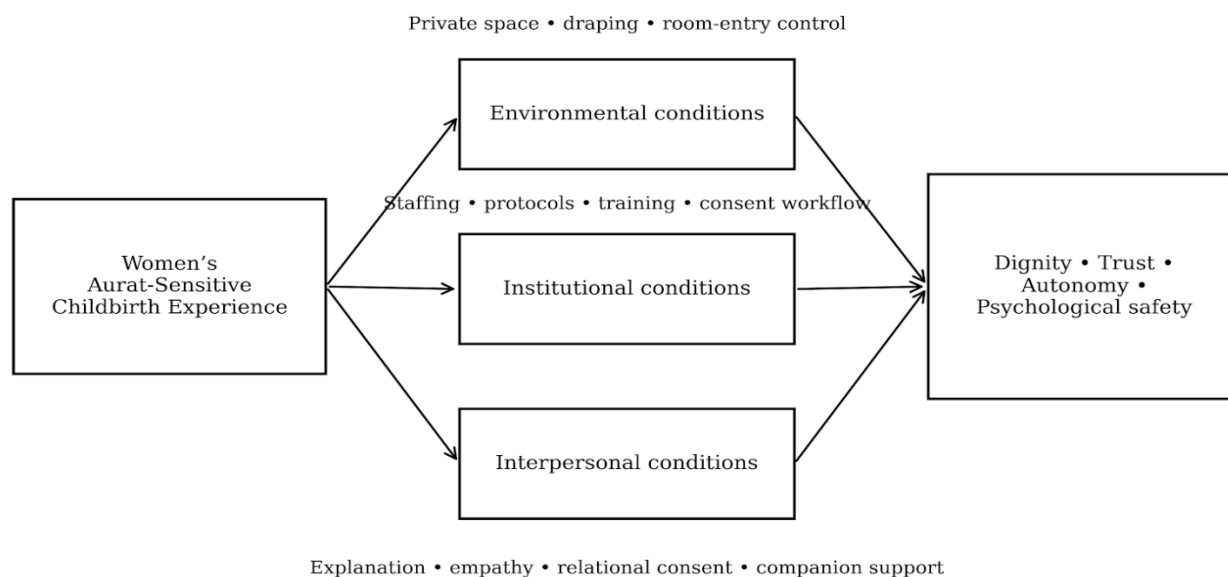
***Aurat* as an Organisational and Workflow Issue**

A second finding is that bodily privacy is produced or compromised by the organisation of maternity care. Environmental, institutional, and interpersonal factors interact rather than operate independently. Environmental design determines whether visual privacy can be maintained through private rooms, curtains, door placement, and control of traffic. Institutional arrangements determine who enters the room, how teaching encounters are managed, whether gender preferences can be accommodated, and whether staff are trained to identify religious needs without stereotyping. Interpersonal practice determines whether exposure is preceded by explanation, consent, reassurance, and respectful negotiation (Turan et al., 2022; Chen et al., 2023; Al-Mubarak et al., 2025; Rala et al., 2026). The importance of environmental design and institutional arrangements is further supported by evidence on childbirth environments, organisational access factors, and staff-related contributors to disrespect and privacy compromise (Kazemi et al., 2023; Xu et al., 2025; Alzyoud et al., 2026; Gurung & Van Wees, 2025).

The literature therefore reframes a common clinical misconception: a privacy breach is not always the result of an insensitive individual clinician. It may be embedded in workflow. For example, a woman may be appropriately draped by one provider but repeatedly exposed when several staff members enter sequentially, when a teaching examination is not separately consented to, or when movement between triage, labour, theatre, and recovery requires repeated gown changes. Similarly, provider-gender preference is often contingent rather than absolute. Evidence suggests that women may accept necessary care from male professionals when urgency

is clearly explained, alternatives are genuinely considered, and exposure is limited to what is clinically required (Al-Mubarak et al., 2025; Halim & Ismail, 2024). This shifts the analytical focus from ‘female provider versus male provider’ to the broader quality of institutional preparation, communication, and proportionality. This relational interpretation is consistent with scholarship that frames birth integrity and respectful interpersonal care as central to women’s experience of dignity and autonomy (Batram-Zantvoort et al., 2022). Figure 1 illustrates how *aurat*-sensitive childbirth care is shaped by the interaction of environmental, institutional, and interpersonal conditions, which collectively influence women’s dignity, trust, autonomy, and psychological safety during childbirth.

Figure 1: Organisational pathways influencing *aurat*-sensitive childbirth care



Operationalising Modesty and *Aurat* in Clinical Workflow

The third theme concerns translation from values to practice. The evidence supports a sequence of small, workflow-level actions rather than a single ‘Islamic maternity’ intervention. Before an intimate examination, the provider can identify privacy and gender preferences, explain why the examination is required, clarify who needs to be present, and obtain consent. During the procedure, exposure can be limited to the anatomical area and duration required, with curtains or doors secured and non-essential personnel excluded. If a gender-concordant provider is unavailable, the clinical situation can be explained transparently and alternatives considered without delaying urgent care. After the procedure, the woman can be re-covered promptly and asked whether further privacy needs or concerns remain. These actions operationalise modesty through clinical necessity, minimum necessary exposure, relational consent, and restoration of bodily control.

The literature also indicates that implementation must be flexible across phases of care. Antenatal care provides the best opportunity to elicit preferences and document them before labour. Triage and active labour require rapid but explicit communication because repeated examinations and staff changes increase privacy risk. Operative birth requires a stronger emphasis on proportionality because safety may necessitate wider exposure and larger teams. Postpartum care requires renewed attention to covering, breastfeeding privacy, wound or perineal assessment, and the presence of visitors or students. These phase-specific differences show why generic statements such as ‘respect privacy’ are insufficient without corresponding workflow expectations.

