The IDEAL approach to establish contemporary maternity care during labor

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ABSTRACT

Objectives: The objectives of this study were to assess the prevalence of abusive and disrespectful behavior from healthcare workers toward women during childbirth, to determine the type of abuse with the highest prevalence, and to assess the factors that contributed to the prevalence of abuse and disrespectful behavior. Methods: This is a quantitative observational cross-sectional study that was conducted among mothers who gave birth in a tertiary hospital in Riyadh, Saudi Arabia, from September 2019 to mid-March 2020, with a target sample size of 261. Descriptive statistics were described by frequencies and percentages, bivariate statistical analysis was carried out by using Chi-square test. Results: The overall prevalence of disrespect and abuse (D&A) was 62.5%, the non-consented category was the commonest type in this study. D&A was 2.8 times more prevalent in women whose newborn suffered complications during delivery. Likewise, mothers who delivered in a room with 5 or more caregivers were 2 times more likely to be disrespected than others. Mothers who underwent a natural delivery without episiotomy were 53% less likely to face the risk of being disrespected than others. Conclusion: This study reveals that the prevalence of disrespect and abuse towards women during labor in the chosen setting was high. The type of delivery, number of caregivers present, and complications that occurred during delivery were significantly associated with disrespect and abuse. Therefore, the authors of this study present an IDEAL approach as a way to upgrade the maternity care standards.

Keywords: Abuse, childbirth, disrespect, labor, maternity care, Saudi Arabia

Introduction

During pregnancy, the mother passes through a series of physical, psychological, and emotional phases to reach the divine emotional state called motherhood. Among these transitional stages, the perinatal period is very much exposed to various imminent risks, and the experience of birthing a baby leaves a long-term memory on the mother’s life. While the patient bears the labor pains, every encounter with a health professional and sequence of events are well registered in the women’s mind. Therefore, the attitude of health professionals towards laboring patients matters considerably during maternity care.¹ The aim of optimal maternity care is not only safe childbirth but also to develop a maternity culture that addresses the women’s emotional concerns with extra tender care during the intrapartum phase. Although the maternity team is keenly concerned about physical fetal and maternal wellbeing, little attention is paid to the emotional and mental health of women going through parturition.²
During parturition, an element of disrespect and abuse (D&A) toward women during labor and birth has been observed and reported worldwide. Disrespect and abuse are defined as any form of inhumane treatment or uncaring behavior.[4,8] It is considered an issue globally and has been overlooked during maternity care.[5,6] It is established that multiple factors are responsible for indirectly influencing the disrespectful attitude of health professionals towards abuse during maternity. These factors could be health strategy, infrastructure, resources, ethics, working culture, attitudes, and values of practice in services and health communities.[7] Mother’s experience of D&A behaviors during birth affects her trust in the healthcare system and might even leave a lasting effect that will heavily influence her decision to pursue health care in the future.[8]

In 2014, the World Health Organization (WHO) stated that “every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth.” If insulting actions take place in a healthcare facility by health providers, it would negatively affect maternal health by withdrawing women from pursuing care in a medical facility.[9] This distrust and possible subsequent decision to abstain from seeking medical care in times of need can adversely impact the quality of life of both the mother and her children. Hence, family or primary physicians should be watchful for any signs of aversion from the healthcare system, then offer to counsel the mother about her situation while emphasizing the importance of continued medical care for her family or to steer her toward other helpful pathways.

New guidelines released by WHO regarding the quality of care for maternal and newborn health states that the provision of care is of equal importance to the quality of care delivered. Also, it is endorsed for further research on identifying disrespectful and abusive behaviors in both private and public hospitals globally.[10] The prevalence of this issue is not well documented in Saudi Arabia. Saudi Arabia is considered to be one of the countries with a rapidly increasing birth rate and is known to have large family sizes. Despite these facts, a study considering disrespect and abuse during childbirth has never been discussed in the region (Middle East).

The objective of the study is to assess the prevalence of disrespect and abuse by healthcare providers toward women during childbirth at a tertiary hospital in Riyadh, Saudi Arabia. By highlighting the prevalence and characteristics contributing to D&A, it discusses the driving forces for mistreatment and recommends the possible solutions to overcome D&A during maternity care.

