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Exploring factors contributing to mistreatment of women during childbirth in West Bank, Palestine☆

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ABSTRACT

Background: Respectful care during childbirth is a universal right for each woman in every health system, and mistreatment of women during childbirth is a major breach of this right.
Aim: This study aimed to explore the views of Palestinian women and healthcare providers regarding factors contributing to the mistreatment of women during childbirth at childbirth facilities in the West Bank, Palestine.
Methods: A qualitative study was conducted in the West Bank, Palestine, from February 2019 to April 2019. In-depth interviews were conducted with six Palestinian women and five healthcare providers. Consent was obtained individually from each participant, and the interviews ranged from 40 to 50 min. Data collection was continued until thematic saturation was reached. Open-ended questions were asked during interviews. Thematic analysis was used to interpret the data collected from the interviews.
Results: Four themes were identified with regards to the women and healthcare providers' views about factors contributing to the mistreatment of women during childbirth in the West Bank, Palestine: limitation in childbirth facilities, factors within the healthcare providers, the women themselves, and barriers within the community.
Discussion: Mistreatment of women during childbirth may occur due to the limitations of resources and staff in childbirth facilities. Some women also justified the mistreatment, and certain characteristics of the women were believed to be the factors for mistreatment.
Conclusion: As the first known study of its kind in West Bank, the identified contributing factors especially the limitations of resources and staff are essential to provide good quality and respectful care at childbirth facilities.

Statement of significance

Problem or issue
Women are often mistreated during childbirth. Little is known about the factors influencing mistreatment during childbirth in Palestine.
What is already known
A few studies reported Palestinian women experiencing lack of support, inadequate explanation or privacy, and disrespect of dignity during childbirth. All these experiences are considered a breach of women's right during childbirth.

What this paper adds
This paper provides rich understanding of the factors contributing to mistreatment of women during childbirth, from the views of women themselves and healthcare providers. This will inform for future strategies in providing good quality and respectful care at childbirth facilities.

1. Introduction

Childbirth is often thought of as a happy and exciting event in a woman's life. Throughout this period, attention and care are essential as the childbirth experience can affect the future of the woman as well as her relationship with the baby and her family [1,2]. The childbirth experience may empower and reassure women, or it may cause long-lasting damage or emotional trauma

☆ Institutions where the work was done: Maternal and child health clinics in north area – West Bank, Palestine.

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that will persist over their lifetime [3]. In this period, women want and deserve humanised birth, which include respecting and understanding human beings and adhering to ethical principles of caring of women in a dignified way [4–6]. Every childbearing woman has the right to the maximum achievable standard of health, which comprises the right to magnificent, respectful health care during pregnancy and childbirth, in addition to the right to be free from violence and discrimination [5]. Unfortunately, global research has confirmed that women are experiencing mistreatment during childbirth [4,5,7–9]. Therefore, mistreatment contributes to a huge violation of woman's fundamental rights [5,10] as well as intimidating women's wellbeing, health, freedom of discrimination and right to respectful treatment [5].

Mistreatment during childbirth is not a new phenomenon. Recently, it has gained wide attention across global communities. A wide range of mistreatment experienced by women during childbirth was documented in an extensive systematic review of qualitative and quantitative researches. Seven types of mistreatment were reported, including physical, verbal, sexual abuse, encountering of discrimination and neglect, failure to meet professional standards of care, poor relationship between women and providers, and health system conditions and limitations [7].

Moreover, several studies showed that women were mistreated during childbirth because of their race, ethnicity, age, parity, language, HIV/AIDS status, traditional beliefs and preferences, economic status, and educational level [4,7,11,12]. In some places, women received abusive care without complaint and society also accepted and justified this kind of abuse [4,13,14].

The mistreatment of women during childbirth prevents them from seeking good health care and hinders the achievement of Millennium Development Goal 5, improving maternal health [15].

Most studies on the topic were from Africa, with a few conducted in Asia. A study conducted in 2012 among postpartum women in a Palestinian public hospital revealed that some women complained of inadequate privacy, disrespect of dignity, dehumanisation, and lack of explanation during vaginal examination [16]. Additionally, most women reported a lack of support and explanation during childbirth in the Gaza strip [17]. However, there has been a lack of studies explaining factors contributing to the mistreatment of women during childbirth at Palestinian childbirth facilities in West Bank. This study aimed to explore the views of Palestinian women and healthcare providers regarding factors contributing to the mistreatment of women during childbirth at childbirth facilities in the West Bank, Palestine.

