EXPLORING OBSTETRIC VIOLENCE IN THE EASTERN MEDITERRANEAN REGION

Submitted by:
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56th Master of Public Health/International Course in Health Development
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Exploring Obstetric Violence in the Eastern Mediterranean Region

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Science in Public Health

by

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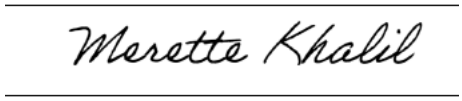
Egypt

Declaration:

Where other people's work has been used (from either a printed source, internet, or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis, "***Exploring Obstetric Violence in the Eastern Mediterranean Region****",* is my own work.

Signature: 

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Abbreviations

ANC	Ante-natal visit coverage
B&H	Bowser and Hill
D&A	Disrespect and Abuse in Childbirth
EMR	Eastern Mediterranean Region
FBD	Facility-based deliveries
GBV	Gender-based violence
GCC	Gulf Cooperation Council
HIC	High Income Countries
LIC	Low Income Countries
LMICs	Low- and Middle-Income Countries
MIC	Middle Income Countries
NGO	Non-governmental Organization
OV	Obstetric Violence
QoMC	Quality of Maternal Care
RMC	Respectful Maternal Care
SBA	Skilled-birth attendant/ce
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
TLTL	Too Little Too Late
TMTS	Too Much Too Soon
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

Glossary

Key Terms	Definition
Women	For the purpose of this study, "women" referenced in this thesis refer to birthing, laboring, parturient or immediate postpartum mothers; most of whom are either interviewees, survey-respondents or study-participants in included studies.
Provider	Includes all maternal health workers (including, doctors/OBGYNs, nurses and midwives, providing intrapartum care to women at birth, mostly in facilities but also including health workers in community-settings (e.g. community midwives in studies from Afghanistan and Yemen)
Obstetric Violence (OV)	OV is a form of gender-based violence (GBV) which comprises a range of violations and abuses, targeting laboring and childbearing women. OV is a form of institutional and systemic violence against women, that is embedded and normalized within health systems and societal norms. It violates women's rights, evidence-based medicine (by providing interventions in a manner that is Too Much Too Soon) and inhibits the provision of respectful maternal care.
Disrespect and Abuse in Childbirth (D&A)	Disrespect and Abuse in Childbirth is a term coined by Bowser and Hill in 2010 to define and conceptualize 7 categories of abuses against women in childbirth. These 7 categories include: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention. For the purpose of this thesis, D&A will serve as a proxy to measuring or capturing examples of OV perpetrated against women at birth
Respectful Maternal Care (RMC)	RMC is a universal human right for every childbearing woman globally. It comprises of the use of evidence-based guidelines and practices in managing maternal routines and complications in childbirth (in a manner that is not TLTL or TMTS), in addition to ensuring that respect and dignity are integral parts of the provision of health services that women receive throughout pregnancy, childbirth, and the postnatal period. Upholding RMC is essential to improving women's experiences and the quality of maternal care
Quality of Maternal Care (QoMC)	In this study, quality is defined according to the Institute of Medicine's 6 criteria, as care that is safe, effective, efficient, equitable, timely and patient-centered.

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First and foremost, I thank God for every strength, blessing, and opportunity at every step in my career up to this point, it is only possible by supernatural grace. Endless thanks to my parents and family for their continued support, without whom, this opportunity to complete my masters would not be an option.

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To the class of 2020, graduating in the middle of a pandemic, is not a joke! Many thanks to our community, near and far, for the encouragement, love, support, and refreshing laughter shared throughout these tough months.

Finally, to all birth workers, women's rights advocates, and doulas in Egypt, in the Region, and around the world who have spearheaded the fight against obstetric violence, we stand on your shoulders to push this agenda of human rights and dignity in childbirth forward. This work is dedicated to all the brave mothers who have shared their experiences, stories, narratives, and perspectives, exposing gaps in quality, abuses, and disrespect in childbirth.

Introduction

My name is Merette Khalil from Cairo, Egypt. I have always been motivated by social justice; and I am passionate about ensuring the right to health for all, especially women and girls and those in vulnerable settings. I aspire to transform the landscape of maternal health, not just in Egypt, but across the surrounding region. My dream is to reform health systems to become more gender-inclusive and equity-sensitive.

Prior to starting my masters at KIT, I was working as a birth doula and childbirth educator. In assisting women in labor, with physical, emotional, and informational support, I observed the symptoms of obstetric violence as normalized and routine 'standards' of intrapartum care. The ubiquitous violations of women's rights are embedded in a culture and health system that sees the physician as a "pharaoh." These abuses minimize women's autonomy and enable the continued objectification of women's bodies, intimidation in maternal care, and stigmatization of information-seeking (especially related to sexual and reproductive health and rights).

Obstetric violence threatens providing women with dignified, respectful, rights-based, high-quality maternal care. It violates dozens of human rights through the provision of disrespectful and abusive non-evidence-based care, reduces utilization and trust in health systems, and results in poorer health outcomes for women, children, families, and communities.

In 2018, I started a small organization, YourEgyptianDoula, the first of its kind in Egypt, to advocate, educate, and empower expecting parents on their rights and options, to ensure that every family starts with a dignified and empowered birth. On the second anniversary of its inception, it is with great honor that I submit this thesis titled "*Exploring Obstetric Violence in the Eastern Mediterranean Region."* This is particularly timely in light of Egypt's #MeToo movement catching fire and sparking conversations related to women's rights and empowerment, gender-based violence, and debilitating patriarchy across every sector of society, including health.

In advocating for dignity and respect for every birthing woman, this thesis aims to provide an overview of Obstetric Violence in the Eastern Mediterranean Region, using the experiences and narratives of birthing women as the foundation, to offer recommendations on improving Respectful Maternal Care.

ABSTRACT

Background

Obstetric Violence (OV) violates women's rights and inhibits Respectful Maternal Care (RMC). The Eastern Mediterranean Region (the Region or EMR) ranks second-worst globally on reproductive and maternal health with urgent progress needed for women's empowerment. While efforts to improve quality of maternal care have long existed, women's perceptions of dignity and respect during childbirth are not adequately or systematically recorded.

Aim

This study is among the first in the Region to provide an overview of OV and offer recommendations to improve RMC by centering women's experiences in childbirth.

Methods

A mapping literature review was used; 38 articles met the inclusion criteria and were analyzed using Bowser and Hill's framework of the seven categories of Disrespect and Abuse (D&A) in childbirth.

Findings & Discussion

In the EMR, women's narratives indicate the normalization of OV in childbirth. Findings show the most common types of D&A are physical abuse and non-dignified care, generally comparable to global literature. The intersection of these abuses enables the objectification of women's bodies and overuse of unconsented routine interventions in hierarchical and patriarchal health systems. If unchecked, the implications include perpetuating the cycle of OV and passivity towards human-rights violations.

Conclusion

To eliminate OV, a paradigm shift is required involving infrastructural changes, education, empowerment, advocacy, health system strengthening, and policy development. Recommendations are given at individual, community, health system and policy levels, to ensure that every woman achieves her right to health and birth in a dignified, respectful, and empowered manner.

Key Words

Obstetric Violence; Disrespect and Abuse in Childbirth; Respectful Maternal Care; parturition/childbirth; Eastern Mediterranean Region

Word Count

11,506

Exploring Obstetric Violence in the Eastern Mediterranean Region

"Every woman has the right to the highest attainable standard of health, including the right to dignified, respectful health care throughout pregnancy and childbirth, and the right to be free from violence and discrimination." (1)

BACKGROUND

Quality of Care for Effective Coverage

In advocating for the right to healthcare for all individuals, the World Health Organization (WHO) has set an ambitious agenda to achieve Universal Health Coverage (UHC) worldwide. Effective coverage ensures that all persons have access to high-quality, appropriate, acceptable, and essential health services without suffering financial hardship or impoverishment, including and centrally to this paper, maternal care (2). Women around the world deserve the right to access quality maternal care, defined as safe, effective, efficient, equitable, timely, and patient-centered (1,3).

Reducing maternal mortality has historically been at the forefront of the global health agenda and has been halved worldwide between 1990 and 2015 due to an increase in utilization of maternal health services (2). Safe Motherhood initiatives have resulted in 75% of women delivering with a skilled-birth attendant (SBA), 66% have at least 4 ante-natal (ANC) visits, and about 50% having facility-based deliveries (FBD) (with differences based on socio-economic status) (4). Despite these advances, a reduction in maternal mortality and increase in utilization of health services did not signify high quality of maternal care (QoMC); many mothers worldwide continue to suffer due to delays, ineffective, inefficient, inadequate, unnecessary, harmful or disrespectful services (2,4).

To better maternal outcomes and achieve UHC, an explicit focus on improving quality is needed. Yet, the Sustainable Development Goals (SDGs) do not specifically include a goal or indicator related to quality of care. Structural causes of poor QoMC include inadequate staff, deficient training, outdated equipment, limited supplies, rundown infrastructure, and insufficient evidence-based clinical guidelines (or more often inadequate adherence to existing guidelines) (4).

In 2016, WHO established eight *Standards for Improving Quality of Maternal and Newborn Care In Health Facilities* namely (5):

1. evidence-based management of routine and complications,
2. actionable information systems,
3. functioning referral systems,
4. effective communication,
5. respect/dignity,
6. emotional support,
7. motivated personnel, and
8. availability of essential resources.

These guidelines are embedded in the six building blocks of health systems, integrate the three aspects of the Donabedian model for quality (structure, process, and outcomes), and highlight both the demand and supply-sides of care (provision and experience) ***(Annex 1).*** Historically, QoMC researchers have used outcome indicators (e.g. maternal mortality and births attended by SBA), or process indicators (e.g. C-Section rates by wealth-quintile, length of stay after delivery, availability of emergency obstetric and newborn care). However, these indicators require further development, standardization, validation and revision as they do not address the issues of timeliness, costliness, provider skills and attitudes, or women's perceptions and satisfaction (2,6).

Respectful Maternal Care and Disrespect and Abuse during Childbirth

Scholars have identified that poor QoMC is usually associated with deviation from evidence-based guidelines where care is either "Too Little Too Late (TLTL)" or "Too Much Too Soon" (TMTS) (4). TLTL is characterized by inequitable and untimely access to services, resources, health workers, and information, usually in lower-income countries (LICs). TMTS is characterized by expensive, potentially harmful, overmedicalization and poor regulation (especially in private sector), usually in middle or higher-income countries (M/HICs) where FBD are increasing (4). These deviations from evidence-based care threaten quality of care in almost every country. Notably, data on non-evidence-based care (TLTL or TMTS) focuses on one-angle, provision of health services, without sufficiently capturing women's experiences of childbirth (4).

Bowser and Hill's groundbreaking 2010 landscape analysis initiated the momentum of global health research on Respectful Maternal Care (RMC) and its violations (7). In 2011, global maternal health scholars created the RMC Charter, recognizing RMC as a universal human right for every childbearing woman in every health system globally (8,9). Furthermore, to operationalize RMC, scholars recommended the "use of evidence-based guidelines to tackle TLTL and TMTS, coupled with efforts to ensure that respect and dignity are integral parts of QoMC that women should receive throughout pregnancy, childbirth, and the postnatal period"(4). Upholding RMC is necessary not only because women (and newborns) subjected to poor standards of clinical care might be physically harmed, but also because childbirth is personal and cultural, and negative experiences may result in damaging memories, generational emotional trauma, and mistrust in health systems.

Violations to RMC are considered disrespect and abuse (D&A) in childbirth. Bowser and Hill (B&H) and the RMC charter identified seven categories of disrespect and abuse, each correlating to one or more human rights, which will serve as the analytical framework for this thesis (see methodology) (7,10).

Obstetric Violence

Responding to outcries and advocacy from human rights and birth advocates, grassroots organizations, and civil-society voices globally, the Special Rapporteur of the Human Rights Council presented a global analysis of the violence experienced by women during facility-based childbirth, introducing "Obstetric Violence (OV)" to the UN General-Assembly in 2019 (11). Shortly after WHO

conducted and published a multi-country study to uncover and measure mistreatment of women in childbirth in developing countries (12). That study indicated that over a third of women experienced D&A in childbirth, with young women being 1.8 times more likely to experience physical abuse, and less educated women 3.6 times more likely to experience verbal abuse. Moreover, 60% of women were subjected to unconsented vaginal exams, 75% to unconsented episiotomies, 27% to unconsented inductions, and 11% to unconsented C-sections (12).

OV exists at the intersection of institutional violence and violence against women and can occur to women during pregnancy, childbirth and postpartum regardless of the type of facility used (11). WHO describes OV as "outright physical abuse, profound humiliation, 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" (1).

