The Open Nursing Journal

Content list available at: https://opennursingjournal.com

RESEARCH ARTICLE

The Present Status of Respectful Maternity Care during Labor and Childbirth in Jordan: A Cross-sectional Study

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Abstract:

Background:

Exploring the status of respectful maternity care (RMC) during labor and childbirth helps in determining the quality of maternity care. Therefore, this study aimed to investigate the perception of pregnant women about RMC that they received during labor and childbirth and to evaluate the determinants of RMC perception.

Methods:

A cross-sectional descriptive design was used in this study. A convenience sample of 310 participants from two major hospitals in northern Jordan completed the RMC questionnaire. Thereafter, multiple regression was performed to identify the determinants of RMC perception.

Results:

The mean score of all the items of the questionnaire was 2.83 out of 4 (SD = 0.33), which indicated that the women experienced a moderate level of RMC. The lowest mean scores were obtained for the quality of healthcare (mean= 2.63, SD= .38), 48.7% and 56.8% of the participants indicated that they were not allowed to move or eat and drink during the first stage of labor, respectively. In addition to the right to information and informed consent (mean= 2.67 ± 0.54), 56.8% of the participants revealed that staff did not introduce themselves. Women with high family income or assistance from a midwife reported significantly higher RMC scores compared to those with low family income or those tended by doctors ($p \leq 0.05$).

Conclusion:

Immediate action is needed to improve and support RMC as a critical component of maternal care by adopting standardized measures, and training healthcare providers to practice the code of ethics as a core component of RMC.

Keywords: Respectful maternity care, Pregnant woman, Labor, Childbirth, Maternal care, Midwife.

Article History	Received: August 7, 2022	Revised: November 13, 2022	Accepted: November 24, 2022

1. INTRODUCTION

Childbirth is a critical event in the life of a woman. However, pregnant women are still exposed to various forms of disrespect and abuse worldwide [1]. The prevalence of disrespectful maternity care in India, Pakistan, Ethiopia, and Tanzania was 77.32%, 99%, 49.4%, and 70%, respectively [2 - 5]. Browse vand Hills (2010) classified disrespectful and abusive behaviors into physical abuse; non-consented, non-confidential care; discrimination; nonchalant, undignified care; and confinement to a health facility [1]. Pregnant women who experience any of these disrespectful and abusive behaviors either do not use or delay attending healthcare facilities till the later phases of labor or until the occurrence of complications, which escalate the incidence of morbidity and mortality [1, 3]. Furthermore, disrespectful maternal care results in postnatal depression, altered birth outcomes and traumatic birth experiences [6, 7] that lead to delayed lactation and a poor relationship between the mother and newborn [8, 9].

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Thus, the World Health Organization (WHO, 2018) recommended respectful maternity care (RMC), which refers to providing supportive care without discrimination to all pregnant women. While ensuring humanized treatment, RMC preserves the dignity, confidentiality, privacy, and autonomy of pregnant women as an essential determinant of a positive birth experience and ensures high-quality care [10]. Additionally, White Ribbon Alliance (WRA) advocated RMC as a universal human right and proposed the first RMC charter, which addressed seven maternal-health rights as a standard of care within the context of human rights extracted from the classification of disrespect and abuse by Browse and Hills [1]. The components of this charter focused on the rights of women to freedom from physical abuse and mistreatment, freedom to dignity and respectful care, information and informed consent, confidentiality and privacy, quality healthcare, and liberty and security [11].

RMC, with effective communication and improved interpersonal relationships between pregnant women and healthcare providers, has been associated with the progression of labor. Labor is also facilitated by ensuring the privacy and confidentiality of a patient, in addition to providing timely and dignified care that is free from physical or verbal abuse. In contrast, RMC is negatively affected by poor communication, such as talking loudly and using threatening language, ignoring the right of women to be involved in decision-making, performing procedures without permission, and discriminating against them based on personal, cultural, or financial characteristics [12]. However, Smith *et al*. (2020) emphasized that few healthcare provide*et al*.rs practice rationalized abusive and violent behaviors without providing RMC. Moreover, these healthcare providers assume that RMC is more harmful than beneficial and that disrespectful behaviors help them achieve their clinical objectives under certain circumstances [13]. In contrast, Bohren (2015) delineated that few healthcare workers associated mistreatment with stressful work conditions such as work overload, extended working hours, staff shortage, and lack of infrastructure and resources [14].

