Mistreatment, disrespect, and violence practices in obstetric care in Lebanon: A right-based approach research

By

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Foreword

Obstetric violence is a serious issue that affects women all over the world. It refers to any act or omission by healthcare providers that results in physical or psychological harm or suffering to women during pregnancy, childbirth, or the postpartum period. In recent years, there has been growing recognition of obstetric violence as a global issue, with studies conducted in various countries highlighting its prevalence and impact on women's health and well-being.

Lebanon, like many other countries, has seen its share of cases of obstetric violence. Unfortunately, due to a lack of research on this topic in Lebanon, the true extent of the problem is not known. However, anecdotal evidence suggests that women in Lebanon have experienced mistreatment and abuse during pregnancy and childbirth.

Therefore, a study on obstetric violence in Lebanon helps shed light on this important issue and raise awareness about the need for better protection and care for women during pregnancy and childbirth.

The current study involved conducting interviews with maternal healthcare providers in Lebanon as well as focus group discussions with pregnant women or women who gave birth in the past one to three years to explore their attitudes, perceptions and experiences regarding obstetric violence, mistreatment and abuse across pregnancy and childbirth. The study also explores the factors contributing to obstetric violence in Lebanon, such as cultural norms, gender-based discrimination, and inadequate training and resources for healthcare providers.

The findings of this study could be used to inform policy and practice, helping to improve the quality of maternal healthcare in Lebanon and ensure that women receive the respectful and compassionate care they deserve. Moreover, it could contribute to the global conversation on obstetric violence and help to promote a culture of human rights and gender equality in the field of maternal health.

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Background

Obstetric violence is a type of gender-based violence that women might face during pregnancy and childbirth endangering quality respectful maternity care and undermining the efforts towards reduction of maternal mortality [1]. It is known as "the appropriation of women's bodies and reproductive processes by healthcare providers, which is expressed in inhumane hierarchical treatment, the misuse of medical treatment and the patronization of natural processes, which leads to the loss of autonomy and free decision-making in women regarding their own bodies and their sex lives, all of which have a negative impact on their quality of life" [2].

In a landscape analysis, Bowser and Hill described seven categories of disrespectful and abusive care during pregnancy and childbirth—physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities [3]. This Bowser and Hill classification has limitations related to methodological issues according to Bohren and colleagues [4] arguing that despite growing recognition of neglectful, abusive, and disrespectful treatment during childbirth, no consensus is established globally. Using a mixed-methods systematic review, Bohren and colleagues aimed to inform the development of an evidence-based typology of the phenomenon, suggesting seven domains be adopted to describe the phenomenon and be used to develop measurement tools and inform future research, programs, and interventions. These domains are (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints.

The World Health Organization (WHO) has highlighted the importance of prioritizing, evaluating, and eliminating the occurrence of obstetric violence towards women during childbirth [5]. According to WHO [6], violence during childbirth is described in the following statement:

"Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue."

The statement identifies different ways of mistreatment, violence, abuse and disrespect that occur during childbirth, and that range from "*outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay*."

In its report to the Special Rapporteur on Violence against Women and girls (SRVAW), UNFPA [7, 8] supported WHO's statement and identified discriminatory structural factors that directly affect the prevalence of these violations. These factors are part of the continuum of VAW and are related to the socioeconomic, educational and legal status of women, social and cultural norms, gender equity as well as the healthcare setting's internal culture. This necessitates an intersectional approach that will take into consideration ableism, age, and gender (trans and bisexual). SRVAW and WHO have recognized that the harmful, disrespectful and abusive treatment of women before, during and after childbirth in health facilities by healthcare personnel, is a human rights violation of respectful care. It threatens women's "rights to life, health, bodily integrity and freedom from discrimination" [9]. These practices need global attention and due diligence to support programmatic interventions. Research and knowledge generation remain crucial to promote respectful obstetric care. A recent statement by WHO [5] called for greater research, action, advocacy and dialogue on this important public health issue, in order to ensure safe, timely, respectful care during childbirth for all women. Globally, research work and several studies and reports, albeit limited, generated evidence on the poor treatment being experienced by pregnant and delivering women globally, including abusive, neglectful, or disrespectful care [4].