**Material and Methods**

This is a quantitative observational cross-sectional study that was conducted among mothers who gave birth in a tertiary hospital in Riyadh, Saudi Arabia from September 2019 to mid-March 2020. This particular study took place in the postnatal wards and participants were selected using a convenience sampling process that had considered the inclusion and exclusion criteria. We included all women over the age of 18 years who have undergone vaginal birth or emergency cesarean section under spinal or epidural anesthesia and excluded women below the age of 18 years due to it being under the legal age for marriage in Saudi Arabia. Also, we excluded the women undergoing elective cesarean sections, deliveries under full general anesthesia, and patients more than three days postpartum to reduce recall bias.

The sample size was estimated based on the average of four studies of the prevalence of abuse and disrespectful behavior toward women during childbirth that were similar in method, setting, and resources. Using the single proportion equation, the proportion considered was 0.83 with a precision of 5%, and $Z_\alpha$ is 1.96 for the 95% confidence level, the required sample size was 217. Anticipating 20% non-response, the target sample size was 261.

We collected data through the paper-based questionnaire and ensured the maximum response rate by explaining the purpose of the study to patients. To reduce courtesy bias, we confirmed privacy and confidentiality as we have made sure there were no healthcare providers in the room while filling in the questionnaire during the data collection. The questionnaire was divided into three sections. The first section was to assess the sociodemographic characteristics of the mother which included: age, marital status, educational level, occupation, and family monthly income. The second section assessed the mother’s obstetric history and healthcare provider characteristics through closed answer questions, which includes the number of total deliveries, deliveries at a health facility, type of healthcare facility, number of antenatal visits, type of birth, complications of birth, main provider’s gender, main provider’s specialty. The third section contained the assessment of the 23 indicators of abuse and disrespect that were under the seven categories of Browser and Hill. This included physical abuse, non-dignified care, discrimination based on specific patient attributes, non-consented care, non-confidential care, abandonment of care, and detention in facilities.

The participants were asked the closed answer question to either affirm or deny. Such as (Healthcare provider physically hit, slapped, pushed, pinched, or otherwise beat you). A pilot study was conducted on 10% of the total sample size (26 mothers) to test the logistics of the data collection, clarity of the data collection tools, estimation of timing for data collection. The questionnaire was found as valid to generate optimal results that reflect the study aim. The pilot study was not included in the final results.

We analyzed data using SPSS version 25.0 statistical software. Descriptive statistics (frequencies and percentages) were used to describe the quantitative and categorical variables. Bivariate statistical analysis was carried out using appropriate (Chi-square test, Binary logistic regression for adjusted odds ratio, for n <5
yates’ correction and Fisher exact test were used) statistical tests, based on the type of study and outcome variables. A P value of <0.05 and 95% CI were used to report the statistical significance and precision of results.

The informed consent was clear and indicated the purpose of the study and the right of the participant to withdraw at any time without any obligation toward the study team. Participants’ anonymity was assured by assigning each participant with a code number for analysis only. No incentives or rewards were given to participants.

Results

The total number of women who participated in the study were 261. The overall prevalence of disrespect and abuse was 62.5%, the non-consented category was the commonest type in Saudi Arabia. Based upon the types of abuse and disrespect, non-consented care (n = 125, 47.89%) was the most prevalent type, followed by physical abuse (n = 50, 19.15%), then abandonment/neglect of care (n = 30, 11.49%) as shown in Figure 1.

Complications during birth, the number of caregivers present, and the type of birth are some of the factors that play a role in the possible maltreatment.

The results indicated that the majority of the participants (n = 124, 47.51%) were in the age group 18–29 years, followed by the age group 30–39 (n = 123, 47.13%) as shown in Table 1. All of the women who participated in the study (n = 261, 100%) were married, and (n = 163, 62.5%) had a college level of education. Most of the women (n = 167, 64%) were housewives while some (n = 48, 14.8%) were government employees. Most (n = 109, 41.8%) had a monthly income of 5001–10,000 SAR followed by (n = 69, 26.4%) 10,001–15,000 SAR.