Several studies have been conducted to assess the status of RMC in different countries as a basic intervention to prevent disrespect and abuse that invade maternal rights and ensure safe motherhood. For example, a study in Ethiopia surveyed 173 postpartum women for disrespectful and abusive behavior and reported that most women were discouraged to ask questions, underwent procedures without permission, and were unaware of the identity of the healthcare provider [15]. Another study in Ethiopia surveyed 500 postpartum women to assess respectful maternity care during childbirth and revealed that less than a quarter of women received emotional support, received pain killer, or chose their companion [16].

Reports suggest that the subjective experiences of disrespect and abuse of pregnant women are fewer than their objective experiences, indicating the normalization of these behaviors in several societies [3, 17]. For example, a survey funded by USAID conducted in several countries revealed that lack of privacy, implementing harmful practices, not informing the patient about procedures, not obtaining informed consent, and verbal abuse were the most common forms of disrespect and abuse [1]. In concordance, a recent study in Westbank revealed that women were exposed to similar types of mistreatment during childbirth [18].

In Jordan, despite the decline in maternal mortality ratio from 54 deaths per 100,000 live births in 2009 to 38.5 deaths per 100,000 live births in 2020 [19], the satisfaction of pregnant women regarding intrapartum care was significantly low [20]. Women during labor experience sensitive procedures such as a vaginal exam. Disrespecting maternal health rights will negatively affect women's birth experiences. For instance, 38 Jordanian women participated in a qualitative study aimed to explore their experiences of the first pelvic examination. They described it as a negative shocking experience because they were neither provided with the needed explanation prior to this procedure nor involved in making decisions about the provided care [21].

Women who delivered in public hospitals in Jordan reported neglect, lack of privacy, and non-supportive care. For example, one qualitative study interviewed 27 women in Jordanian public hospitals. They reported that more than 4 patients shared the same room; the curtains were not always closed between patients, and the sheets provided did not cover all parts of their bodies. Moreover, the vaginal exam was done many times by different people which was embarrassing [22]. Another qualitative study interviewed 21 women who delivered vaginally. They expressed their negative birth experiences such as feelings of disrespect and humiliation; not achieving their requests for privacy, not listening or providing choices of care, and not supporting them emotionally [23].

Nonetheless, RMC enhanced satisfaction and improved the birth experience of pregnant women [24]. As there have been limited studies in this field, further investigations are necessary to collate quantitative data and determine the present situation of RMC in Jordanian hospitals considering fundamental national and international maternal health rights. Therefore, this study aimed to assess the status of RMC as perceived by women during labor and childbirth in Jordanian public hospitals. The objectives of this study include the following: 1) examining the perception of pregnant Jordanian women about RMC during labor and childbirth, and 2) identifying the determinants of RMC perception.

2. METHODS

2.1. Design and Setting

This study adopted a descriptive cross-sectional design. In northern Jordan, 99% of childbirths occur at hospitals, of which 70% occur at public hospitals [25]. Thus, we recruited participants from two major public maternity hospitals that provided antenatal, gynecological, obstetrics, and postnatal healthcare services and served urban and suburban populations in Irbid and Al Mafraq cities.

2.2. Population and Sampling

The target population included women who underwent vaginal deliveries in public hospitals in Jordan. The accessible population included women who underwent vaginal deliveries in the two hospitals in northern Jordan from February 15 to April 30, 2022. We used purposeful sampling to recruit women

who underwent vaginal deliveries at least 6 hours before in the postpartum department, exhibited full-term pregnancy, and had a live baby. Additionally, all participants were ≥ 18 years of age, fluent in Arabic, and consented to participate in the study. The minimum sample size determined using the software G power (2014) and a power value of 0.05 ($\alpha = 0.05$ and $1\text{-}\beta = 0.80$) with a medium effect size was 295 participants. However, 325 women were approached for the study to compensate for missing data, of which 310 women agreed to participate with a 95.4% response rate.