In Lebanon, more than 95% of pregnant women are generally followed up by a skilled healthcare provider, and as much deliver in hospitals under skilled attendance (PAPFAM), including the Syrian women refugees (MOPH reports). Although clinical observation and verbal communication indicate some form of mistreatment against pregnant women in general and refugees in particular, there is no published research to date that is related to obstetric violence in Lebanon. A recent review in 2022 showed that mistreatment, in different forms, is common in the Arab Region, including Lebanon [10]. Research is needed to understand perceptions, structural causes, and

specific manifestations of obstetric violence in the Lebanese healthcare system from the perspective of both the pregnant woman's and the provider's experiences.

This is expected to be the first qualitative research looking at obstetric mistreatment in Lebanon. It is supported by UNFPA and was conducted by a team from AUB WISH program and ABAAD who are experienced with this type of research. The research aimed to explore pregnancy and childbirth care experiences in relation to reproductive rights, consent, violations, mistreatment, and the level of women's awareness about dignified care. It is expected that the outcome of this research will inform interventions in Lebanon that align with international best practices, WHO, and SRVAW recommendations. Specifically, the research results will help contribute to:

- Promote standard care guidelines in respectful care and reproductive rights during pregnancy and childbirth.
- Sensitize healthcare providers to adopt/commit to pregnancy and childcare practices that are guided by human rights and Respectful Maternity Care frameworks.
- Integrate elements of respectful care within national guidelines and medical schools' and allied health curricula and training programs, as core elements in the provision of obstetric care, and integrate it in evaluations and accreditations.
- Integrate a respectful care agenda in the RH service delivery guidelines to contribute to opportunities for maternal mortality reduction.
- Develop policies (both for hospitals and on the national level) that emphasize right-based respectful care as per international guidelines and recommendations.

Methods

Approach

The current study adopted a qualitative methodology, using Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). Through KIIs, (with healthcare providers such as physicians, nurses, midwives, and administrative staff), data is gathered on the perceptions of healthcare providers regarding obstetric violence, disrespect, and mistreatment towards pregnant, birthing and postpartum women. The FGDs generated information regarding pregnant and postpartum women's perceptions and experiences of mistreatment, disrespect, or other forms of obstetric violence across pregnancy and childbirth. They went further to investigate their attitudes and perceptions towards obstetric violence and mistreatment and abuse during childbirth.

Profile of participants

In order to generate context-specific evidence, the research looked into clustering research participants as per the following categories:

Participants	**Frequency**
Nationality	
Lebanese	6
Syrian	6
Patient's status	
Pregnant	4
Postpartum	8
Type of facility (number of patients recruited/facility)	
Private	2 (6 patients/facility)
Public	2 (6 patients/facility)

Health providers	**Frequency**
Type of work	
Physician	6
Midwife	2
Sex disaggregated number of participants	

Male	3
Female	5
Geographic location	
Bekaa /Rashaya	1
South	1
North	1
Mount Lebanon	3
Beirut	2

Recruitment strategy

Recruitment and data collection

Key Informant Interviews included 8 healthcare providers: 5 females and 3 males. Two of the KIs were midwives, and 6 were obstetricians in the maternity department. One healthcare provider was chosen from 8 different maternity wards.

A total of 8 KIIs were conducted with healthcare providers in person and online (when logistical constraints occurred).

On the other hand, the Focus Groups were intended to examine the perspective of pregnant and postpartum women on obstetric disrespect and abuse. Pregnant and postpartum women were approached through maternity wards in 8 different hospitals across all Lebanese governorates.

The director of each maternity department was contacted and debriefed about the purpose of the research study and asked for permission to contact pregnant women or women who gave birth in the past 1-3 years. Lebanese, and Syrian refugees, participated in separate panel discussions to explore the differences in perceptions based on nationality and sociocultural and economic context. The average age of the participants was 36 years, multipara, 4 of whom were pregnant, and the others have given birth during the past 2 years.

A total of 4 group discussions were conducted. All participating women gave verbal consent and were informed about their right to withdraw at any time from the study. The transportation fees were covered by the project.

An interview guide was developed for the purposes of this study (Refer to Annexes 1 and 2):

All FGDs and KIIs were conducted in spoken Arabic in the following settings:

FGDs – neutral places such as hospitals, NGO offices, online etc.