OV is a form of gender-based violence (GBV), targeting laboring and childbearing women that violates women's rights, evidence-based medicine, and RMC. Its gendered, structural, and institutional nature makes it difficult to recognize due to its normalization and embeddedness in health systems and societal norms (***Figure 1***). **D&A in childbirth is an expression of OV in the health system as such will be used as a proxy to analyze its prevalence in this study.**

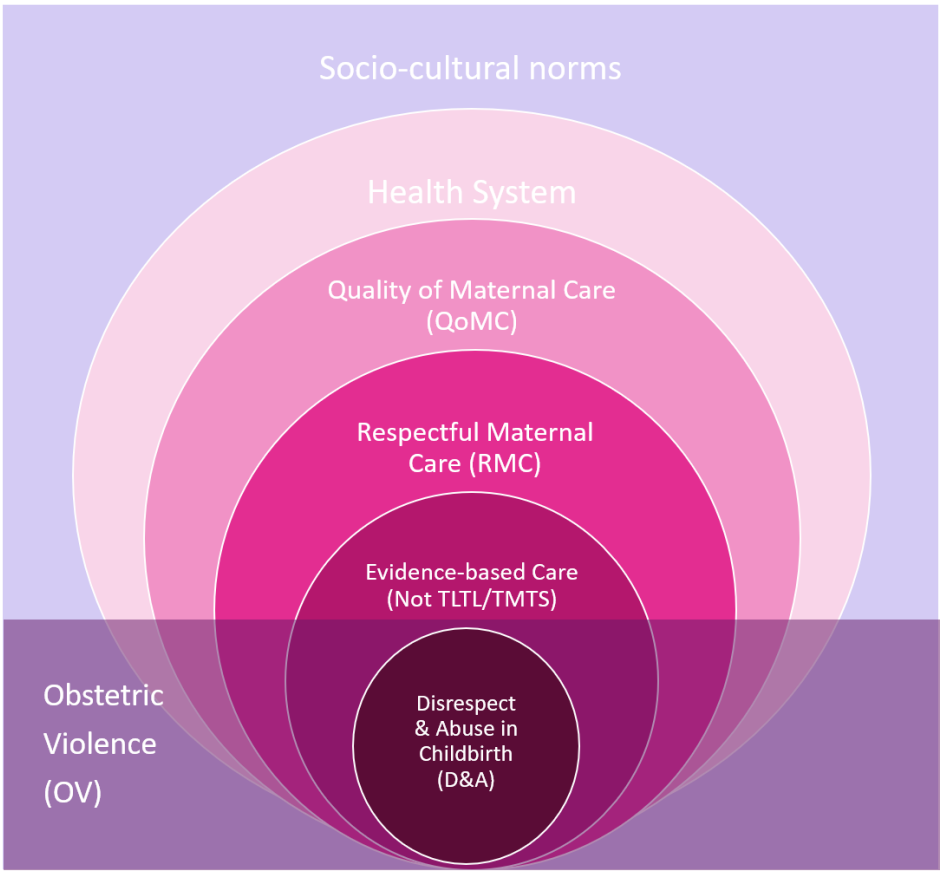

FIGURE 1: CONCEPTUALIZING OBSTETRIC VIOLENCE AND ITS RELATIONSHIPS WITH D&A, RMC, QOMC, HEALTH SYSTEMS, AND SOCIETY

Eastern Mediterranean Region (EMR)

The EMR comprises 22 countries and is characterized by diversity in demographics, socioeconomics, security, and health systems, from relatively stable to fragile (***Table 1***).

There are almost 583 million people living in the Region, the majority are youth under 30 and a fifth are adolescents between 13-18 (13). The countries with the largest populations are Pakistan, Egypt, and Iran (13). Total fertility rates range from 1.5 children per woman in the UAE to 6.4 in Somalia; while adolescent fertility rates range from 0.1 per 1000 girls aged 15-19 in Lebanon to 87 in Afghanistan (14).

Table 1: Countries in the EMR based on World Bank Income Classification and WHO Emergency Operations

High Income (HIC), i.e. Gulf Cooperation Council (GCC)	Middle-Income (MIC) (Upper and Lower)		Low-Income (LIC)
		WHO Emergency Operations	
Bahrain	Djibouti	Iraq	Afghanistan
Kuwait	Egypt	Libya	Somalia
Oman	Iran	Pakistan	Sudan
Qatar	Jordan	Palestine	Syria
Saudi Arabia	Lebanon		Yemen
United Arab Emirates (UAE)	Morocco		
	Tunisia		

The EMR is the only Region globally where extreme poverty increased over the last decade due to ongoing wars and political uprisings. More than 20 million people are living on less than $2/day (USD), with an estimated 1.7 million jobs lost in 2020, and 8 million falling into poverty, half of which are children (15). In 2019, 53.3% of persons receiving humanitarian assistance lived in the Region, and 45.3% of all global refugees and internally displaced persons originated from the Region (13). Since COVID-19, the situation has deteriorated as many health systems have been further strained.

With two-thirds of EMR countries directly or indirectly affected by emergencies, many health systems suffer from (16):

- insecurity and infrastructural damages
- workforce shortages and maldistributions,
- limited availability of medicines and supplies,
- concentration of facilities, resources, staff in urban centers,
- fragmented data and information systems,
- poor coordination with private sector, and
- weak regulations, among others.

There are wide variations among health systems in the EMR, from war affected and disrupted to some of world's richest oil producing countries (GCC), which affect health services delivery and maternal health indicators (***Table 1***). The UHC service coverage in the EMR ranges from 22% Somalia to 77% in Qatar and Kuwait (14). Hospital bed density ranges from 3.9 beds per 10,000 people in Afghanistan to 32 per 10,000 in Libya (14). Health workforce density ranges from 0.8 doctors, nurses and midwives per 10,000 people in Somalia to 94 per 10,000 in Kuwait (***Figure 2***) (14).

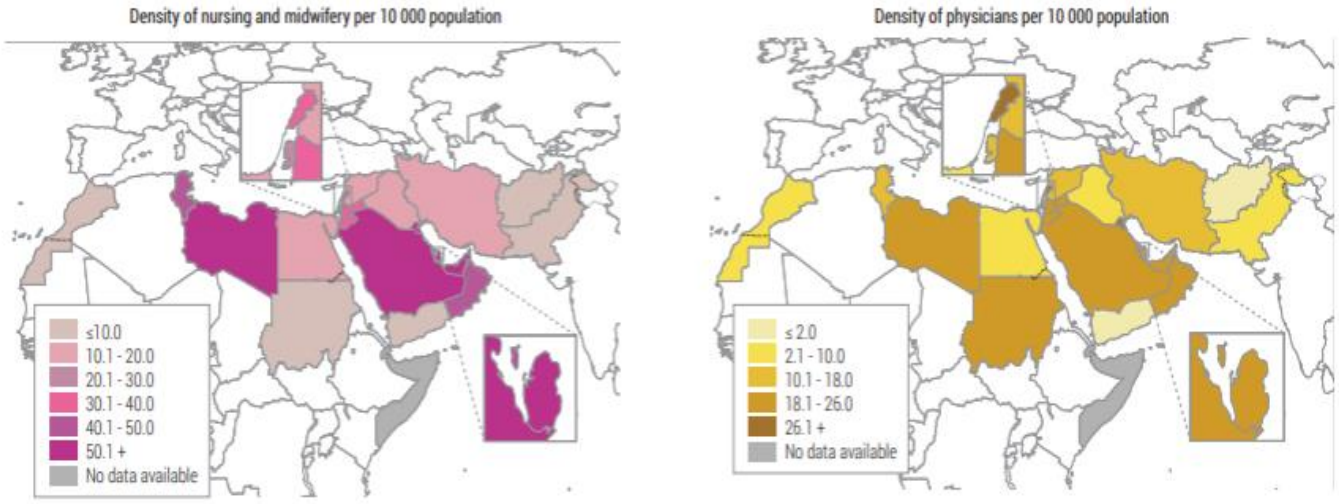

FIGURE 2: DENSITIES OF DOCTORS, NURSES, AND MIDWIVES PER 10,000 PERSONS ACROSS THE EMR. SOURCE: WHO EMRO FRAMEWORK FOR HEALTH INFORMATION SYSTEMS AND CORE INDICATORS FOR MONITORING HEALTH SITUATION AND HEALTH SYSTEM PERFORMANCE, 2019

With regards to reproductive and maternal health, the EMR ranks second-worst and has the highest rate of neonatal mortality globally (13). SBA ranges from 38.4% in Somalia to 100% in most of the GCC countries while ANC coverage (four visits or more) ranges from 3.3% in Somalia to 100% in the UAE (14). The EMR contains some of the lowest and highest C-Section rates globally, ranging from 2% in Somalia to 52% in Egypt, with an average of 21% (13).

The EMR is generally culturally conservative and diverse, with numerous sub-cultures in each country. Much progress is yet to be made regarding women's health, rights, and empowerment, particularly related to decision-making, stigma, and access to information on various topics related to Sexual and Reproductive Health and Rights (SRHR) (17,18).

JUSTIFICATION AND OBJECTIVES

Problem Statement

Global evidence suggests that OV and D&A in childbirth are ubiquitous in every health system (19). Like many MICs, many countries in the EMR are characterized by the provision of non-evidence-based maternal care, often TMTS, with high rates of routinely used interventions during labor and delivery, including but not limited to, inductions, amniotomy, c-sections, and episiotomies (4). Unfortunately, studies have found that overmedicalization and technocratic care are common themes in

the provision of maternal care in the Region (20,21). While advancements have been made to improve the provision of maternal care in the EMR, as seen through reductions in maternal deaths and increased utilization of SBA and FBD, laboring women's experiences and perceptions of their care are not sufficiently captured. Providing RMC not only improves patient satisfaction and women's perception of power and dignity during delivery, but also increases health services utilization and QoMC resulting in better maternal and neonatal outcomes (19,22).

However, even in the strongest and most resilient health system, OV can be found because it is systemic and engrained in socio-cultural norms (***Figure 1***) (23–25). In the EMR, there is generally a culture of silence around many SRHR topics, including maternal health, which are considered taboo. This stigma affects women's perceptions of their bodies and their autonomy over them, health literacy, and health seeking behaviors (18). Generally, the patriarchal and conservative culture in the Region sets rather strict gender norms and roles. In many countries in the Region, decision-making power on matters of maternal health, and SRHR, remains often with men, religious leaders, and doctors (17,18,26).

Justification

A paradigm shift is required to provide rights-based, high-quality, patient-centered, culturally-contextualized, and effective health coverage (23,27). Since 2019, the UN and global players advocated and recognized the urgency of addressing OV, to dignify the experiences of childbearing mothers, protect women's rights, and improve QoMC (25). Notably, women's voices and experiences must be at the center of improving QoMC and ensuring RMC.

Since Bowser and Hill's 2010 report, there have been various studies attempting to capture the prevalence of D&A and analyze RMC. The majority of published evidence on OV and D&A is concentrated either in Sub-Saharan Africa (SSA), North America, or Europe, with limited literature from the EMR. In one global systematic review on RMC, only four articles from the Region met the inclusion criteria (19). Evidently, this thesis will be the first to explore the magnitude of OV in the EMR using the B&H model.

As with all forms of GBV, it is likely that the magnitude and severity of OV is underreported and underestimated. It is expected that due to the conflicts, conservative cultural norms, and under-reporting of GBV in the Region, the findings of this study will be similar, if not higher than the global prevalence estimates of OV. While global studies indicate a correlation, this thesis does not factor the impact of COVID-19 as a risk factor for OV (28).

Given the global momentum towards dignifying childbirth and dearth of evidence on OV regionally, this study aims to center the experiences of women's mistreatment in childbirth to address the present knowledge gap through the following objectives:

Objectives

- **General Objective:** To provide an overview of OV in the EMR from the experiences and narratives of birthing women and offer recommendations on improving RMC in the Region.
- **Specific Objectives:**
    1. Describe the experiences of OV for women in the EMR,
    2. Analyze patterns of D&A in childbirth between countries in the EMR,
    3. Compare the findings from the EMR with other regions and global experiences, and
    4. Offer recommendations on interventions to improve RMC in EMR.

METHODOLOGY

Study design

This thesis follows a descriptive study design, as a reproducible mapping literature review, based on available peer-reviewed and grey literature.