2.3. Measurements

We developed a structured RMC questionnaire based on the RMC rights of the WRA (10) and a comprehensive literature review of various tools used to assess RMC, person-centered maternity care, disrespect, and abuse [15, 17, 26, 27]. The first section of the questionnaire included demographic data (age, educational background, occupation, residential address, insurance status, and monthly income of the family), antenatal and obstetric history (parity, number of antenatal visits, diseases developed during pregnancy, complications during labor and delivery, time of delivery, episiotomy, and primary healthcare provider), and questions related to the overall hygiene of the labor environment. The second section comprised 22 questions to assess the seven rights of RMC, except for the presence of the companion or partner of the pregnant woman because of the restrictions imposed by the standard procedures in Jordanian public hospitals. The six measured rights of women included: freedom from exploitation, physical abuse, and mistreatment (items 8, 9, and 11), freedom to dignity and respectful care (items 2, 3, 19, and 21), information and informed consent (items 1, 4, 5, 6, and 7), confidentiality and privacy (items 13 and 14), quality healthcare (items 10, 12, 15, 16, and 17), and liberty and security (items 18, 20, and 22) [11]. A four-point Likert scale graduated from "strongly disagree" to "strongly agree" was utilized, with 15 positive and 7 negative questions (items 8, 9, 11, 18, 19, 20, and 22) which were reversed. To determine the perception of RMC during pregnancy, the following interpretation of the Likert scale was used: a mean score of 1–1.99 was considered low-level perception, 2–2.99) was considered moderate-level perception, and 3–4 was considered high-level perception [28].

The questionnaire was translated from English to Arabic and then back-translated to English by two professional Jordanian translators, who were fluent in both languages, to ensure content validity. A panel of experts reviewed the validity of the questionnaire to ensure the eligibility, inclusivity, comprehension, and simplicity of the items.

A pilot study with 30 pregnant women was conducted to validate the content and ensure the clarity and readability of the questionnaire. The questions were simple and required minor modifications. The reliability of internal consistency was verified using Cronbach's alpha, whose value was 0.87 for the overall questionnaire.

2.4. Ethical Considerations

Ethical approval was obtained from the Institution Review Board (IRB) at Al Balqa Applied University (reference number: 26/3/2/211) and the Ministry of Health. The cover letter of the questionnaire addressed the code of ethics, and a research assistant explained the purpose of the study to eligible participants and prompted their decision to participate in the study.

Additionally, the participants were notified that they could withdraw at any time and their answers were considered implicit consent for participation in the study. We also ensured the anonymity and confidentiality of the participants.

2.5. Data Collection

After obtaining ethical approval, data were collected from February 15 to April 30, 2022. The questionnaire was filled in by a research assistant who was an experienced staff nurse with a postgraduate degree in maternal–child health nursing and a lecturer at the university trained to ensure research ethics. The interviews were conducted in a private room in the postnatal department out of the reach of healthcare providers to ensure the privacy of participants before discharge from the hospital. The interview lasted for approximately 10 min.

2.6. Data Analysis

The Statistical Package for Social Sciences (SPSS) version 22 was used for data analysis, and descriptive statistics (frequency, percentage, mean, and standard deviation) were used to analyze the characteristics and RMC perception of the participants. The responses to RMC questionnaire items were quantified from 1 (strongly disagree) to 4 (strongly agree) for positive statements and 4 (strongly disagree) to 1 (strongly agree) for negative statements.

Multiple logistic regression analysis was used to investigate the determinants of RMC perception of pregnant women, with a *p*-value of 0.05 and a confidence interval of 95%.