KIIs – according to the participant's preference or online

Results

Participants are represented by two main categories: The first category includes the Lebanese women (LW) and Syrian women (SW) receiving healthcare during their pregnancy and childbirth, whereas the second category includes the healthcare providers who are expected to deliver a maternal and child care practice guided by human rights and respectful consented care.

Mixed positive and negative experiences were revealed by the first category interviews. The majority of women in this category revealed negative experiences which could endanger not only the women's health but also the health and life of the newborn. The practices of the healthcare providers (KIIs) are presented as follows:

- Themes: Reproductive rights with the provision of right-based care, awareness and provision of information about the process and care, trust, and security, and the level of women's awareness about respectful care.

- Sub-themes: Medical consent, violation of reproductive rights, mistreatment, and violence with ineffective communication.

Reproductive rights

Reproductive rights embrace a collective of rights aiming to attain the highest standard of care. The provision of right-based care enables women to receive quality and respectful care during pregnancy and childbirth. Promoting women's awareness about the maternal care and childbirth process, as well as ensuring an environment that builds trust and imparts security are also components of reproductive rights.

Provision of the right-based care

Concerning service provision, the interviews revealed some positive feedback from a few Lebanese and Syrian women on the provision of right-based care. "I am probably one of the few

lucky persons. I was receiving a good pregnancy follow-up and the team was very nice because I had diabetes during gestation. It was a scary experience, but their psychological support was great" (LW3). One Syrian woman stated: "I had a medical problem that required special care. The treatment of the physician and the medical team was good during the delivery" (SW6).

Other Lebanese and Syrian women reported that the quality of service they received was bad, and it endangered their lives or that of the newborn. One Lebanese woman said: "I had a bad experience during my first pregnancy. I had some health problems and the preparation period for childbirth was long. After delivery, the newborn required intensive care and I needed oxygen." The same participant declared that during her first pregnancy, there was negligence and she will not forget this experience. She also added "Whenever the healthcare providers know that there is an urgent delivery, they have to move fast and perform their duties" (LW1).

"I was following up with an obstetrician in his private clinic, but the fetus died due to health problems. It was left for three days in my uterus and the physician told me that no health risk will endanger my life. He assured me that the stillborn baby will be delivered via natural labor. But I entered the hospital because of severe pain and in the delivery room, the treatment of the midwife and doctor was bad." (LW2).

"In the private clinic where I used to follow up with my obstetrician, I usually waited for hours to see him and no precautions against the COVID-19 epidemic were respected. The obstetrician's follow-up was not good, and he did not request the needed laboratory exams. I had iron deficiency anemia and this situation exerted pressure on me. Pregnancy was an exhausting and scary period for me" (LW4).

Most of the Syrian women reported that the care offered by the HCPs was bad. "The treatment in hospitals and primary healthcare centers was bad. They kept delaying my care saying later on." (SW2).

The long waiting time in the primary healthcare centers was one of the poor "bad" indicators of the services as reported by most Syrian women: "I used to go to a primary healthcare center and wait for a long time. I was suffering" (SW4).

While healthcare providers knew about the importance of the right-based process in delivering care, there was a variance in providing the right care depending on expertise: "From the beginning of the pregnancy, it is necessary to have a midwife or a specialized gynecologist follow up the pregnancy with the provision of all needed information, and to take the woman on a tour of the hospital where she will deliver, to give her an idea of the setting, the delivery room, the medications that are used and will be given to her, and the required care for her and her child, such as breastfeeding, dealing with the child, … she should be prepared before the sudden birth time " (HCP2).

"Every doctor has his expertise. Accelerating childbirth is unacceptable. The enema is not obligatory, at the same time we do not force the patient. I am all for continuous development and all that helps, of course, each intervention should be done prior to an explanation" (HCP4).

Provision of information

Some participants declared that HCPs did counsel them about healthy and safe pregnancy and childbirth. "During my pregnancy, there was always someone to tell me about what will happen day by day, and this was very important for me" (LW3).

However, most of the women reported that they were not being provided with the needed information about maternal care and childbirth. "During my second pregnancy, the fetus was suffering from health problems. I didn't have any information about what the laboratory or imaging tests needed. The physician canceled the tests without informing me" (SW1).