Search Strategy

A search of PubMed, CINAHL/EBSCO, Google, Google Scholar, VU Libraries, Cochrane Databases, Harvard Maternal Health Task Force (MHTF) Publications, and the Eastern Mediterranean Health Journal (EMHJ) was used to identify relevant publications on "RMC", "D&A", and "OV" in each of the 22 countries in the EMR. Search of Google, Academia, and MHTF were conducted to identify other relevant grey literature, reports, blogs, and medias on the subject. Literature was searched between April and May 2020. Systematic reviews and peer-reviewed publications were snowballed, and reference lists were screened to identify frameworks used in the global literature, articles relevant to the EMR, and experiences of other LMICs for comparison. Keywords and detailed search strategy presented in ***Table 2.***

Table 2: Summary of Search Strategy by Publication Type and Objectives		
Search Strategy	**Details/Keywords**	**Objective**
Includes	Systematic reviews and peer-reviewed articles, grey literature, media and news articles, WHO/UNFPA/UN publications, and reports	All
Language	English	
Time Frame	Only articles published after 2010	
Peer-Reviewed		
PubMed	((((("disrespect and abuse"[All Fields] OR (obstetric[All Fields] AND ("violence"[MeSH Terms] OR "violence"[All Fields])) OR (respectful[All Fields] AND ("mothers"[MeSH Terms] OR "mothers"[All Fields] OR "maternal"[All Fields]) AND care[All Fields])) OR ("parturition"[MeSH Terms] OR "delivery, obstetric"[MeSH Terms])) OR (mistreatment[All Fields] AND ("pregnant women"[MeSH Terms] OR ("pregnant"[All Fields] AND "women"[All Fields]) OR "pregnant women"[All Fields]))) OR "patient satisfaction"[MeSH Terms] AND ("middle east"[MeSH Terms] OR "africa, northern"[MeSH Terms] NOT "Turkey"[All Fields]) NOT "Israel"[All Fields] AND "2010/04/23"[PubDate] : "2020/04/19"[PubDate]	1, 2
CINAHL	"respectful maternal care" OR "obstetric violence" OR "disrespect and abuse" OR "childbirth or labour or birth or labor or delivery" AND "perceptions or attitudes or opinion or experience"; (Published Date: 2010-2020, English Lang, Geographic Subset Middle East)	1, 2
Cochrane Databases	"Respectful Maternal Care", "Obstetric Violence", "Disrespect and Abuse"	All
Eastern Mediterranean Health Journal (EMHJ)	"Respectful Maternal Care", "Obstetric Violence", "Disrespect and Abuse"	1,2
VU Libraries	"Respectful Maternal Care", "Obstetric Violence", "Disrespect and Abuse" [AND} "Middle East" OR "North Africa" (2010-2020; English Language)	1,2
Google Scholar	"obstetric violence", "Disrespect and Abuse in Childbirth", "Respectful Maternal Care", "Dissatisfaction in intrapartum"; English after 2010	2, 3, 4
Grey Literature		
Google Scholar	"obstetric violence", "Disrespect and Abuse in Childbirth", "Respectful Maternal Care", "Dissatisfaction in intrapartum" AND each of the 22 countries in EMR; Publications in English after 2010, removing duplicates)	1, 2
Google	Keywords variations: RMC, OV, D&A, facility-based deliveries, quality of maternal care, mistreatment in childbirth, neglect, verbal or physical violence, dignity, rights-based, patient-centered, routine care, labor, delivery, C-sections, maternal health, pregnant women, women's perceptions of deliveries, women's expectations of deliveries, Eastern Mediterranean Region, Middle East, North Africa, Arab States, Fragile Conflict Settings, Humanitarian, Post-Conflict, emergencies AND each of the 22 countries in the EMR	1, 3
Academia	"Obstetric Violence" AND "Middle East North Africa"	1, 2
Harvard Maternal Health Task Force (MHTF)	"Respectful Maternal Care"	All
Snowballing	Due to literature limitations, review of references of systematic reviews and global literature will identify other relevant literature, especially related to EM Region, low- and middle-income countries and developing countries.	All

Inclusion and Exclusion Criteria

Language: English

Inclusion criteria comprised of articles published in English. Although the EMR's main languages also include Arabic and French, an initial search of literature published on this topic indicated that publications (peer-reviewed and grey) in these other languages were few in quantity, of poor quality, usually direct translations of English counterparts, or not relevant to this thesis's objectives.

Dates: 2010-2020

Articles published starting 2010 were reviewed as this was when the B&H landscape analysis was published. A 10-year cap was prioritized to remain within more updated publications.

Geography:

Regarding the geographic context, while various geo-political arrangements exist to define the "Middle East and North Africa Region", WHO's "regional division" was used for this thesis, limiting the search to the 22 EMR member states (and excluding: Algeria, Israel and Turkey). Articles related to the EMR diaspora were also excluded.

Exclusion Criteria:

In hopes of emphasizing and highlighting the voices and perspectives of women in the Region related to their childbirth experiences, articles were excluded if related to: provider knowledge, attitudes, skills, or malpractice, randomized clinical trials, postpartum outcomes, quantitative QoMC indicators (e.g. ANC, FBD, SBA) or assessment tools.

Inclusion and Quality:

The search initially yielded 1,386 articles, of which 38 records were included for analysis (***Figure 3*** and ***Annex 2***). Of these 38 articles, 34 are peer-reviewed publications: 14 using qualitative methodologies, 14 quantitative, five mixed-methods, and one literature review. Of these included articles, 17 were from PubMed, three from CINAHL, and 18 from Google and Google Scholar (most of which were cross-published in reputable academic journals including Reproductive Health, Midwifery, PlosOne, and BMC-Pregnancy). With 90% of included articles as peer-reviewed, the author relies on extensive revisions for technical strength, rigor of methodology, and clarity of objectives prior to publication in esteemed journals. The author also depends on the high number of citations and collective works of different authors to ensure sources are dependable and of sufficient substance. Four non-peer-reviewed records were included, namely: one accepted but not yet peer-reviewed literature review, an NGO report, a PhD Thesis, and a news article on OV from a doula's perspective, due to their explicit relevance to this thesis scope.

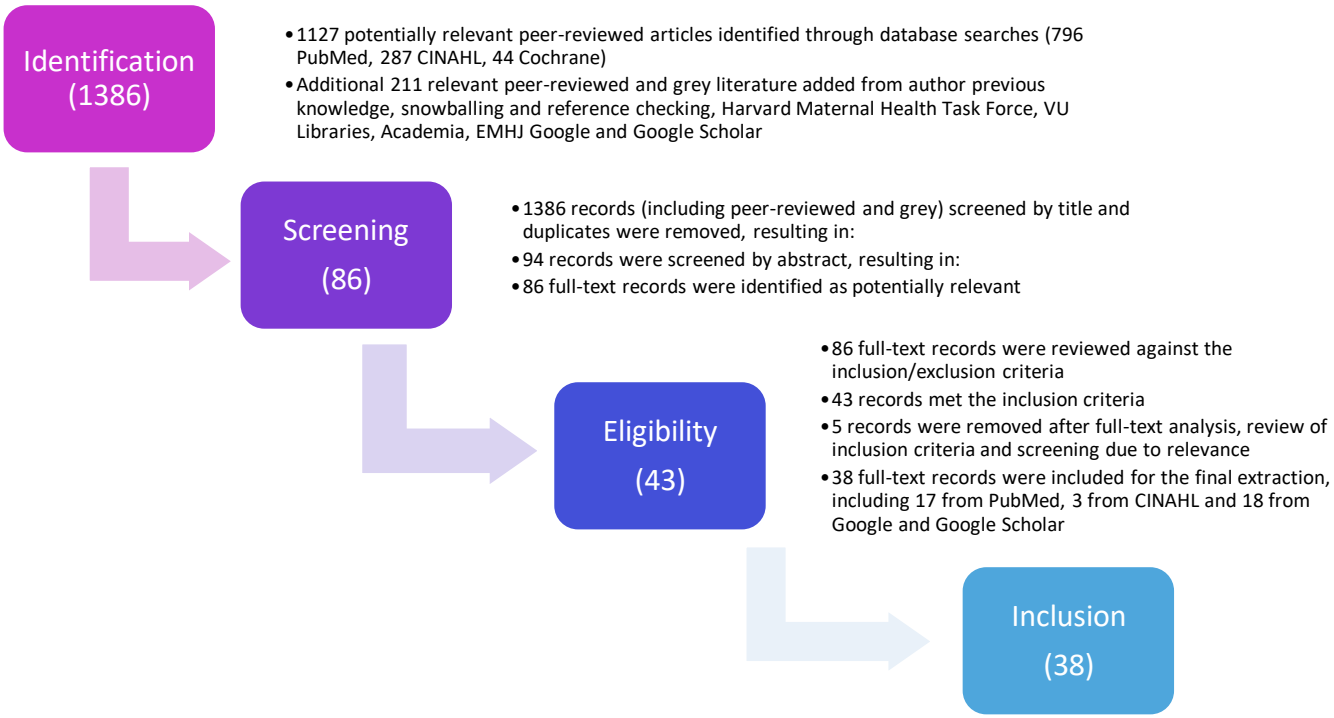

FIGURE 3: PRISMA FLOWCHART OF SEARCH AND SCREENING STRATEGY

Of the 38 articles meeting the inclusion criteria, most records were published between 2017 and 2019 (***Figure 4***). Three articles provided a multi-country or regional analysis while 35 were country-specific. Two-thirds (15/22) of the Region was represented in the literature with half of the Region (11/22) having country-specific publications. A quarter of countries in the Region (6/22) had 4 or 5 country-specific publications included in this analysis indicating that despite limited literature, there was not a specific country bias (***Table 3***). Egypt, Iran, Jordan, and Saudi Arabia had the highest and an equal number of publications, likely since these countries contribute to a bulk of evidence-generation and publications in the Region (13). Most studies were based in large, public, urban hospitals (***Annex 2***). Almost all included publications were written by teams of authors from the Region.

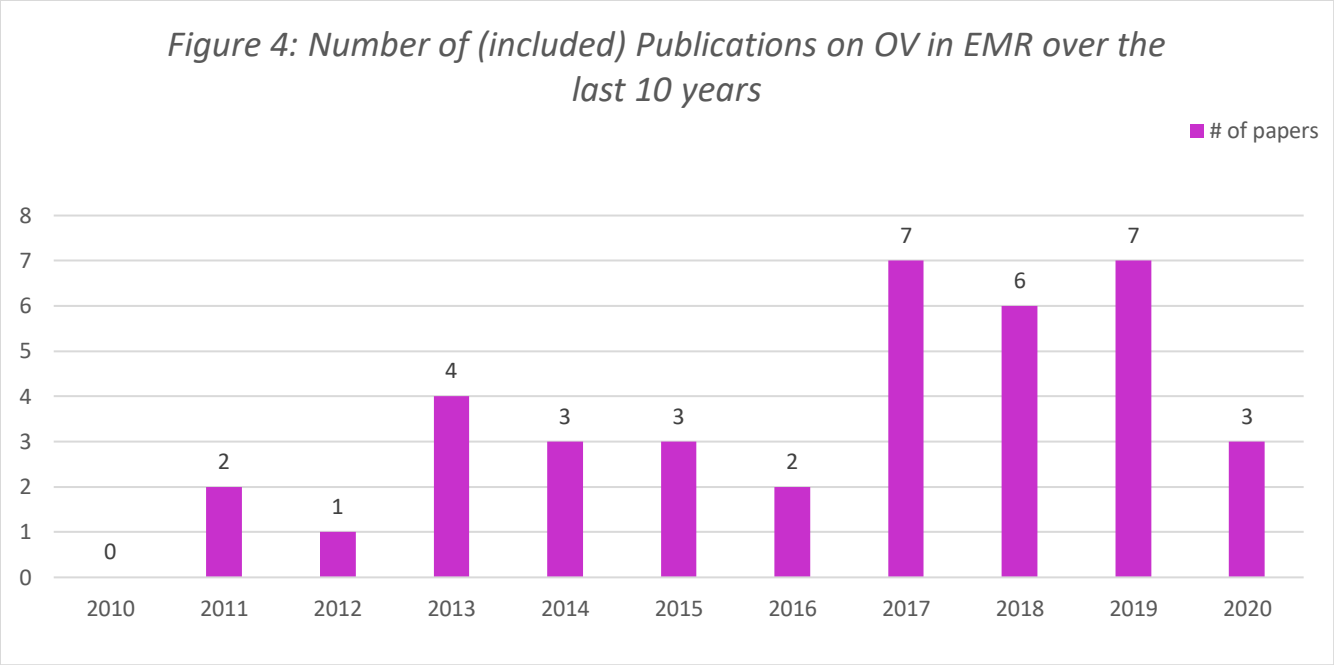

FIGURE 4: NUMBER OF PUBLICATIONS ON OV IN EMR OVER THE LAST 10 YEARS

Selection of Framework

Initially, the WHO's *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities, 2016* (***Annex 1***) was reviewed to guide this study. However, that framework was too large for the scope of this thesis. Subsequently, Bowser and Hill's model of the seven categories of D&A was selected (***Figure 5***), as a review of global literature on D&A found that most studies continue to use this framework due to its simplicity. One of the major strengths of this framework is its deep roots in human rights and person-based approach to healthcare which is foundational to achieving UHC. Moreso, WHO's statement against OV is based on this model for its rights-based approach (1).