Table 2: Proposed *Aurat*-Sensitive Respectful Maternity Care workflow

Clinical phase	Common privacy risk	Minimum practice	Escalation/exception	Intended outcome
Antenatal /	Preferences	Ask and document privacy,	Explain that availability and	Anticipatory

admission	unknown until labour	clothing and provider-gender preferences	emergency needs may limit accommodation	planning and trust
Examination / labour	Repeated exposure; multiple room entries	Explain, seek permission, secure door/curtain, expose only required area, limit observers	If urgent, state clinical necessity and proceed proportionately while preserving as much coverage as possible	Dignity, agency and reduced embarrassment
Operative / emergency care	Larger team and broader exposure	Clarify roles; remove non-essential persons; maintain draping where compatible with safety	Clinical safety takes priority, but exposure should remain no greater or longer than necessary	Reconciliation of safety with religious values
Postpartum	Ongoing examinations, breastfeeding and visitors	Prompt re-covering; protect breastfeeding/perineal-assessment privacy; re-check preferences	Adapt to clinical monitoring needs and ward constraints	Continuity of dignity after birth

DISCUSSION

This review extends the literature by conceptualising modesty and aurat as a form of relational and organisational privacy rather than a narrow requirement for body covering. That distinction matters because the same amount of physical exposure can be experienced differently depending on whether it is necessary, explained, consented to, time-limited, and managed respectfully. In this sense, aurat-sensitive care converges with core principles of respectful maternity care dignity, autonomy, privacy, communication, and freedom from unnecessary or non-consensual procedures while adding a faith-specific vocabulary through which some Muslim women understand those rights. The contribution of the present synthesis is therefore not to create a parallel religious standard of obstetric care, but to show how Islamic modesty values can sharpen the operational meaning of respectful care in intimate clinical contexts. It also accords with wider work on culturally appropriate and culturally safe maternity care, which emphasises respectful adaptation of services to women's social and cultural contexts (Jones et al., 2017; Egger et al., 2024; Kosiak, 2017).

A key implication is that the unit of intervention should move from the individual clinician to the care system. Training staff to be culturally sensitive is unlikely to be sufficient if ward design, staffing patterns, teaching practices, or documentation processes routinely generate avoidable exposure. Hospitals could incorporate privacy checkpoints into standard maternity workflows: documenting preferences at admission, requiring separate consent for observers or students, defining minimum-personnel expectations during intimate procedures, and embedding privacy prompts into handover or birth-plan documentation. These measures are concrete enough to be audited, yet flexible enough to accommodate emergency conditions. They also reduce the risk of essentialising Muslim women because preferences are elicited individually rather than presumed from religious identity.

The question of provider gender illustrates the need for proportionality. Female-provider preference is recurrent in the literature, but it should not be translated into an inflexible rule that risks delaying urgent obstetric care. A more defensible approach is a stepped response: attempt gender concordance when feasible; explain limitations early; distinguish routine from urgent care; restrict exposure and personnel; and obtain ongoing consent as circumstances change. This approach recognises clinical necessity while still taking religious preference seriously. It also reframes consent as relational and iterative, particularly during labour when pain, urgency, staffing changes, and repeated examinations can alter what a woman is willing or able to accept.

The evidence base nevertheless remains methodologically uneven. Much of the literature is qualitative, context-specific, and stronger in describing needs than in evaluating interventions. This limits claims about prevalence, generalisability, cost, feasibility, or clinical effectiveness. The present study shares that limitation because it

relies exclusively on secondary documents and did not apply a systematic-review protocol capable of establishing comprehensive retrieval or risk-of-bias estimates. Future research should therefore move from descriptive accounts to empirical testing: qualitative interviews with women, midwives and obstetric staff; observational or clinical-audit studies of privacy breaches and room-entry patterns; surveys of preference heterogeneity; and implementation studies comparing outcomes before and after aurat-sensitive protocols. Multi-site research would be especially important for examining how proposed practices function across public, private, teaching, rural, and high-acuity maternity settings.

On this basis, the proposed Aurat-Sensitive Respectful Maternity Care approach should be understood as a testable practice framework rather than a validated clinical guideline. Its core principles are: clinical necessity, minimum necessary exposure, individual preference elicitation, relational consent, gender accommodation where feasible, and institutional accountability. Future validation could assess patient-reported dignity and psychological safety, acceptability to staff, protocol adherence, delays in care, and unintended consequences. Such evaluation is necessary before the framework is recommended as a standardised institutional protocol.

CONCLUSION

Modesty (*haya'*) and *aurat* are significant dimensions of childbirth experience because they shape how bodily exposure, consent, provider interaction, and dignity are interpreted during labour and delivery. The documentary synthesis indicates that privacy protection is not solely a matter of individual sensitivity; it depends on environmental design, institutional workflow, staffing, communication, and the proportional management of clinical necessity. Translating these values into practice therefore requires more than generic cultural awareness. It requires concrete processes that minimise unnecessary exposure, elicit individual preferences, support gender concordance where feasible, maintain relational consent, and restore bodily coverage promptly after procedures.

The proposed Aurat-Sensitive Respectful Maternity Care framework offers a conceptual bridge between Islamic modesty values and the broader goals of respectful, woman-centred maternity care. However, because the present study is based on secondary document analysis, the framework should be empirically tested rather than treated as a validated protocol. Future multi-site studies involving women and healthcare professionals are needed to determine feasibility, acceptability, clinical safety, and measurable effects on dignity, trust, psychological safety, and birth experience.

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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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