The association of each independent variable with disrespect and abuse was evaluated by performing binary logistic regression. The results of the bivariate analysis revealed that the type of birth, the number of caregivers that were present during the birth, and the complication that occurred during birth were significantly associated with disrespect and abuse (p < 0.05). For instance, mothers who underwent a natural birth without episiotomy were 53% less likely to face the risk of being disrespected and abused than those who delivered in other ways (OR, 0.535; 95% CI 0.320–0.896; P = 0.017). Likewise, mothers who delivered in a room with five or more caregivers were two times more likely to have been disrespected and abused than mothers who delivered in a room with less than five caregivers (OR, 2.95% CI, 1.186–3.466; P = 0.009). Also, in deliveries where complications occurred to the child only, abuse and disrespect were 2.8 times more likely to happen than in situations where complications occur to both mother and child, to mother only, or when no complications occur at all (OR, 2.818; 95% CI 1.054–7.532; P = 0.032) as shown in Table 2.

The prevalence of disrespect and abuse is 62.5% (n = 163), the most commonly experienced form of physical abuse was “not demonstrating care in a culturally appropriate way (n = 23, 8.8%)”, followed by “being verbally insulted during labor (n = 8, 3.1%)” and “being banned from food and fluids during labor without medical necessity (n = 8, 3.1%)”. From the domain of non-consented care, (n = 68, 26.1%) women were not allowed to assume the position of choice during birth, followed by “not being encouraged by the provider to ask questions (n = 52, 19.9%)” as mentioned in Table 3.

Table 1: Sociodemographic characteristics of mothers in a Tertiary Hospital in Riyadh, Saudi Arabia, Mid-February to Mid-March, 2020 (n=261)

| Mother's Characteristics          | n=261 Freq. (%) |
|-----------------------------------|----------------|
| Age (years)                       |                |
| 18-29                             | 124 (47.51%)   |
| 30-39                             | 123 (47.13%)   |
| 40 and more                       | 14 (5.36%)     |
| Marital Status                    |                |
| Married                           | 261 (100.0%)   |
| Divorced                          | 0 (0.0%)       |
| Single                            | 0 (0.0%)       |
| Education Level                   |                |
| Illiterate                        | 3 (1.1%)       |
| Primary                           | 4 (1.5%)       |
| Intermediate                      | 10 (3.8%)      |
| Secondary                         | 60 (23.0%)     |
| Collage                           | 163 (62.3%)    |
| Higher Education                  | 21 (8.0%)      |
| Occupation                        |                |
| Unemployed                        | 167 (64.0%)    |
| Private Sector Employee           | 30 (11.5%)     |
| Government Employee               | 48 (14.8%)     |
| Student                           | 16 (6.1%)      |
| Income                            |                |
| <5000                             | 50 (19.2%)     |
| 5001-10,000                       | 109 (41.8%)    |
| 10,0001-15,000                    | 69 (26.4%)     |
| >15,000                           | 33 (12.6%)     |
Table 2: Factors and their association toward abuse and disrespect in a Tertiary Hospital in Riyadh, Saudi Arabia. Mid-February to Mid-March, 2020