B&H's framework will serve as the conceptual framework for this research to:

a) organize the findings of the literature review based on these categories,
b) analyze the trends and prevalence of various types of abuse in childbirth, and
c) allow comparison between countries in the Region and other LMICs.

Type of Disrespect & Abuse	Corresponding Human Rights
1. Physical Abuse	Freedom from harm and ill treatment
2. Non-consented Care	Right to information informed consent and refusal Right to have choices and preferences respected, including companionship during maternal care
3. Non-confidential Care	Right to confidentiality and privacy
4. Non-dignified Care (including verbal abuse)	Right to dignity and respect
5. Discrimination	Right to equality, freedom from discrimination and equitable care
6. Abandonment (or denial of care)	Right to timely health care Right to the highest attainable level of health
7. Detention	Right to liberty, autonomy, and self-determination Freedom from coercion

FIGURE 5: FRAMEWORK DEFINING CATEGORIES OF DISRESPECT AND ABUSE IN CHILDBIRTH AND RESPECTIVE HUMAN RIGHTS VIOLATIONS, ADAPTED FROM BOWSER AND HILL, 2010. SOURCE: RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN – MATERNAL HEALTH TASK FORCE

Study Limitations

This research aims to capture a snapshot of the status of OV in the EMR from the perspective of women. Ideally, primary data collection of perspectives and experiences from birthing women throughout the Region, in addition to key informant interviews, would have enriched this research. However, due to the COVID-19 pandemic, that was not practically feasible.

Due to the novelty of the topic and impetus towards researching and advocating against OV, there is generally a limitation of published literature. This is worsened particularly in LMICs with a great dearth in the EMR. While an exhaustive literature search was conducted on mistreatment in childbirth, it is possible new publications and other relevant documents may have been missed.

Additionally, publications related to QoMC are complex and heterogenic in nature, due to the variety of factors which influence patient satisfaction, especially during and following FBD. Patient satisfaction surveys in hospitals would have been a good source of data, however they are seldom tailored specifically towards RMC. Furthermore, most literature on QoMC in the Region is written in a positive light to highlight patient satisfaction and not to expose D&A.

Due to the sensitivity of this subject, qualitative studies might contain recall bias from participants on their exposure to OV. It is also likely that many women are not aware that they have been victims of OV due to the newness of this form of GBV in the public domain and its normalization. Consequently, it is expected that under-estimation and under-reporting exist in the data.

FINDINGS

Literature shows that women from the Region have experienced all seven types of D&A. Most country-specific studies mentioned at least 4 of the 7 types of abuses with the majority mentioning 6 of the 7 (***Table 3***). Physical abuse and non-dignified care were most frequently mentioned in the literature. Detention was the least mentioned, which is comparable to findings from numerous studies in the African Region (12,29). Literature from Pakistan, Saudi Arabia, and Sudan mention all 7 categories of D&A because studies from these countries used the B&H model as their analytical framework.

Table 3: Number of articles mentioning the categories of D&A in the EMR Literature

By Country	1. Physical abuse	2.Non-consented care	3.Non-confidential care	4.Non-dignified care	5. Discrimination	6. Abandonment	7. Detention		Total Types mentioned (x/7)	Total Number of included articles
Afghanistan	2	-	1	3	-	3	2		5	4
Egypt	4	3	2	5	1	4	-		**6**	**5**
Iran	3	2	1	2	1	1	-		**6**	**5**
Iraq	2	2	3	4		2	1		**6**	4
Jordan	3	3	4	3	1	4			**6**	**5**
Lebanon	1	1	-	-	-	-	-		2	1
Pakistan	2	2	2	1	1	1	1		**7**	2
Saudi Arabia	4	3	4	4	1	4	1		**7**	**5**
Sudan	2	2	2	2	1	1	1		**7**	2
Tunisia	1	1	-	1	1	-	-		4	1
Yemen	1	1	-	1	-	1	-		4	1
Total number of countries* mentioning Type of D&A	11	10	8	10	7	9	5		7/7	N/A
Total number of country-specific studies with Type of D&A	**25**	20	19	**26**	7	21	6		7/7	**35**
MC added**	2	3	2	2	-	2	-		5	**3**
Total number of studies with Type of D&A**	**27**	23	21	**28**	7	23	6		**7/7**	**38**

** not counting multi-country studies*

****= Multi-country studies from the Region (MC)**

- Egypt, Lebanon, Palestine, and Syria **(21)**
- Egypt, Lebanon, Syria **(30)**
- Egypt, Jordan, Lebanon, Qatar, Saudi Arabia, and United Arab Emirates**(20)**

This review identified various sub-themes under each category of D&A (***Table 4***). Many of these sub-themes are similar to those in global systematic reviews, particularly under Types 5 and 7, due to their narrower definition ***(Annex 3)***. This review also identified some elements of OV which are overdone in the EMR, particularly under Types 1, 2, 3, 4 and 6, discussed further in the findings below. The subsequent sections will discuss women's experiences of each of the seven types of D&A and the sub-themes identified from this review.

Table 4: Types of D&A and respective sub-themes based on literature in the EMR	
Types of D & A	**Sub-themes identified through this literature review**
1. Physical Abuse	a. Overuse of routine interventions b. Hitting c. Insufficient pain medication
2. Non-Consented Care	a. Hierarchical care and limited decision-making power b. Limited information for decision-making and consent c. Unconsented routine interventions
3. Non-Confidential Care	a. Lack of physical protection of patient confidentiality b. Overcrowding
4. Non-Dignified Care	a. Verbal abuse b. Dehumanized care
5. Discrimination	a. Personal characteristics b. Language
6. Abandonment	a. Lack of companionship b. Neglect
7. Detention	a. Culture of bribes and Informal payments

Type 1: Physical Abuse

Physical abuse was the most referenced form of D&A in the regional literature, found in 27 studies in 15 countries (***Table 3***). While only a few studies in the EMR use the B&H model to measure D&A; they indicated an overall prevalence 6.5% (n=459) of Iraqi, 8.3% (n=263) of Sudanese, and 18.6% (n=360) of Pakistani women experienced physical abuse in childbirth (31–33). The following sub-themes for physical abuse will be discussed below: overuse of routine interventions, hitting, and insufficient pain relief.

Overuse of Routine Interventions

In the EMR, obstetric care is technocratic, overmedicalized with non-evidence-based interventions pushed on women TMTS (20,34–38). Kabakian-Khasholi et al. noted that "childbirth is highly medicalized in the [EMR], with substantial numbers of unnecessary or even harmful practices being routinely applied" (21). While routine obstetric interventions have historically been associated with M/HICs, in the EMR, this abuse is seen across low (Afghanistan), middle (Egypt, Jordan, Lebanon, Palestine and Syria), and high (Saudi Arabia)-income countries (4,21,23).

The overuse of routine interventions and overmedicalization of childbirth have become a normalized and expected part of obstetric care (20,34–38). The routine use of **induction** is commonly observed in many countries in the EMR (20,21). One Jordanian woman mentioned: "*As soon as I got to the hospital, he ordered the induction straight away so that my cervix would open*" (37), indicating over-medicalizing and over-managing second-stage of labor. In Egypt (34), Jordan (39) and Iran (36,40), these unnecessary inductions have resulted in readmission due to contracted infections. Frequent and routine use of **episiotomies** was reported across the Region; one Afghani woman compared doctors to butchers, emphasizing this forceful and aggressive behavior (41). Another common routine practice is **bed confinement**, with limited mobility, and often having bladder catheters inserted rather than allowing to walk to the bathroom, as seen in Egypt (34,35), Iran (36), Jordan (37), Saudi Arabia (38,42) and Yemen (43). Moreso, most women do not have the option to choose their preferred position in labor due to hospital policies and routine practices. Many women are **forced to deliver on their backs (lithotomy position)** which not only contributes to increase dissatisfaction, restriction, loneliness, and sense of powerlessness but may delay labor and result use of other unnecessary interventions (33,43). Furthermore, the **use of frequent vaginal exams** was another normalized obstetric practice which women not only fear but consider more painful and traumatic compared to the labor and delivery (20,34,38). One woman from Jordan recounted: *"I did not receive any care other than having vaginal examinations frequently"* (37), indicating the overuse of this intervention. Expecting frequent vaginal checks, women in Pakistan have reported requesting C-Sections to avoid being violated and traumatized by health workers (44). Another regional systematic review mentioned providers violating women by forcing open women's legs for vaginal exams and births (20).

Further examples of experiences from various countries are found in ***Table 5***; the differences in prevalence could be attributed to sample sizes, provider skills and attitudes, and hospital policies between countries; nonetheless, the overuse of these interventions defies evidence-based recommendations.

Table 5: Women's experiences of overused routine interventions in select EMR countries					
Country	**Type of overused routine intervention**	**Examples of experiences reported by surveyed women**	**Sample size**	**Setting**	**Source**
Sudan	Induction	73.2% of participants reported being artificially augmented/induced	284	One large teaching hospital in major city, Omdurman	(45)
	Episiotomy	94.7% of study-participants reported being routinely subjected to episiotomies			
	Forced labor position	17% of respondents were allowed to adopt a preferred labor position			
Jordan	Induction	95% of all women having their labor augmented as a routine policy	460	Three major public hospitals in Jordan	(39)
	Episiotomy	More than one third (37%) of study participants had an episiotomy with varying degrees of laceration (96%)			
	Forced lithotomy position	100% of women were routinely placed in lithotomy position for labor and delivery			
	Frequent vaginal exam	The majority of women (89%) had frequent vaginal examinations, which were defined as being carried out less than once every 4 hours			
	Frequent vaginal exam	45% of respondents receiving more than 8 vaginal exams	320	Three major public hospitals in Jordan	(46)
Saudi Arabia	Frequent and forceful vaginal exam	25% of participants reported painful vaginal examinations	358	Tertiary, urban, public hospitals (Maternity hospital of King Faisal medical complex and Al-Hada armed forces hospital, Taif city, Saudi Arabia)	(47)
	Bed confinement	Only nine (2.5%) participants responded that staff members used any kind of mouth muzzle or restricted them in bed during childbirth.			
Iraq	Bed confinement	51.6% of surveyed laboring women were confined to the bed	459	14 public and urban primary health care centers	(33)

Other routine interventions in the EMR include:

- Staff applying pressure on uterus in labor, as in Egypt (34), Iran (40), one study shows 36.2% (n=459) of Iraqi women undergoing this routine intervention (33),
- Being denied food and drink in labor (11.2% (n=358) in Saudi Arabia (47) and its substitution with routine intravenous (IV) infusions as in Jordan (37) and Sudan (with 60% (n=284) receiving IV (45)), and
- Continuous and restrictive blood pressure and fetal monitoring as in Egypt (35), Saudi Arabia (42) and 77% (n=460) of women in Jordan (39).

These studies (including ***Table 5***) are set in public urban tertiary hospitals, which confirms the deviation from evidence-based medicine in many hospital-based deliveries across countries of all incomes in the Region. Nonetheless, it is important to note the risk of ecological fallacy of generalizing these study data as overall prevalence across these countries.

Hitting

Hitting is a form of physical violence against women in labor, common among various countries in the EMR, irrespective of income-standing. In studies from Afghanistan, patients reported incidences of hitting, slapping, or being pulled by the hair by doctors and midwives (48,49). An interviewee from Tunisia reported "*being subjected to physical violence during the delivery, being beaten on the hips, slapped on the face and having finger marks on her body*."(50) A study in a large teaching hospital in Egypt found that 15.6% (n=501) of survey-participants were hit by a health worker (51). In Saudi Arabia, a questionnaire on OV in one of the largest medical complexes found 4.5% (n=358) of respondents reported hitting, slapping, pushing, and pinching by staff during childbirth (47).

Insufficient pain medication

Denying laboring women pain medication is another form of physical abuse. Women in the EMR have expressed not receiving sufficient pain medications both in labor and during stitching, and indicated feeling neglected by health workers when in pain (see Type 6: Abandonment). One study from Iran indicated women being induced artificially without the provision of adequate pain relief (40). Another study in Iraqi health centers found that 76% and 35% (n=459) of survey-respondents were dissatisfied by the availability and strength of pain medications (33). Further, a study of public facilities in Jordan found that 35% (n=390) of women reported not receive pain medication during labor (52).

On the other hand, many women also reported that providers have started operating on them without waiting for the effects of the anesthesia to settle;13.4% (n=358) in Saudi Arabia, and 28% (n=390) of interviewees in Jordan reported having their episiotomies stitched without anesthesia (47,52). One Saudi woman reported "*they started cutting the incision and I felt the scalpel and the stretching; of course, I screamed very loudly. Finally, they said fine and gave me complete anesthesia*" (53).

Type 2: Non-Consented Care

Non-consented care was mentioned in 23 studies and at least 10 countries in the EMR (***Table 3***).