3. RESULTS

A total of 310 postpartum women participated in the study. Approximately 50% of the participants were 26–36-year-old, 54.5% attended primary or secondary educational institutes, 81.9% were housewives, and 79.7% had medical insurance. Moreover, 45.8% of the participants reported a monthly income < 300 JD, whereas the remaining participants (54.2%) reported a monthly income ≥ 300 JD. Most of the participants were multigravida (90%), reported regular antenatal visits (74.5%), did not report any disease during pregnancy (76.8%), and underwent labor and childbirth without complications (83.9%). However, about 52% underwent episiotomy, and 55.5% delivered during the BC shift (3:00 pm–6:59 am). Furthermore, the primary healthcare provider of 47.7% of the participants was a doctor, while 52.3% were tended by midwives (Table **1**).

Table 1. Distribution of the sample by demographic and obstetric variables (N=310).

Variables	N (%)	Variables	N (%)
Age 18-25 26-36 More than 36	82 (26.4%) 158 (51.0%) 70 (22.6%)	**Antenatal Visit** Regular Irregular No visit	230 (74.2%) 68(21.9%) 12 (3.9%)
Education Level Illiterate Primary or secondary education Diploma Bachelor and high studies	29 (9.3%) 169(54.5%) 47 (15.2%) 65 (21.0%)	**Disease During Pregnancy** Yes No	72(23.2%) 238 (76.8%)
Occupation Employed Housewife	56 (18.1%) 254 (81.9%)	**Complication During Labor** Yes No	50 (16.1%) 260 (83.9%)
Income Less than 300 JD 300 – 500 JD More than 500 JD	142 (45.8%) 128 (41.3%) 40 (12.9%)	**Episiotomy** Yes No	162 (52.3%) 148(47.7%)
Insurance Yes No	247 (79.7%) 63 (20.3%)	**Time of Birth** A shift (7am-2:59 pm). BC shift (3 pm- 6:59 am).	138 (44.5%) 172 (55.5%)
Parity 1st birth Second birth or more	31 (10%) 279 (90%)	**Health Care Provider** Doctor Midwife	148(47.7%) 162 (52.3%)

Table 2. Responses to respectful maternity care items (N = 310).

Respectful Maternity Care Questionnaire Items	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)	Means (SDs)
1-Staff introduced themselves to me.	44(14.2%)	132(42.6%)	113(36.5%)	21(6.8%)	2.36 (.80)
2- Staff called me with my name.	24(7.7%)	52(16.8%)	205(66%)	29 (9.4%)	2.77 (.72)
3- The staff spoke to me in a polite manner.	9 (2.9%)	57(18.4%)	191(61.6%)	53(17.1%)	2.93 (.68)
4- The staff explained to me any proposed medical procedure in a language that I can understand.	28(9%)	41(13.2%)	209(67.4%)	32(10.3%)	2.79 (.75)
5- Staff asked for my consent to conduct any procedure or examination.	24(7.7%) 16(5.2%)	33(10.6%) 94(30.3%)	225(72.6%) 167(53.9%)	28(9.0%) 33(10.6%)	2.83(.69) 2.70 (.73)
6- The staff explained to me the progress of my case during labor.	25(8.1%)	79(25.5%)	183(59%)	23(7.4%)	2.66 (.73)
7- I was not exposed to coercion for any procedure I do not want.	59(19%)	175(56.5%)	56(18.1%)	20(6.5%)	2.88 (.79)
8- Staff shouted and screamed at me to stop crying or complaining of pain.	156(50.3%)	1e.g17(37.7%)	23(7.4%)	14(4.5%)	3.34 (.80)
9- I was exposed to beats and slaps during delivery.	37(11.9%)	86(27.7%)	157(50.6%)	30(9.7%)	2.58 (.82)
10- Staff used anesthesia to do painful procedures as suturing and episiotomy	32 (10.3)	149 (48.1)	99 (31.9)	30(9.7)	2.59 (.80)
11- Staff pressed on my abdomen to fasten the baby's delivery.	16(5.2%)	40(12.9%)	215(69.4%)	39(12.6%)	2.89 (.67)
12- The time that I waited to receive the services was appropriate.	7(2.3%)	18(5.8%)	250(80.6%)	35(11.3%)	3.01 (.51)
13- Staff maintained confidentiality that no one can hear my secret information during history taking and examination.	8 (2.6%)	31(10.0%)	224 (72.3%)	47(15.2%)	3.00 (.59)
14- Staff maintained my privacy by closing the door, curtain, and blanket during any examination or delivery	18(5.8%)	54(17.4%)	205(66.1%)	33(10.6%)	2.82 (.69)
15- Staff used pharmacological and not pharmacological methods to decrease my pain.	14(4.5%)	137(44.2%)	142(45.8%)	17(5.5%)	2.52 (.67)
16- Staff allowed me to move if my health status permits that.	35(11.3%)	141(45.5%)	122(39.4%)	12(3.9%)	2.36 (.73)
17- Staff allowed me to eat and drink if my health status permits that.	91(29.4%)	175(56.5%)	35(11.3%)	9(2.9%)	3.12 (.71)
18- Staff disrespected me because of my specific traits such as age, weight, financial status, and disease. etc.	84(27%)	173(55.8%)	47(15.2%)	6(1.9%)	3.08 (.70)
19- Staff threatened me to stop crying and complaining because of labor and birth pain.	63(20.3%) 13(4.2%)	179(57.7%) 44(14.2%)	56(18.1%) 217(70%)	12(3.9%) 36(11.6%)	2.95 (.73) 2.89 (.64)
20- Staff left me alone without attention.	104(33.5%)	177(57.1%)	24(7.7%)	5(1.6%)	3.23 (.65)
21- Staff assured me and dealt with my fear and pain with empathy.					
22- I was not discharged from the hospital because I could not pay the bill.					