| Variables | Disrespect and Abuse | χ² | P | OR (95% CI) | aOR (95% CI) |
|-----------|---------------------|----|---|-------------|--------------|
| Age       |                     |    |   |             |              |
| 18-29     | Yes n=163           | 82 | 0.741 (0.447-1.227) | 0.991 (0.976-1.006) |
|           | No n=98             | 42 | 0.243 | 0.764 (0.428-1.349) |
| 30-39     |                     | 70 | 1.565 (0.945-2.590) | 0.956 (0.942-0.970) |
|           |                     | 53 | 0.081 | 3.046 (1.502-5.78) |
| 40 and more|                    | 11 | 0.200 | 4.363 (1.019-1.604) |
| Education Level |                  |    |   |             |              |
| Illiterate | Yes n=163           | 2 | 0.023 | 0.830 (0.074-9.274) | 0.680 (0.000-7.562) |
|           | No n=98             | 1 | 0.879 | 3.046 (1.502-5.78) |
| Primary   |                     | 4 | 2.442 | 1.113 (0.306-4.048) |
| Intermediate |                | 6 | 0.027 | 0.986 (0.088-1.654) |
| Secondary |                     | 33 | 1.845 | 1.498 (0.835-2.689) |
| Collage   |                     | 102 | 0.003 | 0.947 (0.398-1.942) |
| Higher Education |          | 16 | 0.017 | 0.947 (0.398-1.942) |
| Occupation |                     |    |   |             |              |
| Unemployed | Yes n=163           | 101 | 0.023 | 0.830 (0.074-9.274) | 0.680 (0.000-7.562) |
|           | No n=98             | 66 | 0.382 | 1.266 (0.747-2.146) |
| Private Sector Employee |       | 22 | 1.711 | 0.570 (0.243-1.335) |
| Government Employee |            | 28 | 0.027 | 0.986 (0.088-1.654) |
| Student   |                     | 12 | 1.144 | 1.456 (0.075-2.689) |
| Income    |                     |    |   |             |              |
| <5000     | Yes n=163           | 27 | 1.884 | 1.545 (0.828-2.882) |
|           | No n=98             | 66 | 0.382 | 1.266 (0.747-2.146) |
| 5001-10,000 |                | 74 | 2.360 | 0.668 (0.399-1.119) |
| 10,001-15,000 |           | 44 | 0.069 | 0.926 (0.523-1.639) |
| >15,000   |                     | 18 | 1.838 | 0.494 (0.175-1.394) |
| Total Number of Deliveries, Including Stillbirths and Newborn Deaths | | | | | |
| 0         | Yes n=163           | 32 | 0.761 | 0.921 (0.485-1.748) |
|           | No n=98             | 18 | 0.802 | 1.266 (0.747-2.146) |
| 1         |                     | 44 | 0.010 | 0.922 (0.586-1.604) |
| 2-3       |                     | 56 | 0.050 | 1.062 (0.628-1.794) |
| 4 and more|                     | 31 | 0.017 | 0.958 (0.503-1.824) |
| From the Total Number of Deliveries, How Many of Them Happened in a Health Facility? | | | | | |
| 0         | Yes n=163           | 34 | 0.008 | 0.973 (0.523-1.808) |
|           | No n=98             | 20 | 0.931 | 1.028 (0.586-1.804) |
| 1         |                     | 50 | 0.010 | 1.046 (0.609-1.795) |
| 2-3       |                     | 52 | 0.050 | 1.062 (0.628-1.794) |
| 4 and more|                     | 27 | 0.003 | 0.983 (0.500-1.933) |
| What Type of Health Facility Did Your Last Delivery Occur in? | | | | | |
| Home      | Yes n=163           | 3  | 0.273 | 0.550 (0.056-5.360) |
|           | No n=98             | 20 | 0.601 | 1.046 (0.609-1.795) |
| Governmental Medical City |           | 110 | 1.028 (0.586-1.804) |
| District Hospital |            | 1  | 0.133 | 1.670 (1.037-2.077) |
| Private Hospital |                | 17 | 1.413 | 0.560 (0.213-1.472) |
| NO previous deliveries |          | 32 | 0.063 | 0.921 (0.485-1.748) |
| Other     |                     | 0  | 2.0(0% | 3.352 (0.0% |
| Did You Follow Up with a Specialist During this Pregnancy? | | | | | |
| Yes       | Yes n=163           | 162 | 0.133 | 0.599 (0.037-9.683) |
|           | No n=98             | 97 | 0.715 | 1.461 (0.0-2.094) |
| How Many Times Did You Follow Up this Pregnancy? | | | | | |
| <9       | Yes n=163           | 80 | 0.657 | 0.973 (0.958-0.989) |
|           | No n=98             | 38 | 0.395 | 1.093 (0.998-1.191) |
| >=9       |                     | 83 | 1.522 | 1.028 (1.012-1.044) |
| When was the Delivery? | | | | | |
| At work hours |                | 49 | 1.128 | 0.117 (0.0-3.325) |
| At night-shift hours |            | 114 | 1.128 | 0.854 (0.0-2.426) |
| What was the Type of Delivery for this Pregnancy? | | | | | |
| Natural Delivery with Episiotomy |       | 49 | 1.128 | 0.117 (0.0-3.325) |
| Natural Delivery without Episiotomy |          | 83 | 1.128 | 0.854 (0.0-2.426) |
| Vacuum Extraction or Forceps Delivery | | | | | 