Studies from the Region using the B&H model to capture D&A, found overall prevalence of non-consented care experienced by 100% (n=11) of respondents in Tunisia, 97.5% (n=360) in Pakistan, and 35% (n=263) in Sudan (31,32,50). These small sample sizes are not indicative of prevalence across these densely populated countries but rather display cases of non-evidence-based and disrespectful care in childbirth across the Region. Further, a study from a large urban teaching hospital in Sudan identified a notable discrepancy regarding consent and type of intervention as 77.5% (n=284) of study-participants were asked permission for an exam but only 22% before a procedure (45).

The subthemes for non-consented care found through this literature review include hierarchical care and limited decision-making power, limited information for decision-making and consent, and unconsented routine interventions.

Hierarchical care and limited decision-making power

A regional review concluded that "women in the Arab world are not encouraged to participate in decision-making processes related to their obstetric care; it reflects the overall culture of patient–provider relationships in these countries" (21). The power-dynamic between physicians, nurses, midwives, and patients creates a hierarchy that is seldom questioned, where the patient is the lowest and the physician the highest. Rahmani et al. noted "physicians occupy an authoritarian position in society and their opinions and behaviors are supposed to be accepted" (49). Lowest-ranked, patients feel inferior to doctors, intimidated to ask questions fearing to be shamed or insulted, and passively under their authority. Doctors usually make the decisions on behalf of laboring women often without asking consent or providing adequate information for patients to make informed decisions (20,34). One Irani woman confirmed: *"Women are not involved in decision-making, they trust their caregivers to make decisions for them and don't challenge their [providers] who are more knowledgeable*" (40). Many women in the Region reported limited or no participation in decision-making at birth (***Table 6***). In some cases, providers push or coerce patients into certain procedures, using their vulnerability and fear to push medical decisions along without their consent. For example, a Lebanese woman shared: "*I was scared when thinking about birth. My physician said not to worry as I had taken the right decision by requesting a caesarean. I didn't know much.*" (54)

Table 6: Experiences of women's dissatisfaction with limited decision-making power in select EMR countries				
Country	**Example of experience of limited decision-making**	**Sample size**	**Setting**	**Source**
Egypt	100% of survey respondents reported dissatisfaction with their involvement in decision-making	214	Public, urban, a large teaching hospital in a city-center	(55)
Sudan	57% of survey respondents reported not being involved in decision-making	284	Public, urban, a large teaching hospital in a city-center	(45)
Iraq	48.3% of survey respondents reported not being involved in decisions of their injections	459	Public, urban, primary health care centers (14)	(33)
Jordan	45% reported no participation in clinical decision-making	390	Public, urban, primary health care centers (4)	(52)

The lack of decision-making autonomy leaves women feeling powerless and inhibits feeling in-control; one Yemeni woman explained "*to be in-authority meant sharing decision-power with the care provider*" (30,43). An Egyptian doula further noted "*OV begins with a culture and society telling women that their voices do not have weight during their births compared to the voice of a medical professional*" (34). Yet, physicians from Saudi Arabia explained: "*within this hierarchy, women are expected not to interfere with medical practice and decision-making. Instead, they are expected to comply and co-operate. We need to explain all the possible complications and we need her to agree with what we are doing. So, it's better to explain thoroughly to her and then finally we follow our decision rather than hers*" (42).

Furthermore, the hierarchy in patient-provider relationships not only affects non-consented care but enables various types of D&A to occur across EMR countries of all contexts (34,43,47,49).

Limited information for decision-making and consent

Many women in EMR were not satisfied with the information received from their health providers, feeling disempowered to make any decisions, and feeling objectified as procedures were done to their bodies (20). Surveys conducted at urban public facilities in major cities found that 88% of Egyptian (n=435), 80% of Jordanian (n=390), 76% of Sudani (n=263), and 45% of Iraqi (n=1196) respondents were deprived of information and updates related to their labor (32,51,52,56).

Women were also disappointed by the types and amounts of information presented to them. A study on verbal and non-verbal abuses in public urban facilities in Iraq found that almost half of participants were dissatisfied with providers' assessments, explanations of diagnoses, and untailored treatments (56). Women in Saudi Arabia expressed their providers did not share information before injections, nor explain aftercare for stitches (53). Others were not offered options or alternatives in childbirth; in Lebanon, women felt they were robbed of the opportunity to make an informed-choice

related to their C-sections (30,54). Further, the lack of communication from providers explaining treatments or interventions caused patients to feel dominated and disrespected as passive subjects receiving care. This was especially true during routine interventions.

Unconsented Routine Interventions:

The normalization of overmedicalized care in the Region enables women to expect overused routine interventions; however the problem extends that these interventions are commonly done without women knowing or consenting (20,34,36,42). In Iran, although routine inductions and episiotomies are expected, women reported not being informed of being cut, which was disrespectful and dehumanizing (40). In Saudi Arabia, distrust from the midwife that a laboring woman won't push in the toilet, led her to unconsentedly insert a urinary catheter causing violation and pain (42). Another study from the largest medical complex in Saudi Arabia found 19% (n=358) of women underwent episiotomies, 3.6% C-sections, 1.4% tubal ligations and 0.3% hysterectomies, routinely administered without consent (47). When confronting providers about their attitudes towards these unconsented routines; one Saudi doctor justified the policies to maintain patient-flow (42).

Type 3: Non-Confidential Care

Tabrizi et al. noted that women perceived confidentiality and autonomy in birth among the most important elements of QoMC; however, lack of confidential care was and is experienced by women regardless of the types of facility and country-income (30,57). Nonconfidential care was mentioned in 21 studies in at least eight countries in the Region (***Table 3***). Literature indicated a range of experiences across and within EMR countries which conclude that women experience violations of privacy, and exposure of their bodies and private information to strangers (***Table 7***) (40,44,58). In addition to the above, the literature also identified the following sub-themes for non-confidential care: lack of physical protection of patient confidentiality and overcrowding.

Table 7: Experiences of non-confidential care in select EMR countries				
Country	**Examples of non-confidential care, reported by surveyed women**	**Sample size**	**Setting**	**Source**
Jordan	67% of surveyed women reported lack of privacy	460	Three major public hospitals in Jordan	(39)
Pakistan	58.6% of surveyed women reported lack of privacy	360	Household based study conducted in tehsil Kharian of district Gujrat. (Community-level, semi-urban, public facility)	(31)
Sudan	19 % of surveyed women reported lack of privacy	284	One large teaching hospital in major city, Omdurman	(45)
Iraq	44% of surveyed women were not satisfied with privacy during medical exams	1196	3 public large maternal hospitals in major city, Erbil	(56)
	64.3% of respondents felt their privacy was not preserved during birth	459	14 public and urban primary health care centers	(33)
Egypt* (*Indicates contradicting results across different studies**, see discussion**)	63% of survey respondents were satisfied with confidentiality in care	435	Large public teaching hospital in major urban city center, Assiut	(51)
	86.5% of respondents in another study who reported the need for maintaining privacy in all procedure	400	Major public teaching hospital in capital city, Cairo	(35)

Lack of physical protection of patient confidentiality

In Afghanistan, Egypt, Pakistan, and Sudan, shortages in beds, curtains, and equipment resulted in women birthing on the floor, in corridors, or sharing birthing spaces which contributed to discomfort and privacy violation (20,32,44,58). Findings from Afghanistan found that "only 54% of facilities offered visual and auditory privacy in antenatal consultation rooms, and only 58% of facilities provided visual and auditory privacy in the delivery room" (58). While women in high-income Saudi Arabia also faced this problem as 5.6% (n=358) delivered in rooms without curtains separating beds (47).

In the cases where appropriate furniture is available, differences are observed in confidential care between geographical settings and hospital types. In Afghanistan, urban women felt shame to access maternity clinics in Kabul, compared to their rural counterparts, fearing loss in modesty by being exposed for exams or birthing in overcrowded and underequipped facilities (58). In Sudan, health workers were less likely to use curtains and visual barriers in the Khartoum tertiary teaching hospital compared to smaller, secondary, and specialized maternity hospitals where 53% were noncompliant in protecting privacy in childbirth compared to 6.8% in the latter (32). Another issue comes from prioritizing provider convenience, whether seeing patients in groups in Iraq or the open-door policy in maternity hospitals in Saudi Arabia, which inhibit mothers from maintaining intimacy in childbirth (38,56).

In both HICs and LICs in the EMR, patient confidentiality was violated by providers discussing private information in public as in Saudi Arabia, or by misuse of filing systems as in Sudan (32,47).

Overcrowding

Overcrowding is one of the biggest factors contributing to poor perception of QoMC in public hospitals in LMICs (30). Studies from Jordan found 60% (n=460) of respondents dissatisfied with privacy due to having to share a room with other laboring women; one woman shared: "*we were three women in labor room, no privacy at all, I asked for screen curtains but no response, I was very embarrassed of being exposed*" (37,59). Additionally, women felt uncomfortable with having frequent unwanted visits from an overload of unknown staff (20,35). Across all income-contexts in Sudan, Jordan, and Saudi Arabia, women's privacy was interfered by the large number of students (32,46,53).

Type 4: Non-Dignified Care

Undignified care is one of the most prevalent forms of obstetric violence in the EMR (***Table 3***), mentioned in 28 studies and at least 13 countries. Azhar et al. reported that this is the most common form of D&A experienced by women and studies from Pakistan and Iraq confirm that about half of laboring women experience undignified care in childbirth (31,33). Undignified care compromises not only the QoMC but access, compliance, and effectiveness as women fear humiliation, neglect, loss of control and disrespect (6,34,59). This literature review identified verbal abuse and dehumanized care as sub-themes to this category.

Verbal Abuse

Regardless of parity and stage of labor across EMR countries, verbal abuse was the most common form of undignified care reported by women (***Table 3***). Being scolded, belittled, insulted, shouted at, gaslighted, and threatened while laboring in pain were examples given across EMR countries, regardless of income-standing (20,49,50,60). Afghani women reported being insulted by providers both in their country and as refugees in Iran: "*You behave like a donkey*"; "*If you can learn to get pregnant, you should learn to tolerate pain*"; "*Stupid Afghanis; if your baby dies, you'll come back next year with another*" (41,49,58). Similarly, a study in Jordan found one in five survey-respondents reported verbal abuse, e.g. "*I will cut your vagina [episiotomy], if you don't push good*" (52). While in Saudi Arabia, women were gaslit, called liars, and told to "*stop whining like children or leave the hospital*" (53). Examples in ***Table 8*** show a wide range in experiences; variations also depend on the definition or inclusivity of "verbal abuse", methodology, and sample size of studies.

Table 8: Women's experiences of verbal abuse from select EMR countries				
Country	**Example of verbal abuse as reported by survey-respondents**	**Sample size**	**Setting**	**Source**
Sudan	58% reported being insulted and 28% verbally abused	263	Three public teaching hospitals in the capital and urban city-centers.	(32)
Egypt	45.9% postpartum mothers reported being yelled at by healthcare workers because they have not done what they were told to do during childbirth.	501	Large public teaching hospital in urban city center (Minia University Maternity and Child Health Hospital in Minia, Egypt.)	(61)
Jordan	40% of the women reported having experienced at least one form of verbal abuse during their last birth experience	390	Urban, governmental Maternal and Child Health Centers (MCHCs) in Zarqa, Jordan	(52)
Saudi Arabia	21% reported being scolded and 20% threatened	358	Tertiary, urban, public hospitals (Maternity hospital of King Faisal medical complex and Al-Hada armed forces hospital, Taif city, Saudi Arabia)	(47)
Iraq	10.1% reported being exposed to verbal violence	459	Urban, public primary health care centers	(33)

Dehumanized care

OV renders childbirth as a dehumanizing experience as women described treatment by staff as 'unfriendly', 'unprofessional', 'rude', 'unempathetic', 'hostile', 'absent', 'impersonal' and 'authoritative' (20,43,49,56).

Some women were dissatisfied with receiving obstetric care from unfamiliar providers, who often did not introduce themselves, thus, creating an unwelcoming environment and distance in the patient-provider relationship. Studies from large teaching hospitals in Jordan and Sudan found that 80% (n=460) and 66% (n=284) of their respondents experienced this, rendering care mechanical and technocratic (37,45). In a study from Iraq (n=1196), half of participants were dissatisfied with verbal communication (66.5% didn't have provider introduce themselves while 62% didn't receive a greeting); a quarter considered poor non-verbal communication (i.e. eye-contact, tone or facial expressions) an enabler to impersonal care (56).