Table 3. Multiple Linear Regression Analysis of Factors Associated with Respectful Maternity Care.

Predictors	Unstandardized Coefficient		Standardized Coefficient	t	sig	95.0% Confidence Interval for B	
	B	St. error	Beta			Lower Bound	Upper Bound
Age	.199	.626	.019	0.317	0.751	-1.033	1.430
Education	.407	.531	.051	0.766	0.444	-0.638	1.452
Occupation	-1.145	1.318	-.060	-0.869	0.386	-3.738	1.448
Income	1.406	.702	0.133	2.003	0.046	0.025	2.787
Parity	.920	1.416	.038	0.650	0.516	-1.866	3.706
Health care provider	2.390	.816	0.163	2.93	0.004	0.785	3.996

The mean score of all items of the questionnaire was 2.83 out of 4 (SD = 0.33), indicating that the postpartum women experienced a moderate level of RMC. Considering the right to information and informed consent (mean= 2.67 ± 0.54), 56.8% of the participants revealed that staff did not introduce themselves, whereas 22.2% and 18.3% of the participants disagreed and strongly disagreed, respectively, with the proposition that the staff explained or asked for consent for any procedure before performing it. Moreover, 33.6% of the participants indicated that they were coerced to undergo procedures they did not want.

Regarding the maternal right to respect and dignity (mean = 2.92, SD= .50), the percentage of participants who disagreed or strongly disagreed with the proposition that staff addressed them by their names or communicated politely was 24.5% and 21.3%, respectively. In terms of physical abuse and disrespectful behavior (mean = 2.94, SD= .56), approximately 24.6% of the participants reported that they were exposed to verbal abuse, such as shouting or screaming, to force them to stop crying and complaining of pain, 12% participants were exposed to physical abuse, including beating and slapping, during birth, and 41.6% participants were exposed to abdominal pressure during childbirth. In terms of the quality of healthcare (mean= 2.63, SD= .38), 48.7% and 56.8% of the participants indicated that they were not allowed to either move or eat and drink during the first stage of labor, respectively. Additionally, 23.2% of the participants reported that they did not receive any pain-relieving interventions. Regarding the confidentiality and privacy of pregnant women (mean = 3.00 ± 0.47), the confidentiality and privacy of patients were ensured in > 85% of the cases. However, 8% of the participants indicated that their confidentiality was not maintained and 12.6% reported that their privacy was intruded on by keeping the door or curtains open. Considering discrimination and detention (mean = 3.09 ± 0.52), 22% of the participants suggested that they were left unattend column="double"ed during labor and childbirth, 14.2% were exposed to discrimination because of their attributes, such as age, weight, or financial status, and 9.3% were detained in the hospital until payment (Table **2**).