2. Participants, ethics and methods

2.1. Setting and participants

A qualitative study using in-depth interviews was conducted in the West Bank, Palestine, from February 2019 to April 2019. Two groups of participants were involved: Palestinian women and healthcare providers, consisting of nurses, midwives, public health officers and healthcare facility administrators.

The inclusion criteria for women were those in the reproductive age group (18–49 years old) who had given birth through normal vaginal delivery within the past six weeks. Women with complications after childbirth, who had had a fetal death or with known psychiatric illness were excluded from the study. Purposive sampling was used to recruit these women among those who attended Palestinian Ministry of Health clinics in the North West Bank that provided vaccination for the newborns, postnatal care, and family planning. The women who came to the clinics and fulfilled the study criteria were included until data saturation was achieved. Variation in the sample of those women was applied including variation in age, residency, education level and place of delivery.

As for the healthcare providers, purposive sampling was also used to include those who had had at least one year of experience working in childbirth facilities in West Bank. The sampling included those with experience in childbirth facilities, and consisted of managerial posts and employees. They were purposively included into the study until saturation of information was achieved.

2.2. Data collection

The women were approached at the health clinics and the study explained to them. Once they agreed to participate, the time and place for the in-depth interviews were chosen, based on the women's preferences. All the women chose to be interviewed at the health clinics during their routine postpartum follow-up appointment. Written consent was obtained prior to the interviews. Women were interviewed by a single researcher using an interview guide. The guide consisted of open-ended questions exploring the women's experience during childbirth, any mistreatment, and their views on possible factors contributing to mistreatment during childbirth (Table 1).

With regards to the healthcare providers, in-depth interviews were conducted after obtaining written consent. The date, time, and venue for each interview were chosen. Most of the interviews took place in private places. Open-ended questions were used to

Table 1
Interview guide for postpartum women.

Topics	Questions	Examples of probing questions
Childbirth experience	Would you please share your experience of childbirth at the hospital?	Are you satisfied with this experience? Why?
		Can you tell me about the situation affecting your childbirth experience? In a positive or negative way?
		Could you please try to explain why that situation happened?
		Do you think that situation was mistreating to you and why?
Mistreatment during childbirth	Would you explain the possible contributing factors to mistreatment of women during childbirth?	Could you describe why mistreatment happened?
		What are the hospital conditions that were leading to mistreatment of women during childbirth? Why?
		Do you think that women's characteristics like age, economic status, or obstetric conditions has any role in the occurrence of mistreatment? Why?
Closing	Would you like to add any comments?	

Table 2
Interview guide for health care providers.

Topics	Questions	Examples of probing questions
Treatment of women during childbirth	Would you please describe how women were treated during childbirth?	Could you tell me about the situation affecting the treatment of women during childbirth? In a positive or negative way? Do you think women were mistreated during childbirth? Why?
Contributing factors to mistreatment during childbirth	Would you explain the possible contributing factors to mistreatment of women during childbirth?	Could you describe why mistreatment happened? Could you explain any difficulties/obstacles preventing providers from providing good treatment? What are the hospitals factors that were leading to mistreatment of women during childbirth? Why?
Closing	Would you like to add any comments?	

explore their views on how women were treated during childbirth, and possible contributing factors to mistreatment during childbirth (Table 2).

Interviews for both the women and the healthcare providers were conducted in Arabic. One of the research team members, who is a trained public health nurse, acted as a leader in organising the data collection. She had been previously involved with qualitative research. Three training sessions were conducted with the research team to enhance her skills in qualitative methods. She had also attended some qualitative research workshops to improve her professional experience for this research. She conducted all the interview sessions. The interviews were recorded and transcribed, and then translated and coded in English. The duration of each interview ranged from 40 to 50 min. The selection of participants and data collection was continued until thematic saturation was reached.

2.3. Ethics approval

The study was approved by Human Research Ethics Committee, Universiti Sains Malaysia (USM/JEPeM/18080400) and Research Ethics Committee, Al-Quds University, Palestine (reference no.: 57/REC/2018).