Contd...
The most commonly reported type from the non-confidential care category was “not using curtains or other visual protection barriers by the healthcare providers for protecting the privacy of mothers (n = 17, 6.5%)”. From the non-dignified care category, (n = 17, 6.5%) of women reported being shouted at or scolded by healthcare providers during birth. The most commonly reported type from the domain of abandonment/neglect of care was “the mother being left alone or unattended during active birth (n = 21, 8%)” (n = 17, 6.5%) of women reported that their transfer to the postnatal ward was postponed without a valid reason. The least reported category of abuse and disrespect was discrimination (n = 7, 2.6%).

**Discussion**

During pregnancy, meticulous attention is paid to provide continuous support to women; from pre-marriage and pre-conception to post-birth and this care aims to achieve a healthy fetomaternal outcome.11

Our study revealed that the element of abuse and disrespectful behavior and mistreatment exist in the country and needs to be addressed seriously during childbirth.12 Our findings represent that although D&A prevails in the region, however, its magnitude is not as severe as reported in the following states: Nigeria, Peru, Pakistan, Southeastern, Southwest Ethiopia and in Tanzania is 91.7%, 97.4%, 97%, 98%, and 96.1%, respectively.13-17 Our findings are comparable to an Ethiopian study where researchers found that the occurrence of disrespect and abuse was 67.1%.18 This issue is not only the concern of low-income countries but also few high-income countries have reported this matter which indicates that any disturbance in the multifactorial birth process has a significant effect on the quality of care delivered.19-24

D&A is a multistage issue that can occur at various levels of the healthcare delivery process. These factors could be at the level of patients, healthcare providers, health facilities, or even at a greater level as healthcare policymakers.18,21

This study revealed no significant statistical associations between D&A and women’s age, education, and socioeconomic status. The lack of association could be a result of women overlooking ethically wrong behaviors and possibly normalization of the issue.22 Furthermore, many women could be unaware of an accountability system for D&A. Additionally patients may believe that reporting D&A will not make a difference in improving the healthcare system.23

The most common type of non-consented care was “The provider did not allow me to assume my position of choice during birth” (26.1%), which was higher than the study conducted in Southwest Ethiopia (11%) and lower than Bahir Dar town (30.7%).18,24

The standard position adopted by the hospital in which the study conducted is the lithotomy position. This standardization may be associated with two factors: the use of monitor equipment that restricts the movement of the mother during labor, as well as this position is considered to be universally adopted and the most convenient. It is preferred by the healthcare provider because it is practical as it allows for more space and control during the process of birth.

The second most reported category was physical abuse (19.15%). It was also the second most reported in studies such as Southwest Ethiopia (87.9%), and Southeastern Nigeria (35.7%).20,24-25 Besides, the study established that the presence of less than five healthcare providers during childbirth was associated with less likelihood (OR: 0.493) of reporting D&A. On the other hand,