"According to my experience, guidance is not given to pregnant women in all places. Some places provide guidance because it might be listed in the hospital policies and thus the personnel is obliged to deliver it. This means that education is very important for maternal care, especially for new mothers" (LW6).

On the other hand, most healthcare providers claimed to provide information and counseling because of women's lack of knowledge about maternal care and reproductive rights.

"The healthcare provider must inform women about what happens in the delivery room, the medications given during labor and delivery, and also about newborn care and breastfeeding." The same healthcare provider also suggested that informing women about the course of the pregnancy, laboratory tests, labor medication, and expected mode of delivery, "can relieve the stress which is sometimes perceived by her as mistreatment" (HCP1).

Ensuring trust and security

Previous knowledge about the medical team, process of childbirth, and place of birth ensures trust and security according to one of the participants. "I met all the medical team that was going to be present during my delivery beforehand. I also visited the delivery room. Their approval of my requests and the comfort they delivered gave me trust." The same woman stated: "The presence of someone who can give you details about what might happen will make you feel comfortable and secure" (LW3).

However, all the remaining women did not mention anything that related to trust-building and feeling safe and secure, mainly because they had felt this bonding with their healthcare providers during their pregnancies, repeated visits and follow-ups.

Moreover, in case of accidental mistreatment some HCPs resort to corrective actions to rebuild trust and assure women while delivering care: "If mistreatment happens against our will, we try to explain to the patient the pros and cons of the situation, so she understands the situation, and reassure her that the medical team is always beside her during childbirth. And before taking any other action, it is necessary to obtain her consent immediately" (HCP5).

Medical consent

Informed medical consent is fundamental to quality care and essential health rights. It is part of patient-centered services, allowing patients to be part of their healthcare plan and making them aware of any medical act and to give signed informed permission before receiving any type of medical treatment or intervention.

When women were asked whether they know about their health rights, some Lebanese and Syrian women had a mixed response, while others said it depended on the healthcare provider of service. "There are physicians that help guide patients, whereas others do not" (SW5).

Regarding HCPs' responses, some of them said that women are made aware of their health rights either by the physicians themselves or the healthcare facilities. "Yes, I provide the woman with information about her rights and her duties" (HCP3). However, another medical staff gave a negative response. "No, pregnant women are not provided with information about their rights. Most of them reach the labor room without knowing anything and lack the necessary information" (HCP7).

Violation of the reproductive right

Violation of women's reproductive rights includes violations affecting the decision-making process concerning pregnancy and delivery. It also includes low-quality, and often negligent, abusive care or treatment.
Violations of reproductive rights were reported by most Lebanese and Syrian women. Some were denied labor companions and experienced abusive care. "I had to deliver during COVID. The hospital where I delivered was far from home. The most difficult problem is that they did not allow my husband or any other member of the family to accompany me while giving birth, although the hospital was horrifying. The most important thing for the woman to feel secure is to have a member of her family with her in the labor room. After delivery, the physician left me for hours and the midwife was the one who sutured my wound. The closure of the wound was done again by the physician when he returned. It was very painful and none of my family was there to support me emotionally and physically." (LW4)

"During the 8th month of my second pregnancy, I had a medical problem. However, the physician did not provide me with the right treatment even though he is considered one of the best. Here,

there was negligence from the physician's side, leading to premature delivery. The newborn was hospitalized in the intensive care unit" (LW5).

Syrian women also reported severe violations, i.e. bad communication and shouting, long waiting time, negligence, and delay in proper care: "Although I was prepared for delivery, I suffered, waiting from 12 pm till 12 am. There was physical fatigue, and they didn't deliver me. I had a C-section and tubal ligation. I suffered a lot" (SW4). Another Syrian woman mentioned that she had an episiotomy even though the anesthesia did not go into effect "They brought me into the delivery room, they gave me anesthesia. The incision was made before I was fully anesthetized. It was very painful, and the amount of pain was indescribable" (SW5).

Other women revealed a lack of resources / vacant rooms for counselling and treatment in the healthcare facilities, "During delivery, I was vomiting all over myself. They kept me in my dirty gown for a long time and there were no clean sheets to cover me" (LW5). "Because we are refugees we had to seek care from the same medical center each time for financial reasons (because the consultation is covered), and because the place was crowded with women waiting for their turn, we were forced to leave the consultation room before putting on our baby's clothes" (SW3).