2.4. Data analysis

Thematic analysis was used to interpret the data collected from the interviews. Each interview transcript was analysed before conducting the subsequent interviews. Line-by-line coding was performed by the researcher who conducted the interviews. The codes emerged naturally from the data as a response to the questions and discussion during the interviews. The codes were linked together under suitable and meaningful themes and subthemes. These codes, themes, and subthemes were discussed with all research team members, and improvements were made after every data collection. Data saturation was reached after interviewing six women and five healthcare providers. The final subthemes and themes were obtained. Member checking was conducted, in which the transcripts and emerging themes were shown to four participants (two women and two healthcare providers). All of them agreed with the findings.

3. Results

3.1. Description of the participants

The participants comprised women and healthcare providers. Table 3 shows the description of the women. All the women were Muslims, Palestinians, married, and had given birth in the hospitals via normal vaginal birth without complications. Their mean age was 25.7 years (range 20–31). Three of them had a bachelor's degree while the rest had a secondary education; all of them were housewives. One of them was primiparous while the others were multiparas.

Table 3
Sociodemographic characteristics of the postpartum women (n = 6).

Variables	n (%)
Age (year)	
20–24	3 (50.0)
25–29	1 (16.7)
30–35	2 (33.3)
Education level	
Primary	0 (0)
Secondary	3 (50.0)
Tertiary	3 (50.0)
Occupation	
Teacher	1 (16.7)
Housewife	4 (66.6)
Student	1 (16.7)
Residence	
City	1 (16.7)
Village	3 (50.0)
Camp	2 (33.3)
Number of children	
0–1	2 (33.3)
2–3	3 (50.0)
4–5	1 (16.7)

All of the healthcare providers involved in this study were Palestinians. One of them had a bachelor's degree in midwifery, while four of them had master's degrees in public health, nursing management, and maternal and child health nursing. They had experiences ranging from 10 to 35 years in clinical settings, nursing, or as hospital managers (Table 4).

3.2. Factors contributing to the mistreatment of women during childbirth

There were four themes identified through thematic analysis with regards to the women and healthcare providers' views about factors contributed to mistreatment of women during childbirth (Table 5).

3.3. Limitation in childbirth facilities

Excessive workloads at Palestinian childbirth facilities act as a barrier to providing good care and treatment of women during

Table 4
Descriptive characteristics of healthcare providers (n = 5).

Interview no.	Occupation	Age	Gender	Education background	Experience	Duration of experience
1	Public health officer	42	Female	Bachelor in Nursing, Diploma in midwifery and Master in public health	Midwife at labour room, midwifery education, WHO employee and public health officer	20
2	Neonatal nurse	40	Female	Bachelor in Nursing, Master degree in public health	Nurse at labour room, community nursing and clinical training	15
3	Midwife	35	Female	Bachelor in midwifery	Midwife at labour room	10
4	Maternal and Child Health Supervisor	58	Female	Bachelor in midwifery, Master degree in maternal and child health nursing	Midwife at labour room, head of the midwifery department, Maternal and Child Health Supervisor	35
5	Hospital Manager	50	Female	Bachelor degree in Nursing, Master in nursing management	Supervisor at hospital, hospital management	30

Table 5
Themes and subthemes of factors contributing to the mistreatment of women during childbirth.

Main theme	Subtheme
Limitation in childbirth facilities	1. Excessive workload 2. Shortage of staff 3. Inadequate or poorly functioning resources 4. Unconducive physical structure 5. Lack of appropriate policies
Factors within healthcare providers	1. Misunderstanding of women's care responsibilities during childbirth 2. Lack of professional responsibility of providers 3. Justification of mistreatment 4. Unfulfilled staff development and needs
The women themselves	1. Normalisation of mistreatment 2. Obstetric factors 3. Lack of readiness before childbirth 4. Age of the women 5. Financial status of the women
Barriers within the community	1. Lack of empowerment and autonomy 2. Social pressure during childbirth

childbirth. The conditions put stress on the healthcare providers, which is reflected in their interactions with women by imposing verbal abuse and demonstrating ignorance of women's care, as illustrated by the following quote from a healthcare provider:

> "Sometimes, the healthcare providers reflect their tension on the women as a result of the work pressure. I mean, they might be angry with her and respond to her in a tough way or neglect some important aspects of her care." HCP1