Multiple linear regression identified only two significant determinants of RMC: family income (β = 0.133 and p = 0.046) and specialty of the healthcare provider (β = 0.163 and p = 0.004). Participants with high family income reported high RMC scores compared to those with low family income, whereas participants tended by midwives reported a high level of RMC compared to those tended by doctors (Table **3**).

4. DISCUSSION

This study examined the perception of postpartum women about RMC during labor and childbirth. The WRA constituted a universal charter for the rights of pregnant women based on the disrespectful and abusive behaviors categorized by Browse and Hills [1]. The participants of this study reported receiving a moderate level of RMC. They were exposed to various forms of disrespectful care that invaded their maternal rights. Pregnant women have the right to information, consent, and choice. The present study revealed that more than half of the participants were not informed about the name and qualifications of the healthcare provider. Moreover, permission before procedures was not obtained from approximately one-fifth of the participants. Similarly, one-fifth of the participants were not explained their progress during labor. These findings were congruent with those of an Ethiopian study, which indicated that 89% of the participants were unaware of the names of their healthcare providers, consent was not obtained from 40% of the participants, and 32.9% of the participants were not updated about their health status [15].

Pregnant women have a right to receive treatment free from harm and physical abuse. The WHO and several obstetric agencies recommend that healthcare providers not use fundal pressure during the second stage of labor to avoid its potentially harmful effects such as perineal and cervical tears, shoulder dystocia, and neonatal birth injuries [10, 29, 30]. Nonetheless, healthcare providers justify the use of fundal pressure to facilitate birth during the second stage of labor [31]. The findings of this study indicated that > 40% of the participants were exposed to abdominal fundal pressure during childbirth. Moreover, approximately 12% of the participants were exposed to physical abuse during labor, which agrees with the findings of a similar study conducted in Iran, where 13% of the participants revealed that healthcare providers slapped them during childbirth [24]. Physical abuse, which is unjustified under any circumstance and must be addressed by the healthcare system, increases the risk of postpartum depression [32]. The present study indicated that more than one-fourth of the participants were exposed to verbal abuse such as shouting and screaming. This can be attributed to the fact that healthcare providers in Jordan consider that women do not have adequate knowledge about labor and childbirth and focus on the medical aspects of labor and childbirth without complications. Thus, they disregard the respectful treatment of

pregnant women [22]. However, negative intrapartum experiences deter the confidence and self-esteem of postpartum women [33].

The WHO recommends oral fluids and food items, in addition to free movement and positioning during the first stage of labor, for low-risk women [9]. Approximately 50% of the participants of this study were not allowed to eat or drink during labor, which was extremely higher than the percentage reported in the Iranian (3.6%) study [24]. Moreover, approximately half of the participants were not permitted to move freely during labor, which was similar to the finding of the Iranian study and higher than that of the Ethiopian one [24, 15]. Restricting fluids and nutrition during labor without assessment is followed as a routine measure by healthcare providers in several countries. However, these measures may lead to serious harmful effects such as hypoglycemia, dehydration, and prolonged labor (9), in addition to intruding on the right of women to dignity.

Emotional support, effective communication, and empathetic behavior towards pregnant women are essential components of RMC [34]. Previous studies suggest that the presence of midwives reduced stress and anxiety in pregnant women, which, in turn, increased blood flow to the uterus and contraction. This shortened the duration of the active phase of the first and second stages of labor [35]. This study demonstrated that 23% of the participants were unattended during labor, which agrees with the findings of another Jordanian study, where 32.2% of the participants reported neglect during previous childbirths [36]. Similarly, a qualitative study of 21 pregnant Jordanian women revealed that the participants suffered humiliation, ignorance, unempathetic caring behaviors, and abandonment during labor [23]. Therefore, the healthcare system must develop and adopt strategies that guarantee RMC and attention to pregnant women during labor and childbirth.