Studies from both Egypt and Jordan provide conflicting inter and intra-country findings of women's perceptions of empathy and kindness from providers. Abdel-Ghani et al. reported that two-thirds of participants in Egypt prioritized the need for nurses to demonstrate empathy in care; two other

studies supported this as 39.1% (n=435) and 37.4% (n=214) were dissatisfied due to poor emotional support from nurses (35,51,55). Another study in Egypt (n=501) found that only about 75% of respondents were treated kindly/friendly by health workers, but about half felt that staff did not treat them empathetically or respectfully (61). Similarly in Jordan, Hatamleh et al. found that 64% (n=460) of women reported friendly/polite treatment but 31% felt disrespected and 36% were verbally abused or neglected (37).

Type 5: Discrimination

Literature from the Region mentioned discrimination seven times, one of the lowest types of abuses reported (***Table 3***). Notably, Azhar et al. revealed that women were five times less likely to report discrimination compared to experiencing it (31). Subthemes identified through this review include discrimination based on personal characteristics and language.

Personal Characteristics

Global literature concludes that discrimination is difference in treatment based on personal characteristics, including but not limited to age, income, race or marital status (***Annex 3***) (6,12,29). One study from Egypt found that 85.1% (n=501) of women experienced discrimination based on unspecified personal characteristic (61). In Jordan, consistently with global trends, younger women (often first time mothers) were more likely to experience verbal abuse (12,52). In Sudan, a study of D&A found that 6.1% (n=263) of participants reported discrimination (33% attributed it to their income), while in Pakistan, women with lower socio-economic status were three times more likely to experience D&A (31,32). Due to the conservative culture of the Region and high stigma against pregnancy outside of wedlock, single mothers can experience unfair treatment or at worst case, be denied treatment. For example, a single Tunisian mother shared: "*I explained that I had not completely healed, they didn't treat me like the other women, one nurse started screaming and shouting at me*" (50).

On the other hand, refugees and non-nationals often experience covert discrimination based on their nationality. This issue must be addressed as the Region continues to produce the largest number of displaced persons globally. In Iran, unregistered Afghans were denied admission, received delayed care, or were mistreated by staff. One couple explained that: *"Afghanis usually don't get any attention until they come dying. My wife is illiterate and embarrassed to ask any question. We never get the right help and the doctor didn't take her complaints seriously. She contented the C-Section was not an informed choice and her husband had inadequate funds to pay the entire cost upon her discharge from hospital. At the accounting department, they said we shouldn't ask why we have to pay so much, but be grateful for being admitted in spite of being Afghani."* (62)

Language

In an ever-globalized world, clear communication, in a language and diction understood by all parties, is basic decency. Unfortunately, although not unique to obstetrics, some women in the EMR experienced this violation by caregivers who chose to communicate with them, often using medical jargon, outside the scope of a lay-patient's understanding. This was experienced by 61.4% (n=501) of Egyptian women but only 2% (n=263) of Sudanese women in respective studies (61) (32). Moreso, in Saudi Arabia, medical staff chose to speak in English as to exclude patients from decision-making: "professionals communicated with one another in English, almost as if the women were not present and certainly as if their input into the clinical decision-making was irrelevant. Although staff members were predominantly Saudi Arabian, they frequently chose to speak in English about their patients rather than talk to these women in a language they would understand." (38)

Type 6: Abandonment

Literature from the Region mentions abandonment in 23 studies in at least 14 countries (***Table 3***). A study from Pakistan found that women were 6.5 times more likely to experience abandonment in care than report it. This review identified lack of companionship and inadequate attention from staff as sub-themes to this category.

Lack of companionship

In many countries in the Region, hospital policies generally prevent women from being accompanied by partners, doulas, and labor companions leaving women to labor and deliver alone, thus contributing to increased feelings of isolation, pain, and abandonment (30,33,43,63,64). This hospital policy was expressed almost unanimously in the regional literature in Afghanistan (48), Iran (64), Iraq (33), Jordan (37,59), Lebanon, Syria, Egypt (30) and Saudi Arabia (38,53). Studies indicated as high as 99% (n=460) of Jordanian and 95% (n=435) of Egyptian survey-respondents were denied labor-companions; while 65.1% (n=459) of Iraqi and 47% (n=358) of Saudi study-participants were dissatisfied to be denied access to family during childbirth (33,39,47,51). Where exceptions to these policies allowed women to have one support person present, doctors discouraged or denied their entry; as expressed by women in Afghanistan: "*companions had to leave the room when it was time to give birt*h" (48), Jordan: "*they did not allow my mother to accompany me in the labor room*" (59), and Saudi Arabia: "*despite having a policy that permits one companion during birth, some doctors actively discouraged the practice*" (38). Furthermore, a regional review found that staff perceived that companions reduce sterility and cause conflict (20).

Neglect

Women reported feeling neglected by staff at health facilities, having to plead for timely attention from providers, not receiving adequate pain management, or having to deliver alone due to delays in receiving care, indicating that consistent and compassionate care is essential for RMC. These experiences were expressed by women in all country-contexts, regardless of income, across various types of facilities from major tertiary hospitals to health centers (***Table 9***).

Insufficient care, including disruptions in continuity of care and ignored requests for support or pain management contributed to the sense of abandonment and poor QoMC for laboring women. Studies display abandonment by staff across all stages, from pain relief in labor to post-partum recovery to breastfeeding. Women, in all income-contexts, had to beg health workers to attend to their care, from Afghanistan: "*The midwife would not come to my bed unless I insisted repeatedly, and finally she came when I was about to deliver*" to Jordan: "*The pain was intolerable, I was alone, I wanted the midwife to help reduce the pain, but she did not respond to me or even come into the room*" to Saudi Arabia: "*I was in pain and I almost kissed their hands to check me. I kept bothering them until they examined me and they found that I was 8 cm dilated"* (48,53,59).

Untimely care was expressed by women, across each of low, middle, and high-income countries, regardless of country-income (***Table 9***). Women in Jordan reported: "*I was left alone in the labor room, I felt my baby coming out, I shouted for help but the midwives' response was very slow*", another recounts: "*she left me for a long period of time, I shouted many times until one midwife responded to me"* (59). At an extreme, these delays resulted in women **delivering alone without a medical provider present**. One Afghan woman remarked: "*women receive little attention and monitoring, no one explains anything, I delivered on the floor of the corridor, while another patient called the doctor and a cleaner to come to me*" (41).

Unempathetic care, in the form of staff socializing, was noted by women, across all income-contexts; contributing to women feeling underprioritized, disrespected, and abandoned during their childbirth. Women from Afghanistan stated that: "*Staff did not care but were busy with other things, joking, chatting, telling stories not paying attention to the patients*" (41). Another in Lebanon recounted: "*when I was in labour, the nurses used to leave me and watch TV. I had to shout for help so that they would come and ask what I needed"* (20).

Table 9: Women's experiences of neglect by staff from select EMR countries					
Country	**Type of Neglect**	**Example of neglect as reported by survey-respondents**	**Sample size**	**Setting**	**Source**
Sudan	Untimely Care	21.7% of mothers reported being left without attention during labor. (46.8% of described this delay as being reasonable, however the other 38.7% said it wasn't reasonable and they couldn't tolerate it at all.)	263	Three public teaching hospitals in the capital and urban city-centers.	(32)
Egypt	Untimely Care	More than half of the postpartum mothers (59.68%) stated that they were not given prompt service and waiting time is long.	501	Large public teaching hospital in urban city center (Minia University Maternity and Child Health Hospital in Minia, Egypt.)	(61)
	Insufficient and Unempathetic care	67.5% of participants indicated the need for quick response to request, 52.8% for frequent monitoring and 47.2% for accessibility of caring medical staff	400	Major public teaching hospital in capital city, Cairo	(35)
Jordan	Unempathetic Care	11% of participants reported the main reason for abandonment was providers "talking to each other"	390	Urban, governmental Maternal and Child Health Centers (MCHCs) in Zarqa, Jordan	(52)
	Insufficient care	21.2% were dissatisfied due to refusal by health professionals to assist them during or after giving birth			
	Delivery alone	30% of survey participants reported delivering without medical provider present			
Saudi Arabia	Delivery alone	11% of respondents reported delivering without medical provider present	358	Tertiary, urban, public hospitals (Maternity hospital of King Faisal medical complex and Al-Hada armed forces hospital, Taif city, Saudi Arabia)	(47)
	Untimely Care	26.3% of women had to wait a long time before getting medical care by staff members			
	Insufficient Care	18.4% faced ignorance for assistance requests from staff members during childbirth			
Iraq	Insufficient and abandoned care	65.1% of respondents dissatisfied that accompanying person could not stay with her, 44.5% did not receive assistance in labor, 27% not examined postpartum (mom and baby), 22% fetal heart rate not checked	459	Urban, public primary health care centers	(33)

Type 7: Detention

In both global and regional literature, detention (particularly due to financial debts) is the least commonly mentioned type of D&A (12,29); mentioned only in six studies and five countries (***Table 3***). Studies which used the B&H model to measure D&A found that detention due to inability to pay was reported by 1.9% (n=263) of women from Sudan, 1.4%(n=358) in Saudi Arabia, and 0%(n=360) in Pakistan (31,32,47). This review identified only one sub-theme which is **the culture of bribes and informal payments**.

The culture of bribes was mentioned as one of the highest causes of dissatisfaction in maternal care, and informal payments as necessary to ensure timely attention from care providers, access to medications, and better quality of care (49). Unfortunately, bribes are common practice in the Region, not only in obstetrics and medicine. Rahmani et al. concluded "corruption disproportionately affect the poor" (49). Bribes and informal payments, for services that should be free, were reported by 86.3%(n=459) survey-respondents in Iraq, 62%(n=360) in Pakistan, and by 2.5%(n=350) in Saudi Arabia (31,33,47). One woman from Afghanistan noted: "*Money changes behavior, angry staff become kind; women have to compensate staff for time spent looking after them, for medicines that should be free, to 'speed up' the labour, to receive a blanket, have the heater put on, and to celebrate the arrival of their baby (more for a boy, less for a girl)*"(41). This culture of bribes and expected informal payments contribute to women's feelings of extortion.

Other drivers of D&A

In addition to the seven categories of D&A and their sub-themes, this literature review uncovered a variety of additional factors which enable the normalization of OV in the EMR. These include personal, health systems, and socio-cultural factors.

Personal Factors

Firstly, in addition to the personal characteristics (see Type 5: Discrimination), Tabrizi et al. identified other significantly associated **personal factors** for traumatic birth experiences including: martial dissatisfaction, lack of insurance, poverty, unwanted pregnancy, fear of childbirth, spirituality/faith, individual perceptions of pain and companionship (36,43). Further, given that two-thirds of the Region is affected by conflict, the intersecting identities of displaced and refugee women (particularly young, poor, uneducated, unaccompanied, and survivors of war) are particularly vulnerable to OV.

Health system factors

Secondly, regarding **health system factors**, poor infrastructure, limited bed capacity, lack of supplies and medicines and unhygienic facilities were mentioned as factors for dissatisfaction and causes for low-utilization of public facilities in Afghanistan, Egypt, Iraq, Jordan and Pakistan (31,35,39,58,65). Systematic reviews in LMICs, especially from SSA, confirmed these barriers to RMC (3,6,24,29). Delivering in public facilities and teaching hospitals were also associated with higher levels of D&A as in Iran, Jordan and Pakistan; while in Lebanon, the health system is predominantly run by private-sector, which may confound the causes for overmedicalized care and overuse of routine interventions, like C-Sections (33,36,39,54).

In countries like Afghanistan and other emergency-contexts, **insecurity** affects women's experience of care, as it places added pressure on the already fragile health systems, suffering from health worker shortages, lack of infrastructure, and limited supplies (49). Factors affecting quality in stable health systems are often exacerbated during conflicts, resulting in inequities in health access, poor (or disrespectful) treatment of women and negative health outcomes (even resulting in deaths) . As 15 of the 22 countries in the EMR face emergencies, fragile health systems are additionally pressured by insecurity, displacement of persons, high pressure on health providers, and reliance on an unqualified informal sector. Scholars noted that women and girls in fragile-contexts are vulnerable, have limited access to reproductive health services, and suffer from an increased risk of exposure to all forms of GBV, including OV (27,68).

Health workforce management, including availability, gender and skill-mix distribution, training, skills, attitudes, payment, workload, and safety further contribute to women's experiences of childbirth and overall QoMC. Shortages and skill-mix maldistribution, particularly in EMR's LICs, threaten access and quality of care; and could result in increased sense of abandonment and undignified care. In addition to overall shortages in maternal health workers, the lack of availability of female doctors is imperative to providing acceptable care, particularly in the Region, due to the conservative cultural norms (35,58). Whether working multiple day shifts as in Afghanistan or attending too many laboring women simultaneously as in Jordan, midwives are overworked and underappreciated; an issue echoed in global systematic reviews (6,46,58). One solution to this problem would be task-shifting or task-sharing obstetric care with nurses and midwives, who are often underutilized in the Region, limited in their scope, and feel powerless awaiting orders from doctors (42,54). Despite their poor experiences and low perceived QoMC, women across the Region empathized with health workers due to the staff shortages, poor working conditions, and high workload which result in exhaustion and burnout (35,41,49,69). Many women have expressed greater satisfaction working with nurses and midwives as compared to doctors, as in Egypt and Saudi Arabia (51,53). Another study from Jordan indicated a significant association between the type of provider and experience of abuse (52). Bradley et al. confirmed that midwives are also victims to the hierarchical system and are pressured by socio-cultural drivers of D&A which limit their capacity to provide psycho-emotional care and enable the cycle of OV to continue (24).