Moreover, some women and healthcare providers claimed that the high number of childbirths at public health facilities leads to a heavy workload and more stressors on healthcare providers. This subsequently affected the quality of care provided to the women:

> "Most of the women give birth at public health facilities, because they have public health insurance. Thus, the healthcare providers couldn't manage the high number of deliveries and the work stressors around. So many problems may arise there." W2, 31

In addition, the long working hours and a high number of childbirths, especially during night duty, put the providers in a stressful situation with increased responsibilities. Therefore, they could provide only minimal care to the patients. One of the healthcare providers stated:

> "Working hours during night duty are very busy, more than day duty, due to a high number of deliveries and shortage of staff in comparison with day duty. All of these factors constitute a high burden on staff." HCP4

The healthcare providers reported that inadequate staff was a significant issue, especially during night duty. The available staff could not cope with the excessive number of childbirths and provide optimal management. Thus, the staff would not be able to perform their tasks effectively due to the high burden.

Several factors contribute to a poor working environment in the labour room, which distract the providers' attention toward the care of the women. For example, necessary resources were not always available, not put in place, not adequate, not functioning well, or not properly maintained. Consequently, the main concern of the providers was how to solve these problems that are fundamental in maternal care. For example, a shortage of fetal monitors and intravenous dropper machines are very serious and may lead to improper care and complications. These issues are illustrated below:

> "It will be a problematic case if I don't find a fetal monitor or dropper machine to monitor oxytocin infusion or linens to cover the woman. So I spend most of the time searching for devices and tools instead of taking care of women." HCP4

The healthcare providers reported that small labour rooms at some Palestinian childbirth facilities cause limited mobility areas for women and providers. Additionally, inadequate space between beds due to multiple beds in labour rooms negatively affects women's privacy and confidentiality during childbirth:

> "Labour rooms are small and narrow, there is no separate room for each woman, nor are there sufficient bathrooms. Also, it's difficult for a woman to do exercises or even to have a birth companion during labor." HCP5

All women who participated complained of the current policy toward birth companions, especially at public health facilities. The women were not satisfied being left alone during childbirth. They were isolated from their companion, so they felt lonely and unsupported. These women preferred to give birth at facilities that allow companions even though it was more costly, regardless of their financial status. Therefore, most of them tried to save money for this purpose. One woman mentioned the following:

> "My mother wasn't allowed to accompany me, so I am planning for next time to have enough money in order to give birth in a private hospital, so that my mother can stay with me." W1, 24

Some healthcare providers indicated that the accountability mechanisms and monitoring systems at childbirth facilities were ineffective and needed to be activated to detect and manage any problems related to women's care, including shortages and

ignorance during childbirth. They added that women were unintentionally mistreated on a daily basis with no one held responsible for this mistreatment because of ineffective accountability systems. One of them explained the situation as follows:

"Although a woman must receive good care regardless of the huge burden we suffer from, still there is a shortage of care because there is no follow up or good monitoring and lack of accountability system." HCP4

3.4. Factors within healthcare providers

Most of the healthcare providers at labour rooms were female; thus, care of the women was the responsibility of female providers (midwives) because male doctors have less contact with women during childbirth. Consequently, male providers (doctors) consider these issues as the midwife or nurse's responsibilities but not their responsibilities. As a result, male providers (doctors) depend on midwives or nurses to ensure privacy, provide psychological support, and prepare women for examination and delivery. This condition led to women feeling ignored and mistreated by the male providers (doctors). These issues are expressed in the following quote:

"Actually, in our society most of the healthcare providers are female. For this reason, doctors depend on midwives to care for women. Thus, doctors unintentionally mistreat women during childbirth." HCP1

The healthcare providers claimed that some providers lack a sense of professional responsibility; that is, they ignored their responsibilities toward a shortage of resources. For example, some of them had no intention to do the appropriate work to make up for the shortage of resources in the labour room but rather automatically accepted and adapted to the shortage of facility resources. Some providers stuck to performing their routine work, neglecting technical work, and created excuses for unawareness and negligence. Women are the most negatively affected patients because any shortage of resources will delay or disturb women's care during childbirth:

"Unfortunately, there is a shortage of the resources and the health care providers deal with this shortage as a given and acceptable; they didn't try to make up the shortage and had no intention to keep the available resources. As a result, women always complain and suffer." HCP1

Most of the healthcare providers justify the mistreatment. For example, they sometimes justify using a loud voice as being for the benefit of the women, as a way to obtain cooperation during childbirth. From the providers' standpoint, women might be mistreated because they had a poor understanding during contraction time of labour and because they were not prepared well during pregnancy:

"Sometimes, the treatment of women may be due to poor understanding during childbirth related to a lack of readiness during prenatal care, so it's useless to teach her how she can handle labour because of contractions and poor concentration." HCP4

Another contributor to mistreatment, as viewed by the healthcare providers, was administrative pressure from the institution itself. This factor usually creates stress and frustration for the providers themselves during work time. Simultaneously, lack of motivation for the staff or lack of facilitation for the providers, such as nursery availability for the babies, were also stressors. In addition, there were inadequate plans for alleviating stress among providers:

"There is a lack of equity, support, and motivation for midwives. I mean I just do my work properly because I consider it a moral role and fear from Allah." HCP3

Moreover, providers also have daily life stressors, especially the female providers. Such stressors affect their work and productivity. For example, they play additional social roles of homemakers, mothers, and more. Thus, they already have other responsibilities and high stressor levels that may cause them to be nervous and moody, which is often reflected in their treatment of women in labour rooms.

3.5. The women themselves

An important contributor to mistreatment is the normalisation of it by women themselves. Most women considered mistreatment during childbirth normal and acceptable. Thus, they did not complain or even say they were mistreated. Women sometimes did not care about the actions and events happening during childbirth because they felt shy and believed that childbirth is a short period and must be tolerated. During that period, women's main concerns were pain relievers and giving birth. One woman stated the following:

"Everything was normal and acceptable; I didn't care about the surrounding situation. I only concentrated on giving birth quickly and getting rid of the pain; when in pain, everything seems normal." W3, 20

Both the women and the healthcare providers stated that obstetric characteristics contributed to mistreatment during childbirth. Some of the multiparous women were unintentionally mistreated because some providers believed that multiparous women should know every detail about childbirth and must tolerate pain without complaining:

"They told me this is your fourth child, so you should not complain. How couldn't I feel pain!? childbirth is a painful process, whether it is the tenth delivery or the first one." W2, 31

According to the women, primiparous women faced ignorance during childbirth because the birth process may be long and difficult. Providers may not devote adequate time to primiparous women, so they may feel alone most of the time and unsupported, especially in the absence of a birth companion.

"During my childbirth, I heard the primiparous women shouting, so I asked the providers to help her. They said that we have already taught her, but she doesn't respond and said she still needs more time." W1, 24

From the view of healthcare providers, women were unintentionally mistreated in cases of complication during childbirth, because the main concern was to save the woman's life. The providers might neglect the psychological aspect of care and concentrate on their medical issues during that particular time. This is expressed in the following quote:

"Logically, the doctors are more involved in a high-risk pregnancy and complications during childbirth. Therefore, they sometimes overlook the way they treat the woman." HCP1

The healthcare providers expressed that women gained their information from their relatives, neighbours, family, and friends. Thus, they usually get misleading information from informal resources. Consequently, women were expecting mistreatment in advance, even before coming to the labour room, because they were unprepared for childbirth during the prenatal period and had insufficient knowledge and fears toward hospitals and a lack of confidence in providers. A healthcare provider described this as follows:

"Some women come with a negative idea that they got from their relatives. So, they fear being neglected during their time in labour rooms. All of that was because they were unprepared." HCP3

The women and the healthcare providers mentioned that young or advanced age women suffered from mistreatment more. The advanced age women were criticised by the providers for getting pregnant at that age, while the young women suffered more due to a poor experience and a longer childbirth period:

"If a woman is old, she suffers more because she faces criticism from the healthcare providers and consequently feels shame of being pregnant at a late age." W5, 35

"Actually, young age women are less cooperative and have no experience, so they couldn't understand the given instructions—pushing, breathing exercises, et cetera—and how to deal with their babies. Consequently, they suffer a lot." HCP2

In addition, the financial situation of the women was very important during childbirth. Most of the women stressed that women can choose a convenient place for childbirth.