In this study, 12% of the participants reported that their privacy was intruded upon during labor which is consistent with the findings of previous Jordanian studies [21 - 23]. Most public hospitals serve as teaching hospitals and are crowded with nursing and medical students from various universities, which may impede the ability of healthcare providers to ensure the privacy of their patients [20]. Treating all women equally, regardless of their age, obstetric history, and weight is necessary for RMC. Approximately 14% of the participants in this study revealed that they were exposed to discrimination because of their traits. This finding was similar to those of other studies conducted in Nepal, Ethiopia, and Pakistan [3, 15, 37]. Additionally, only 9% of the participants agreed to be detained until hospital bills were settled, although 80% of the participants had health insurance. Detention is considered a barrier to adequate healthcare facilities [33].

This study suggested that family income and the specialty of the healthcare provider were the significant determinants of RMC. Pregnant women with low economic status were less likely to receive RMC. This was consistent with a mixed-method systematic review of 65 studies conducted worldwide, which indicated that women from economically backward classes believed that they received less respectful treatment compared to rich women and they were more vulnerable to poor healthcare services [14]. Additionally, in the present study, pregnant women tended by midwives reported improved RMC compared to those tended by doctors (doctors in teaching hospitals were residents). This may be attributed to the increased workload and extended working hours of doctors that resulted in burnout, fatigue, and stress, which negatively affected their performance [38]. Similar results have been reported in Iran [24].

This study has several implications at the levels of education, practice, and research. Introducing RMC in nursing and medical curricula and training undergraduate medical and nursing students about the rights of patients and the code of ethics as a basic element for clinical practice are essential. Improving RMC to achieve the highest quality of healthcare is a shared responsibility of the Ministry of Health, administrators, and healthcare providers. The construction of hospitals with basic infrastructure that facilitates the comfort and privacy of patients is a must. Adapting evidence-based universal standards of care and guidelines must be emphasized for all healthcare facilities and institutions that promote the health of the mother and her baby. Furthermore, training doctors and midwives to be patient with pregnant women and integrate RMC into routine practice may improve healthcare services for pregnant women. Observational studies must be conducted to collate detailed information about each category of disrespectful and abusive behavior that pregnant women are exposed to during labor and childbirth. Moreover, further studies are necessary to identify the barriers to providing RMC from the perspective of healthcare providers.

5. STRENGTHS AND LIMITATIONS

This study provides an overview of the status of RMC in public hospitals in Jordan. It addresses the gap between written standards and guidelines and demonstrated practice. The interviews with pregnant women were conducted before they were discharged from the hospital, which limits the bias of recalling. However, the study exhibits a few limitations. For example, the present study used a descriptive model with a non-randomized convenience sampling method that did not specify the type of disrespectful and abusive behavior for each category. Additionally, the findings of the study cannot be generalized to all hospitals in Jordan because it does not include data from private and military hospitals.

CONCLUSION

RMC is essential for pregnant women to optimize the quality of health care. Sometimes, healthcare providers may normalize disrespectful treatment during childbirth, which intrudes on basic human rights. As childbirth is a critical event in the life of a mother, traumatic childbirth experiences may negatively affect the mental and physical health of women. In this study, the participants received a moderate level of RMC during labor and childbirth. Most of them were not informed about their healthcare providers or were exposed to unnecessary interventions that negatively affected the mother and her child. Thus, participatory actions must be ensured by policymakers, leaders, and healthcare providers to promote RMC at public hospitals in Jordan.

LIST OF ABBREVIATIONS

RMC	=	Respectful Maternity Care
WHO	=	World Health Organization
WRA	=	White Ribbon Alliance

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval was obtained from the Institution Review Board (IRB) at Al Balqa Applied University (reference #: 26/3/2/211).

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All procedures performed in studies involving human participants were in accordance with the ethical standards of institutional and/or research committee and with the 1975 Declaration of Helsinki, as revised in 2013.

CONSENT FOR PUBLICATION

The purpose of the study was explained to the participants and the consent form was obtained. Confidentiality, voluntary participation, and anonymity were maintained.

STANDARDS OF REPORTING

STROBE guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest financial or otherwise.

ACKNOWLEDGEMENTS

The authors would like to acknowledge Al Balqa Applied University and Jordan University of Science and Technology for their support.

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