From the HCPs' points of view, a few major violations were declared (mainly insults, lack of consideration for delivering care and accusations): "A pregnant woman in her 9th month came in for delivery, although she was following up with another physician. She was supposed to have a normal delivery, but she went through difficulties that obliged us to do a C-section. Unfortunately, the newborn died because of his weight. The healthcare provider was negligent" (HCP3).

Even when asked about other types of violations such as incisions without anesthesia, C-sections without pain, preventing women from expressing pain, separation of the mother from the newborn, and giving formula milk instead of breastfeeding, most of the healthcare providers admitted that these practices, without the woman's consent, are forms of mistreatment and are even considered as acts of violence. Some of the healthcare providers revealed that there were complaints of mistreatment reported by women who were admitted to healthcare facilities, but no confirmation that such practices were being committed against them directly.

Nevertheless, while asking them about these violations, HCPs reported the presence of domestic violence practices during pregnancy as revealed by their patients – a serious matter that would seriously affect their care from a psychological point of view (according to the providers) and might impact the mental health of women.

Mistreatment by the HCPs and health systems/facilities

Results show that most of the women admitted to the healthcare facility were being mistreated during their pregnancy and childbirth. Among the adverse experiences reported were negligence,

ineffective communication, mistreatment, verbal abuse, and violence by the HCPs as well as by the healthcare facility and staff.

Ineffective communication

Interrupting conversations and yelling at them were aspects of ineffective communication that were reported by most women.

"When I ask a question, the obstetrician always ends the conversation." (LW4). "During my last visit before delivery the midwife was yelling and blaming me because of my health condition" (SW3).

Some of the HCPs stated that yelling and hostility were present in several settings, which elicited fear in patients. "To deliver in a place where everyone has an angry facial expression will elicit fear and will affect the provision of care" (HCP8).

Mistreatment and violence

Mistreatments practices in healthcare included:

1. Lack of supportive care and disrespect: "The decent provision of care means giving consideration to the pregnant woman, a practice which was not available." The same woman stated: "The way they were dealing with me during labor was bad. They don't feel the pain a person is going through, and I felt there is disrespect" (LW2). "When a physician does not provide an answer to his patient's question, this reflects disrespect." (LW4). "The way the hospital, medical staff, and physician were dealing with me was bad" (LW6).
2. Verbal abuse such as harsh language, blame, accusations of self-indulgence and insults: "They accused me of being spoiled because I asked for their continuous support and the physician was angry" (LW6). A Syrian woman talked about verbal abuse: "The treatment was bad, there were insults and violence. After the delivery, I forgot my infant's health record when I took him for his first vaccination. The nurse in charge yelled at me and blamed me for forgetting it" (SW3).
3. Privacy violations and discrimination were among the main negative experiences revealed by women: when asked about privacy violations, a woman stated "Any student can enter the labor room. There was no privacy and no respect" (LW6). Most of the Syrian women declared that they were treated badly and were subject to discrimination in the provision of care either because they were considered refugees or because of their financial condition/classification. "Because I am Syrian, I was considered a refugee, and I was treated in a bad way." (SW1).

The interviewed physicians reported other types of mistreatments committed by other HCPs such as negligence, yelling, expressions of anger, emotional abuse, verbal abuse, denial of labor companionship, and lack of providing a supportive environment:

1. Denial that mistreatment and violence had been used but was apparent among other HCPs and in their surroundings. Denial of labor companions was declared by some healthcare providers. "I do not allow the husband to enter the delivery room because, in case of pain, he will be affected, and his reaction will negatively impact the patient" (HCP2). "Unfortunately, during the delivery and in emergency conditions, it might happen that there is some negligence of some women's rights and verbal abuse might occur due to stressful conditions" (HCP5).
2. Most HCPs emphasized that social and financial situations take their toll on people, which could be a reason for the mistreatment witnessed in some healthcare facilities. "The financial, social, and work pressure could be a reason sometimes for not providing the right-based care by the physicians or the midwives. After all, HCPs can be married with life responsibilities" (HCP5).