Moreso, issues related to health worker training and skills are questioned as contributing factors to the overuse of non-evidence-based practices. Studies from both Egypt and Jordan indicated the need for refresher trainings for nurses, not only on basic clinical skills to avoid reliance on traditional practices or experience, but also on psychosocial emotional care (35,59). Additionally, Shaban et al. concluded that

many doctors do not have the skills to manage deliveries without cutting episiotomies (39). In Egypt, one of highest rates of C-Sections are attributed to poor training and supervision, financial incentives and convenience, and limited awareness of clinical guidelines (70). Due to the normalization of this overmedicalized care, it is likely that health workers are not even aware that they are perpetrating OV. One study from Zambia confirmed that among chief barriers to improving RMC are ignorant provider attitudes, misconceptions of its definition and violations, and belief of met expectations (71).

Furthermore, one study from Afghanistan found that a third of nurses are subjected to violence and abuse which contributes to the cycle of abusive behaviors towards patients (58). Due to widespread GBV globally, it is likely that this cyclical violence contributes to undignified and unempathetic care in other EMR countries too.

Socio-cultural factors

Thirdly, **socio-cultural factors** are the strongest drivers of OV because they may normalize the mistreatment of women, set the norm for gender-roles in the home, society, and health system, and dictate society's perceptions of control, violence, power, rights, and subsequent hierarchies. These factors are in line with global literature which present institutional structures and processes and intersecting gender and socio-economic inequalities as major drivers for D&A globally (24,72).

Addressing OV requires interventions to tackle deep-rooted socio-cultural beliefs and practices at the intersection of institutional violence against women and failures of the health system to provide respectful, evidence-based, women-centered and quality (72,73).

DISCUSSION

Summary of key findings

This review aimed to overview the situation of OV in the EMR from the experiences of birthing women to identify gaps in RMC and QoMC. The findings of this study indicate birthing women in the EMR experienced every type of D&A, regardless of health systems strength or country-income, with 6 out of 7 types of D&A found in almost two-thirds of included countries. OV in the EMR is expressed by provision of hierarchical, technocratic, overmedicalized care with many routine interventions pushed on women TMTS without their consent (20,34–38).

This review found that in the EMR, the most common types of D&A in childbirth are physical abuse (especially overused routine interventions) and non-dignified care. The power dissonance between providers and patients grounded in patriarchal socio-cultural norms makes it difficult for patients to make informed decisions, advocate for their birth preferences, and experience childbirth non-traumatically.

Notably, the narratives and experiences of women in the EMR are personal and unique and should not be generalized to indicate overall country-wide prevalence of D&A in childbirth. Only three studies from the Region used the B&H model to analyze the magnitude of D&A; this makes it is difficult to accurately estimate the overall prevalence of OV in the Region and compare it among countries and regions. Even in other systematic reviews on OV, the wide range in prevalence is misleading to fully capture the exact magnitude of these violations accurately. Sando et al. reported a range of 15-98% D&A experienced in five countries in SSA while WHO's multi-country study found a range in prevalence from 12.2-98% (12,29). Moreso, most included studies in this review are based on urban, public, (tertiary/teaching) hospitals, where higher prevalence of D&A is observed in the Region and globally; however, it is difficult to compare prevalence of D&A based on facility-type and geographic distribution.

Due to the normalization of overmedicalization and unbalanced power dynamics in the EMR, many women expect unconsented, abandoned, undignified, and technocratic care at birth, may not consider their experiences as abusive, and fail to recognize symptoms of obstetric violence. This may explain inconsistencies in findings between experiencing OV and reporting it, or expressing high levels of satisfaction despite encountering elements of D&A. For example, in Pakistan, 99.7% of women objectively experienced D&A while only 27.2% reported so; similarly in Sudan 77.2% experienced at least one type of D&A but reported 39.3%, 32.3% and 5.6% low, medium and high levels of D&A respectively (31,32). In Saudi Arabia, despite 70% of participants rating their last delivery as excellent and only 11% reporting it as bad, the prevalence of OV is high and requires ministerial interventions (47). These inconsistencies indicate steep under-reporting and bias in available data regarding OV in the Region and limited awareness of these human rights violations at individual, community, health system, and policy levels.

Interpretation and Comparison with Global Experiences

Despite the diversities among EMR countries, the findings of this study are comparable with the global literature, particularly the experiences of the global South. This section interprets the findings in the context of global experiences of D&A and offers some comparisons.

This literature review found that **non-dignified care** was the most common type of D&A in the EMR. One possible explanation could be the broad definition (***Annex 3***), ranging from verbal abuse, impersonal and unempathetic care, rude attitudes, non-verbal expressions by providers, having to receive care from male providers, and feeling dominated, dehumanized, and objectified as a patient (6,19,23,29,30). Similarly, studies from Ethiopia, India, Malawi, and Nigeria reported this form of D&A as most experienced by participants (74–77). Women's experiences of D&A in the EMR are most similar to those in India and Ethiopia, possibly due to geographical and cultural proximity to the Region.

Non-dignified care intersects almost all other types of D&A, especially non-consented care, due to its roots in socio-cultural norms and perceptions of gender and power. Similarly, **non-consented care** is exacerbated by unequal power dynamics between patients and providers, the normalization of overmedicalization, and invasive routine interventions in childbirth. Bradley et al. confirmed the need to reframe overmedicalization, hierarchical, and institution-centered care in the context of socio-cultural (gender) inequalities to adequately identify imbalances in power and improve RMC (24). The structural gender inequalities exacerbated in many patriarchal societies enable the dehumanization and

objectification of women in labor (72). In the EMR, the hierarchical dynamic between patients and providers enables not only unconsented care, but normalizes dominance of medical providers over female and parturient bodies. OV researchers in Latin America conceptualize OV not only as a human rights violation but further as an unethical gender stereotyping (73,78).

A woman's personal characteristics, education, empowerment, upbringing, and socio-cultural norms affect her perception, interpretation, and sensitivity towards verbal abuse, objectification, and consent. The variations in experiences of non-consented and non-dignified care in the EMR can be attributed to differing definitions of 'consent' and 'dignity'. The fluidity of these two definitions have historically overshadowed violence against women by discrediting the victim's feelings, expectations, and perceptions compared to dominant males and doctors. Women's personal attributes, combined with the normalization of OV in many health systems in the Region make it difficult for many women to recognize elements of D&A, define dehumanization as OV, and report accordingly. Systematic reviews confirmed the ubiquity of this issue in many patriarchal LMICs where women's positions are still inferior to men (6,79).

Global systematic reviews found verbal abuse in high, middle and low-income countries, but showed that threats and judgmental attitudes were more common in LMICs while objectification of women's bodies was reported more in M/HICs (6,79,80). Studies from LMICs like Ethiopia, Mozambique, and Brazil but also developed countries like the United Kingdom indicated struggles with unconsented-care; one study from India reported upward of 70% of women experiencing unconsented procedures (6,77,81,82). Another study of LMICs found that poor communication, loss of autonomy, lack of support, and degrading care were chief barriers to achieving patient-centered RMC (3).Similarly to the EMR, a systematic review found high frequency of poor communication and limited information-sharing in 22 countries (28 studies), confirming the need to address non-consented, verbally abuse, and non-dignified care (6).

This literature review found that **physical abuse** was ranked second-most-common form of D&A in the EMR. One global systematic review reported its prevalence in 11 countries (18 studies), predominantly in SSA (6). However, it is important to note that many studies on D&A do not include overused routine interventions in the scope of physical abuse but focus only on hitting and insufficient pain-relief (***Annex 3***). Nevertheless, the overuse of routine interventions was included as a sub-theme to physical abuse in this thesis due to its violation of the right to freedom from harm (***Figure 2***) which may explain the high rank of this category in the Region.

Literature from the Region overwhelming denoted that obstetric care in the EMR is technocratic and overmedicalized with non-evidence-based interventions pushed on women TMTS without consent (20,34–38). Notably, similar trends are seen in neighboring Turkey where routine interventions were overused (e.g. 71% inductions, 73% frequent vaginal exams, 80% restricted food/water, 75% intravenous fluids and 70% episiotomies), resulting in significantly lower satisfaction in childbirth (83). Turkey shares the Region's overarching patriarchal conservative culture, a contributing factor to the trend of overmedicalization (TMTS) and OV in the 'Middle East' Region. The use of non-evidenced-based routine interventions, specifically inductions, C-sections, and episiotomies were found in many other M/HIC, particularly in Latin America (4,73,78).

Unfortunately, hospital policies denying birth companions or allowing students observations contribute to **abandonment**, inadequate, and **non-confidential care** in many countries in the EMR. Similar

experiences of neglect and delays are observed in Mozambique, Ghana, Bolivia, Tanzania, and 20 other countries, while refusal to provide pain relief was reported across all-income and geographic contexts, according to Bohren et al. (6,81). Regarding **detention** and **discrimination**, study findings were almost identical to the global literature, especially from African countries, likely due to the narrow definition of these typologies and the widespread cultures of bribery and seniority (social-hierarchy) in many LMICs (6,24,29,74).

Strengths and Limitations of this study

One of the major **strengths** of this study is that, as far as the author knows, it is the first to use the B&H model to analyze D&A at the regional level in the EMR. Given the novelty of the topic of OV in global health research, this study offers an initial overview of literature from the EMR and identifies gaps and discrepancies in issues related to women's experiences in childbirth and QoMC. Furthermore, this study prides itself on using a feminist lens and analysis centering women's voices and experiences at the core of improving RMC and QoMC. Contrarily, many studies on maternal health are focused on a purely quantitative analysis of process, outcome, or output quality indicators, or qualitative analysis of factors, enablers, and barriers to care.

However, this study is not without **limitations**. Limited literature and prevalence studies in the EMR hinder a comparative analysis intra and inter-regionally, and further research is needed to address this gap. This review included literature from 1/6 HICs, 7/11 MICs, and 3/5 LICs (***Table 1 and 3***). Surprisingly, limited publications were available from HICs in EMR as only Saudi Arabia was included. As seen in ***Table 3***, possible publication bias may be negated by the generally equal distribution of publications among six countries (a quarter of the Region); however, only one study was included for each of Lebanon, Tunisia, and Yemen. Three main factors inhibit conclusions to be made or generalized to national or regional levels. Firstly, small sample sizes of included studies; secondly, half the countries in the Region were not represented or mentioned in the literature; and thirdly, various sub-cultures, diversities, and inequities within each country. Additionally, available data on QoMC, RMC, D&A, and OV is fragmented, inconsistent, and not collected homogenously or routinely at facility, country, or regional levels to allow sufficient estimation of prevalence and comparison.

Finally, the impact of socio-cultural norms on the power-dynamics between patients and providers as well as the overwhelming positive perceptions following birth may cause recall-bias. Inconsistencies and under-reporting may also be attributed to courtesy/desirability-bias, where patients fear criticizing providers or report higher-than-expected satisfaction overshadowed healthy maternal and child outcomes (51). These are commonly observed in many studies on sensitive issues like GBV. Other types of biases may include recruitment-bias, in cases where providers recruited the sample, or interviewer-bias for the qualitative studies (see methods in ***Annex 2***).

Limitations of Framework

While simple in its presentation, the list-format of the B&H model inhibits the conceptualization of the interconnectedness of types of abuses. As per various forms of violence and abuses, violations to RMC are not mutually exclusive as types of D&A may compound one another and may occur simultaneously. The interlinkages between the seven categories are undeniable, but not made explicit through this framework. Further, it was difficult to organize certain sub-themes as they fall at the intersection of multiple categories such as unconsented routine interventions (between Types 1 and 2), decision-making, hierarchy, and perception of control (between Types 2 and 4), and impersonal, inadequate, and delayed care (link between 1, 3, 4 and 6). In some cases, it was even difficult to separate types of abuses under the same theme; for instance, some studies separated emotional and verbal abuse from threats and shouting while others grouped one or more elements set as umbrella definitions for "verbal abuse", without fully clarifying or explicitly defining. The lack of standardized definitions of each category of D&A makes it even more difficult to compare systematically across studies, countries and regions, particularly as various studies set their own definitions and sub-themes (***Annex 3***) (6,20,23,24,29,79).