"Money always affects our life. If we have enough money, life will be easier. So, by having money, sure we can go to a good place for childbirth, a relaxing environment and reduce our pain and suffering." W5, 35

3.6. Barriers within the community

The healthcare providers stated that most of the women were unaware of their rights, such as the right to respectful care. Women of lower social classes were known to accept whatever was available, and did not ask for what they needed. Therefore, uneducated and young women were more prone to maltreatment by providers because they were timid and disempowered. One provider described it as follows:

"Some women do not know their rights during childbirth, so uneducated women or young ones are vulnerable for mistreatment; they often accept whatever is available and have no objection to any kind of treatment." HCP1

Social pressure during childbirth has also been a hidden contributor to mistreatment. For example, women were sometimes forced to be accompanied by an unwanted person during childbirth. This situation occurred because some hospital policies allow for a birth companion without considering the women's choice of companion, leading to the women feeling uncomfortable and mistreated:

"Sometimes, a woman is forced to be accompanied by undesired person such as a mother-in-law, for example. So, the woman feels tension and stress. But in fact, a woman often hides this feeling because it is embarrassing to refuse." HCP2

In addition, family pressure was another important contributor to the mistreatment of women during childbirth. Women's choices were controlled by their families, and they could not make their own decision even in matters related to their bodies. For example, the decision to use a painkiller such as epidural anesthesia was made by other family members. Their family would decide on their behalf whether to reduce childbirth pain or to keep them suffering from contractions. There were many other families and social stressors related to pregnancy, such as if the woman was pregnant with a female infant and already had females in the family and the family wanted a male. All these issues contributed to mistreatment during childbirth.

4. Discussion

There were four main contributing factors of mistreatment during childbirth identified in this study: limitations in childbirth facilities, factors within the healthcare providers, the women themselves, and barriers within the community. This finding was supported by several other studies [4,7]. The participants attributed mistreatment to providers' burdensome daily workload and shortage of staff. When the providers cannot adapt to this situation, they sometimes project their stress by verbally mistreating women or being ignorant of care. Similar situations are also reported in other studies [7,18,19]. It is not possible for overloaded providers to be with all women at the same time during childbirth, which makes the women feel it as a form of negligence. In other studies, some providers and women considered mistreatment that resulted from staff shortages and lack of resources, as unintentional actions [20].

When providers encountered a heavy workload including high number of women giving birth, they are not able to meet the caring needs of women during childbirth [21]. The situation in Palestinian hospitals is very stressful, and providers claimed that they are suffering from a significant daily burden and work stressors that affect their performance. There are also additional challenges related to childbirth facilities that lead to mistreatment, such as overcrowded labour rooms and lack of necessary resources or poor functioning of resources used. This is similar to the findings from other studies which showed that mistreatment was caused by low quality of service [7,20,22]. Moreover, mistreatment might be caused by exposing women to unnecessary procedures such as exaggerating in their vaginal examination or conducting it in rough way [16].

A recent policy preventing the presence of a birth companion in public health facilities in the West Bank is another contributor to mistreatment. Women may consider this as unfair policy for their right during childbirth. Palestinian women prefer to have a birth companion, especially their mothers. One study confirmed that unaccompanied women during childbirth are more prone to mistreatment [23]. This situation kept women disempowered, feeling scared, or lonely during her childbirth [7]. On the other hand, women with birth companion had good childbirth outcomes and less pain [24,25].

Lack of accountability mechanisms and ineffective monitoring systems are common problems not only in the Palestinian health system but also in other countries [4,7,14]. This condition kept women incapable of achieving their right for good treatment [7]. Sometimes, complaints made by women did not reach the decision-maker in hospitals, or at other times, even if complaints reached higher levels of management, real actions were not taken. This is partly due to weakness in the monitoring system regarding following up of the complains made by these women, and absence of accountability mechanism for handling these complaints.

According to doctors, women's care during childbirth is a midwife's responsibility [17]. Moreover, doctors consider that their main responsibility is restricted to emergency and complicated cases but not to regular ones. In a previous study, some women described their vaginal examination conducted by physicians to be painful, performed in a punishing way with a non-sensitive manner with a lack of privacy [16]. Another study in West Bank, Palestine has shown that overloaded doctors often reflect their own stress on the midwives and laboring women and mistreated them [21]. Often, mistreatment is not carried out by healthcare providers on purpose, but it sometimes occurs unintentionally when providing other necessary care [7].