### Table 2: Contd...

| Variables | Disrespect and Abuse | χ² | P | OR (95% CI) | aOR (95% CI) |
|-----------|----------------------|----|---|-------------|--------------|
| Cesarean section under spinal or epidural anesthesia | Yes n=163 No n=98 | | | | |
| Who was the primary Care provider that performed your delivery? | | | | | |
| Doctor | 22 (13.5%) | 25 (25.5%) | 5.982 | 0.014 | 2.195 (1.159-4.158) | 0.460 (0.0-7.006) |
| Nurse | 6 (3.7%) | 1 (1.0%) | 1.660 | 0.198 | 0.270 (0.032-2.275) | 0.662 (0.0-5.971) |
| Midwife | 4 (2.5%) | 2 (2.0%) | 0.047 | 0.829 | 0.828 (0.149-4.607) | 0.668 (0.0-6.807) |
| Other | 3 (1.8%) | 0 (0.0%) | 1.825 | 0.177 | - | - |
| What was the Gender of the primary Caregiver that Oversaw Your Delivery? | | | | | |
| Male | 69 (42.3%) | 37 (37.8%) | 0.531 | 0.466 | 0.826 (0.495-1.380) | 0.919 (0.899-0.939) |
| Female | 94 (57.7%) | 61 (62.25) | 0.531 | 0.466 | 1.210 (0.724-2.022) | 1.089 (1.065-1.112) |
| Who many caregivers were present in the room during your delivery? | | | | | |
| <5 | 73 (44.79%) | 28 (28.57%) | 6.782 | 0.009* | 0.493 (0.289-0.843) | 0.874 (0.837-0.914) |
| >=5 | 90 (55.21%) | 70 (71.43%) | 6.782 | 0.009* | 2.028 (1.186-3.466) | 1.144 (1.094-1.195) |
| Did Any Complications Occur During Delivery? | | | | | |
| Yes (To Mother Only) | 12 (7.4%) | 9 (9.2%) | 0.275 | 0.600 | 1.272 (0.516-3.139) |
| Yes (To Child Only) | 7 (4.3%) | 11 (11.2%) | 4.578 | 0.032* | 2.818 (1.054-7.532) | 0.611 (0.0-1.244) |
| Yes (To Mother and Child) | 2 (1.2%) | 1 (1.0%) | 0.023 | 0.879 | 0.830 (0.074-9.274) | 0.680 (0.0-7.562) |
| No | 142 (87.1%) | 77 (78.6%) | 3.310 | 0.032* | 0.460 (0.0-7.006) | 0.662 (0.0-5.971) |

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Table 3: Prevalence, Category and type of disrespect and abuse reported by mothers during childbirth in a Tertiary Hospital in Riyadh, Saudi Arabia. Mid-February to Mid-March, 2020

| Categories                                      | Yes Freq. (%) | No Freq. (%) |
|-------------------------------------------------|---------------|--------------|
| Abnormally                        |               |              |
| Experienced disrespect or abuse during delivery| 163 (62.5%)   | 98 (37.5%)   |
| Physical Abuse                       |               |              |
| The provider used physical force/slapped me/hit me | 2 (0.8%)      | 259 (99.2%)  |
| The provider verbally insulted me during labor | 8 (3.1%)      | 253 (96.9%)  |
| I was separated from my baby without medical indication | 2 (0.8%)  | 259 (99.2%)  |
| Support staff insulted me and my companion | 6 (2.3%)      | 253 (97.7%)  |
| The providers did not demonstrate care in a culturally appropriate way | 23 (8.8%)  | 238 (91.2%)  |
| Received unnecessary pain-relief treatment | 7 (2.7%)      | 254 (97.3%)  |
| Denied food or fluids in labor unless medically necessitated | 8 (3.1%) | 253 (96.9%)  |
| Non-Confidential Care                  |               |              |
| The provider did not use curtains or other visual barriers for protecting the privacy | 17 (6.5%) | 244 (93.5%)  |
| Providers discussed my private health information in a way that others could hear | 8 (3.1%) | 253 (96.9%)  |
| Non-Consented Care                     |               |              |
| The provider did not introduce himself/herself to me and my companion | 41 (15.7%)  | 220 (84.3%)  |
| The provider did not encourage me to ask questions | 52 (19.9%) | 209 (80.1%)  |
| The provider did not respond to my questions with promptness, politeness, and truthfulness | 17 (6.5%) | 244 (93.5%)  |
| The provider did not explain to me what was being done and what to expect throughout labor and birth | 46 (17.6%) | 215 (82.4%)  |
| The provider did not give me periodic updates on the status and progress of my labor | 28 (10.7%) | 233 (89.3%)  |
| The provider did not allow me to assume my position of choice during birth | 68 (26.1%) | 193 (73.9%)  |
| The provider did not obtain my consent or permission before any procedure | 41 (15.7%)  | 220 (84.3%)  |
| Non-Dignified Care                     |               |              |
| Providers shouted at or scolded me during labor | 17 (6.5%) | 244 (93.5%)  |
| Providers made negative comments during labor | 7 (2.7%)  | 254 (97.3%)  |
| Abandonment/Neglect of Care            |               |              |
| The provider ignored me when I called him/her | 15 (5.7%) | 246 (94.3%)  |
| The provider left me alone or unattended during active delivery | 21 (8.0%) | 240 (92.0%)  |
| Discrimination                       |               |              |
| Healthcare providers discriminated against me due to my economic status | 3 (1.1%) | 258 (98.9%)  |
| Healthcare providers discriminated against me due to my age | 4 (1.5%) | 257 (98.5%)  |
| Healthcare providers discriminated against me because of being HIV-positive | | |
| Detention in a Health Facility         |               |              |
| My transfer to the postnatal ward from the antenatal ward was postponed without a valid reason | 17 (6.5%) | 244 (93.5%)  |