When asked about suggestions to end/eliminate mistreatment and violence, an HCP stated: "Conducting training sessions for the medical staff as well as educational activities for the women to highlight rights and duties are highly suggested" (HCP3).

Level of women's awareness

Women's awareness that the care provided is expected to guarantee respect and privacy during pregnancy and childbirth is imperative.

The only statement that awareness is offered by the medical team was declared by a Syrian woman: "There were lectures on how to deal with the newborn" (SW6).

However, most women and HCPs believed that there is a need for sensitizing women about dignity in the process of care.

"It is important to have educational programs for women before and after marriage since pregnancy is a difficult and critical period." (LW5).

"There was suffering because no one explained anything to me" (SW4).

Most healthcare providers stressed the need to educate women about their rights. When asked if someone informs women about their rights, a healthcare provider revealed: "No, women are not informed about their rights. Most of them reach the delivery room lacking knowledge about their health rights. This always happens" (HCP7).

Discussion

This qualitative study aims to explore pregnancy and childbirth care experiences regarding reproductive rights, consent, violations, mistreatment, and the level of women's awareness about their rights and self-respect in the process of care. It also aims to investigate the attitudes and

perceptions of pregnant women (Lebanese and Syrian) during their childbirth journey, as well as of the healthcare providers towards obstetric disrespect and mistreatment.

The study findings revealed practices of multiple forms of mistreatment by providers in different ranks and positions ranging from ineffective communication and disrespect to cruel practices such as abusive care and violence that threatened the health of women and newborns. The study also revealed practices of mistreatment by healthcare providers (HCP) in both public and private healthcare facilities.

The most frequently reported mistreatment domain by both Lebanese and Syrian women in this study was the failure to meet the standards of care. Standard of care domain includes violations related to negligence, bad quality care, non-consented and non-confidential care, long waiting times, and many other practices that do not meet professional standards and that in some places endangered the health and even the lives of women or their infants.

In this respect, the WHO framework and standards to assess and improve the quality of maternal and newborn care in healthcare facilities should be followed as a support for improving health outcomes and reducing preventable mortality and morbidity among women and their newborns [11]. Moreover, identifying and following human rights norms and standards related to experienced and documented mistreatment is a first step towards addressing these violations during facility-based childbirth, ensuring respectful and humane treatment. This will aid in the development of work programs in order to improve the overall quality of maternal care and upgrading thereafter the weak healthcare system [12].

The poor rapport between women and healthcare providers, translated as ineffective or interrupted communication, was also significant mistreatment stated in the current study concurrent with previous studies [13]. This practice of inadequate communication with the patient could be related to a culture of medical patriarchal hegemony and underestimation of health rights and women's rights due to the absence of patients/women empowerment, in addition to the lack of counselling practice that is expected to be a main part of the healthcare process and should be integrated into the process early on [12, 14].

Moreover, HCPs themselves emphasized the need to improve the level of women's awareness during childbirth regarding their healthcare. Practices reflected in the preparation, coping and support given to women; and empowerment consisting of self-efficacy and self-esteem were found to be the main factors in the provision of a positive experience of childbirth. Cooperation and effort at the level of the individual, family, and educational healthcare system must therefore be tracked and incorporated into the trajectory of dignified care [15]. In other studies, there was a dearth of information regarding delivery care, medical procedures, and health status [16].

The women in this study reported being denied a labor companion. This finding aligns with previous studies that reported a failure to meet a professional standard of care. Denial of

companionship was a common concern stated by women in several Eastern Mediterranean countries. Denial of companionship during childbirth has a negative psychological impact on women [13, 17].

Non-consented care was also shown to be practiced by healthcare providers and facilities. Some women reported undergoing medical acts without their consent. According to the Ministry of Public Health laws and policies, patients should be aware of their rights and sign a consent form before being subjected to any medical act. However, the fact that in Lebanon, the relicensing of physicians is not mandatory, and the culture of medicolegal procedures is feeble, in addition to wide range of training programs with different competence where HCPs had their training, all those factors might lead to violations of evidence-based and standard practices. Therefore, adopting informative models, including shared decision-making away from the paternalistic model, and consequently forming a professional provider-patient relationship is essential [18].

Mistreatment practices during childbirth at health facilities documented in the study align with similar practices documented globally [12]. Moreover, WHO has called upon governments and decision-makers to prevent and eliminate practices of mistreatment of women in all healthcare institutions worldwide [5].