Another vital issue is that some of the healthcare providers felt they are excused for their unawareness to the childbirth limitations and shortage of resources, and they stuck just doing their routine work. This illustrates that these limitations and shortage in childbirth facilities negatively affect the healthcare provider's behaviors towards their performance and loyalty to the

professions. This is equivalent to the result from another study which confirmed that poor working environment also negatively affects the healthcare providers' attitudes towards their profession and discouragement [7,12].

Justification of mistreatment is common among providers [4,9,20]. Healthcare providers consider shouting at and using loud voices with women to be necessary to obtain cooperation and benefits for the women and their infants. This result is parallel to a study in Nigeria that found that providers used verbal and physical abuse as ways to ensure positive outcomes [18]. In another study in Kenya, the healthcare providers used verbal abuse to women to control them and keep them calm during childbirth [20]. According to some women's views, mistreatment is considered to be normal [4]. Palestinian women are very deferential, and most women do not provide objections during childbirth, instead accepting everything. Normalisation was identified by another study where some women viewed slapping to be a normal way to assist them during childbirth [20].

Women also faced some kind of mistreatment during childbirth because of their sociodemographic characteristics. This is parallel with findings from some other studies [4,7,9,12,20,23]. Women from young age group, low social class, low level of education were at greater risk to mistreatment [7,9,20] and primipara women were highly prone to unnecessary vaginal examinations [16] Additionally, the financial status of the woman and her family act as a barrier to receiving a good care because they cannot pay for the needed service [4,7]. Women prefer to be in a separate room with a close birth companion, and to receive strong pain killers. Generally, women know that these facilities are available in private hospitals, but admitting such hospitals requires a significant amount of money. A Palestinian woman is often disempowered; thus she accepts what is offered to her regardless of her preferences. For example, when her childbirth or vaginal examination performed by a male doctor, she usually accepts it although it may be against her wishes. This is because she is likely afraid of being deprived of good care.

5. Strength and limitations

This study provides valuable information on factors contributing to mistreatment of women during childbirth in West Bank, Palestine. To our knowledge, this is the first study to report qualitative exploration of this situation in the local setting. Exploring the issues from the views of women themselves, as well as the healthcare providers, provide a rich understanding on how the women were treated during childbirth. Including women who were within six weeks after childbirth allows them to share their recent experiences with minimal recall bias. The conduct of the interviews not in the facilities where the women had undergone childbirth provides a comfortable environment for them to express their feelings.

However, there were some limitations in this study. The findings were derived just from female health care providers. In order to obtain more understanding of this issue, further research should be conducted to include male health care providers (doctors). Furthermore, mistreatment is a challenging and unfamiliar topic to discuss with the healthcare providers.

According to women involved in this study, some of them might still have been reluctant to talk freely about their experiences during childbirth, because all interviews were conducted face to face at maternal and child health clinics.

6. Conclusion

This study has determined the contributing factors of mistreatment during childbirth at childbirth facilities in the West Bank, Palestine as concluded by postpartum women as well as illustrated by the healthcare providers. This evidence indicates to some extent the presence of mistreatment of women during childbirth at childbirth facilities. Such mistreatment mainly emerged from four themes: limitation in childbirth facilities, factors within healthcare providers, the women themselves, and barriers within the community. There are limitations in childbirth facilities, such as lack of resources, staff shortage and excessive workload. This stressful working environment is confusing and frustrating for the providers and negatively affects their behaviors, which may lead to unintentionally mistreating women during childbirth. Decision-makers are advised to address these limitations by providing the needed resources to help create healthy working environment, which is necessary for providing good quality of care for women during childbirth. In addition, it is a need for continuous education and training of all staff in respectful care as well as education of women to raise awareness of their rights.

Ethical statement

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Author contributions

All authors named in the manuscript have made substantial contribution each to qualify for authorship and have approved of the content of the manuscript. IMMD, TATI, MII and FG designed the methodology of the study and analyses. IMMD conducted the data collection. IMMD and TATI conducted the data analyses. IMMD drafted the manuscript and TATI reviewed and edited it. All authors read and approved the final manuscript.

Conflict of interest

None declared.

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