women who had five or more healthcare providers present in the room during birth were two times more likely to report D&A (OR: 2.028). Similar findings are reported in Jordan, that an association was found between crowdedness and the attendance of unwanted medical, nursing students during birth with the strong dissatisfaction of intrapartum care.[26] These findings highlight that the behavior of both the healthcare providers and the patient on an individual interaction is a crucial factor. This study revealed that in response to the stress, the healthcare provider may mistreat the mother. However, their emotional intelligence, self-control measures, and stress management skills can influence their approach toward patients and prevent further complications.[27]

The IDEAL approach to establish contemporary maternity care

In obstetrics and gynecology practice, it is reported that when women are going through a stressful and traumatic experience, they need extra care from health professionals. For instance, cases of repeated pregnancy losses and intrauterine death need special emotional support and we call it Tender Loving Care.[27] Similarly, the authors presented a mnemonic “an IDEAL approach” as a way to upgrade the maternity care standards. The authors emphasize that there is an intense demand to move away from traditional maternity care and we need to modify the care of laboring patients with excessive emotional support.

Here, the IDEAL approach mnemonic spells out the key factors from various angles to ensure a respectful attitude towards laboring women in distress of pains. These key factors are: Intervene to prevent mistreatment, Devise tools for monitoring and evaluation of events, Establish the audit policy, Authorize the companionship policy for laboring patients, and maternity teams must Learn stress-coping strategies.[28] It is imperative to revise the traditional maternity ward policies and continuously provide suitable attendants along with laboring women to support them emotionally. Additionally, the health team must be provided with

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structured training to cope with the stressful and emotional state of the patient. They must develop emotional intelligence; how to think before acting under nerve-wracking situations; control verbal and nonverbal communication; demonstrate humor and humility.

The implementation of these recommendations can satisfy the patients and women can appreciate the maternity team during the labor experience.[28] Moreover, it will guide the maternity teams to enhance the quality of care for laboring patients and avoid unnecessary complications like postpartum depression, medical errors, and patients complaints.[29] It may lead to grave consequences in the future, for mothers might choose to forgo seeking medical attention for whatever that may bother them or their families later on in life. Overall, this hinders the improvement of healthcare delivery to these women and their children. Reduction of the number of caregivers present during labor, leaving only the essential personnel there, is one of the ways to minimize this problem.

Limitations and challenges

Generally, disrespect and abuse is a challenging concept to measure objectively. As we believe that disrespect and abuse are determined by the women's view, we have chosen the most appropriate method in our opinion which was a self-reporting questionnaire as our method of assessment.[30] One of the ways mentioned in previous studies to reduce the subjectivity, was the addition of interviews conducted four to ten weeks post-birth to the exit interviews, to compare reported D&A.[22,31] Additionally, qualitative studies are required to analyze each factor by in-depth interviews of patients experiencing D&A.[32] It is imperative that what is the exact meaning of disrespect and abuse in patients’ views and such perspectives can only be inquired by interviews.

Besides, our study focused solely on the mother's perception of birth rather than focusing on both the mother's and healthcare providers’ perspectives.[23] We recommend further studies to explore the perspective and views of healthcare workers toward this subject, as it is of great importance to include all aspects for the enhancement of the healthcare system.

Conclusion

This study reveals that the prevalence of disrespect and abuse toward women during labor in the chosen setting is high; as the majority (62.5%) of them have faced some type of mistreatment during that critical time and situation. The type of birth, number of caregivers that were present, and complications that occurred during birth were significantly associated with disrespect and abuse.

As disrespect and abuse is a serious desecration of a patient's right, it is of great importance to solve the issue and diminish the impact that this offense leaves in the minds of mothers. The authors present an IDEAL approach as a way to upgrade the maternity care standards.
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