These kinds of practices have been shown to undermine women's trust in healthcare and discourage them from seeking adequate care from preconception to postpartum in healthcare facilities. Some women would even refer to supportive care with traditional providers instead of medical intervention in health facilities that can threaten their health and life.

In a study assessing positive labor and birth experience, client-care provider interaction was shown with higher women confidentiality scores (64.0%), followed by respect (53.3%), communication (45.1%) and autonomy (36.2%) [19].

In the Lebanese context of maternal health services, the mistreatment of women during childbirth mirrors global evidence of being multilayered and complex. Although its definition is not unified due to the diversity in the types and terms used across the literature, three concepts were shared: "disrespect and abuse," "mistreatment," and "obstetric violence." Moreover, evidence-based types of mistreatment were identified and categorized into seven domains which encompassed [5], sexual abuse; [13] verbal abuse; [20] physical abuse; [16] stigma and discrimination based on ethnicity, socioeconomic status, age, or medical conditions; [17] failure to meet professional standards of care such as any neglect or low standards in the delivery of care; [5] poor rapport between women and HCP including lack of supportive care, ineffective communication, and loss of autonomy; and [5] healthcare system conditions and constraints such as lack of the resources needed to provide women privacy or good care [13].

Our study captured the various types of mistreatment reported globally (abovementioned) except for sexual abuse which may be too shameful to report or too complicated to identify. The absence

of reporting on sexual abuse is in line with previous studies conducted in Eastern Mediterranean countries where sexual abuse was not reported [13,20].

Verbal abuse, on the other hand, was reported mainly by the Syrian women in the form of harsh language, blame, insult, and accusations of "pampering" themselves. This type of abuse was reported previously in the form of humiliating phrases and abusive behaviors and was the most predominant mistreatment domain [7]. In a recent study from Palestine, women during their childbirth reported verbal abuse, though the type of verbal abuse was not mentioned [13]. Regarding physical abuse, Syrian women reported physical violence and initiation of an episiotomy before the full effect of anesthesia. In other studies, physical abuses were reported in the form of beatings, painful vaginal examinations, the application of abdominal pressure by the providers during the second stage of labor, overuse of routine interventions, and insufficient pain medication [13, 17, 20].

Concerning discrimination, the study showed that discrimination based on nationality was a main complaint of Syrian women. They stated that they were treated differently because they were considered refugees. Similarly, two recent studies from the Eastern Mediterranean region revealed practices of discrimination based on personal attributes, sociocultural characteristics, language, or financial status [17, 20].

As for the healthcare system conditions and constraints domain, the findings of the study revealed a lack of resources in the healthcare facilities which impaired the provision of quality healthcare. It appears that this category of mistreatment is common among Eastern Mediterranean countries [13, 20]. The lack of resources is mainly related to the culture of disrespect and the fact that, as healthcare is not a priority it receives less funding and less attention from policymakers. Lack of resources related to women with socioeconomic disadvantages was shown to be associated with poorer access to care. Other factors included being uninsured, postponing needed care, postponing medications, and higher hospitalization rates [21].

On the other hand, to improve healthcare affordability and promote overall economic security as well as financial independence among peripartum women, there is a need for incorporating more targeted policy interventions in the health system rather than supporting services with little funds [22].

Conclusion

This study adds evidence that mistreatment in all aspects exists among HCPs and healthcare facilities, except for sexual abuse. It revealed that women's rights are subject to violation.
This study highlights the need to:

- Develop policies emphasizing right-based respectful care as per international guidelines and recommendations.
- Integrate guidelines in respectful care and reproductive rights among women during pregnancy and childbirth as part of the care at the healthcare facilities and national health system level.
- Incorporate training programs related to human rights in healthcare facilities for all caregivers and motivate them to adopt respectful consented care.
- Integrate elements of respectful consented care at the academic level in health and medical schools' curricula, as core elements of total care in obstetrics, and make it part of evaluations and accreditations.
- Implement health promotional activities to raise women's awareness of respectful care and acknowledge their reproductive rights.

Abbreviations

HCP: Healthcare Providers

LW: Lebanese Woman

SW: Syrian Woman

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