Lastly, the B&H framework fails to capture sexual abuse, verbal abuse, health system and socio-cultural factors which affect women's experience of respectful and dignified care. While an updated version of the B&H model has been created to address some of these limitations, it still uses the list-format and a complex three-tiered organization of themes (6).

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

Obstetric Violence threatens providing women with dignified, respectful, rights-based, high-quality maternal care. It violates dozens of human rights through the provision of disrespectful and abusive non-evidence-based care, reduces utilization and trust in health systems, and results in poorer health outcomes for women, children, families, and communities.

Globally, over a third of women experience D&A in childbirth and in the EMR, while an exact prevalence was difficult to capture, women's narratives indicate the normalization of OV in childbirth as women expect technocratic and dehumanized care. Findings show the most common types of D&A in the Region are physical abuse and non-dignified care; whose intersections enable the objectification of women's bodies and overuse of unconsented routine interventions in a patriarchal system that regards the power and autonomy of doctors above parturient patients.

The structural nature of OV and its embeddedness in the health system and socio-cultural norms normalizes its manifestations as 'standards' of intrapartum care. **The implications** of this include:

- continuance of these abusive, overused, and unconsented routine practices by care providers,
- acceptance, under-reporting, and lack of recognition by women and their communities, and
- passive normalization of human-rights violations by policymakers, further continuing the cycle of D&A in childbirth.

Furthermore, it is imperative to recognize the magnitude of OV in health systems in the EMR and inhibit its spread in order to ensure that every woman achieves her right to health in a dignified, respectful, and empowered manner.

Recommendations

The following interventions are inspired by WHO and global literature (12,79,84,85) to address the challenges and implications of the normalization of OV in the EMR. These recommendations are not comprehensive as multi-sectoral and multi-level actions to loosen the roots of OV from the health system and society. Recommendations should be tailored to country-specific contexts to address women's needs and local challenges and will require various timelines accordingly.

At the individual and community level, advocacy, education, and empowerment are required to raise awareness on OV and women's rights in childbirth and eliminating disrespectful and abusive practices. **Women's empowerment and civil society organizations** must partner and engage with community actors to change socio-cultural beliefs around birth, gender, and power, particularly in a Region with strong patriarchal and conservative norms.

Academia should spearhead improvements to existing medical education to curricula integrate RMC. Evidence-generation in all EMR countries is needed to measure national prevalence and compare patterns based on personal characteristics, settings, facility-types, geography, etc. Further studies are needed to document the experiences of women in childbirth, health workers, advocates, and other relevant stakeholders. Evaluation studies are needed to further expose gaps in QoMC and knowledge-to-practice-translation of clinical guidelines.

At the health system and facility level, infrastructural changes are needed to shift the focus towards high-quality, respectful, women-centered rights-based care.

Health Workforce:

- Introducing a multi-disciplinary team-based approach in intrapartum care (which includes doulas and health advocates), considering task-shifting and task-sharing care with nurses and midwives, and involving patients in the decision-making process to reduce elements of hierarchical care.
- Mandating all maternal health workers receive cultural competency training on providing RMC, specifically on recognizing elements of D&A, understanding patient-provider power dynamics, facilitating informed decision-making and consent, and communicating respectfully.
- Strengthening pre-service medical education as well as in-service refresher trainings, and emphasizing evidence-based practices in childbirth and RMC.
- Considering workload management options including rotations, incentives, and supportive supervision to health workers to reduce provider burnout.

Service delivery:

- Health facilities in the EMR should consider institutionalizing policies that support women's rights to movement and birthing free from violence and discrimination. These recommendations are in line with WHO's latest guidelines for intrapartum care and include:
    - Providing patient-centered and quality childbirth education classes and resources.
    - Reducing routine interventions as standards of care (e.g. overused C-Sections, inductions, uterine pressure, vaginal exams and episiotomies, restricted food and water, bed-confinement).
    - Allowing women to mobilize during labor and push upright (or in their positions of choice).
    - Providing and educating women on pain relief options and alternatives during labor.
    - Allowing choice of labor companions during labor and delivery, which addresses patient's feelings of abandonment and increases positive birth outcomes and experiences.

- Investing in curtains and other tools to protect physical privacy. Limiting number of students observing each delivery and obtaining patient consent should also be of high priority.

- Strengthening referral pathways to mitigate patient overflow and ensure women arrive at facilities when necessary, instead of too-soon or too-late.
- Establishing accountability mechanisms to report abuses in childbirth, which should be accessible to health workers and patients, and monitored regularly by hospital managers, accreditation bodies, and quality-assurance boards.

At the policy level, public recognition of the importance of respecting women's rights in health and childbirth is necessary. Policymakers should consider the return on investment of improving RMC by strengthening information systems and translating evidence-based recommendations into action, through:

- Creating and integrating written policies and benchmarks for RMC including goals, operational plans, and monitoring mechanisms; RMC indicators and measures for OV and D&A which should be formally and routinely collected at facility-level and evaluated nationally, to measure progress over-time and effectiveness of RMC interventions.
- Involving all stakeholders, including women, in efforts to improve QoMC and eliminate OV.

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Annexes:

- Annex 1: WHO's Standards for Improving Quality of Maternal and Newborn Care In Health Facilities(5)

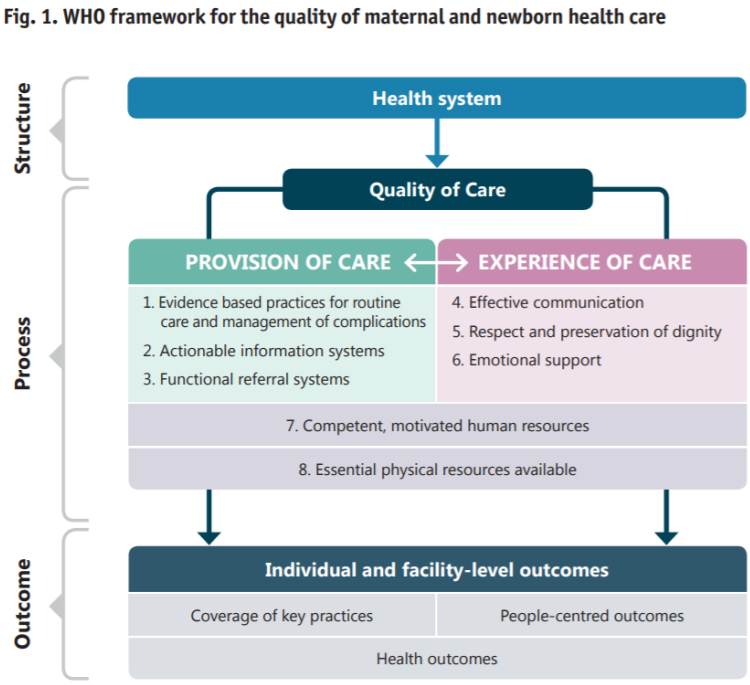

FIGURE 6: WHO FRAMEWORK FOR QUALITY OF MATERNAL AND

- Annex 2: Table of Included Articles by country and category of D&A

Title/Type of Study	Author	Year	Country	Methods	Sample size	Setting (hospital/facility-based or community), urban or rural, private or public, if known	1. Physical abuse	2. Non-consented care	3. Non- confidential	4. Non-dignified care	5. Discrimination	6. Abandonment	7. Detention	Other factors
Mixed Methods														
Assessment of women's perspectives and experiences of childbirth and postnatal care using Q-methodology	Shabila et al	2015	**Iraq**	Mixed Methods, using Q-methodology questionnaire (n=37) purposively selected to increase sample diversity; 2 focus group with 20 women each, 5 indepth-interviews and 3 health workers (2 nurses and 1 gynocologist)	37	Public facility in Erbil, capital of Iraqi Kurdistan Region	x		x	x		x		x
Childbirth Practices in Jordanian Public Hospitals: Consistency with Evidence-Based Maternity Care?	Shaban et al	2011	**Jordan**	Explorative research design with non-participant observation (n=460), proportional stratified sample was recruited	460	Three major public hospitals in Jordan	x	x	x			x		x
Jordanian women's dissatisfaction with childbirth care	Mohammad et al	2014	**Jordan**	Descriptive cross-sectional study, semi-structured interviews using questionnaire (n = 320) with women immediately post-partum (2-24hrs after birth); details of recruitment not specified	320	Three major public hospitals in Jordan		x	x					x
Women's satisfaction and perception of control in childbirth in three Arab countries	Kabakian-Khasholian et al	2017	**Egypt, Lebanon, Syria**	Questionnaire (n =2620), medical charts also reviewed	2620	Three major public teaching hospitals in major cities each country		x	x	x				x

Ethnographic study of the use of interventions during the second stage of labor in Jeddah, Saudi Arabia	Altaweli et al	2019	**Saudi Arabia**	Exploratory study/ethnographic approach. Data collection methods included participant observations of 19 labors and births (n = 8 at City Hospital and n = 11 at King's Hospital) and semi-structured interviews with 29 health care professionals.	Obs (n=19), IDI (n=29)	Two public teaching hospitals in Jeddah (major cities)	x	x	x	x				x
Other/Reviews															
Obstetric Violence in Egypt's Maternal Health System	Khalil	2019	**Egypt**	News Article	N/A	N/A	x	x		x				
Birthing in the Arab region: translating research into practice	Kabakian-Khasholi et al	2012	**Mixed: Egypt, Lebanon, Palestine and Syria**	Literature Review	N/A	N/A	x	x						
Women's experiences of childbirth in Middle Eastern countries: A narrative review	Hussein et al.	2017	**Mixed: United Arab Emirates, Jordan, Egypt, Qatar, Lebanon and Saudi Arabia.**	Narrative Review (accepted but not yet peer reviewed)	N/A	N/A	x	x	x	x		x		x
Maternal mental health matters : childbirth related care in Yemen through women's eyes	Kempe	2019	**Yemen**	PhD Thesis: multi-stage (stratified-purposive-random) sampling(n=220), semi structured questionnaire	220	Both urban and rural settings, including community-level, not specifically limited to facility-based deliveries	x	x		x		x		x
Qualitative															

"The midwife helped me ... otherwise I could have died": women's experience of professional midwifery services in rural Afghanistan - a qualitative study in the provinces Kunar and Laghman	Thommesen et al	2020	**Afghanistan**	Explorative case-study approach, participatory observation, in-depth interviews (n=14) and focus-group discussions (FGDs) (n=39)	53	Rural setting, community-level			x	x		x		x
Antenatal and obstetric care in Afghanistan – a qualitative study among health care receivers and health care providers	Rahmani et al	2013	**Afghanistan**	One-to-one semi-structured interviews of 27 individuals, including 12 women who were pregnant or had recently given birth, seven doctors, five midwives, and three traditional birth attendants.	27	Both urban and rural settings, including community-level, not specifically limited to facility-based deliveries. The interviews were carried out in Kabul and the village of Ramak in Ghazni Province.	x			x			x	x
Key Findings from Qualitative Study: Experiences and Expectations of Childbirth at Health Facilities in Afghanistan	Currie et al	2019	**Afghanistan**	NGO Report (based on qualitative study, FGD, interviews, observations). FGD were conducted with new mothers. In-depth interviews were conducted with 20 policy makers and central and provincial officers from MoPH and other relevant stakeholders	FGD (n=64), IDI (n=20)	Public District hospitals outside provicial capitals. To get a snapshot of women's experiences during facility births in different regions of the country, one district was selected for data collection in each of the four provinces considered regional population hubs: Balkh, Kandahar, Herat and Nangarhar. Using 2017 data from the National Health Management Information System, a list of public district hospitals outside of the provincial capital city was generated and one hospital per province randomly selected. Clients from the catchment area of the clinic were selected using the clinic register book for convenience	x					x		x
Villains or victims? An ethnography of Afghan maternity staff and the challenge of high quality respectful care	Arnold et al	2019	**Afghanistan**	Six weeks of observation, 41 background interviews, 23 semi-structured interviews with doctors, midwives and care assistants. Focus groups were held with two diverse groups of women in community settings	23	Community setting				x		x	x	x

Experiences of inequitable care among Afghan mothers surviving near-miss morbidity in Tehran, Iran: a qualitative interview study	Mohammadi et al	2017	**Iran**	In-depth interviews were conducted with 11 participants who were prospectively recruited (n=11)	11	One university hospitals in capital, Tehran				x	x			x
The best encouraging persons in labor: A content analysis of Iranian mothers' experiences of labor support	Fathi Najafi et al	2017	**Iran**	Exploratory and qualitative study, observations and semi-structured interviews with health workers, birth companions and new mothers (n=25)recruited through a purposive sampling method. A total of 25 women, including 16 women in labor and having the experience of a natural childbirth, two women who had recently given birth, one birth companion, one doula midwife, two midwives, one obstetrician,one resident in obstetrics, and one medical student, were finally selected. The husband of one of the participants, as well as a midwifery student and lecturer in midwifery were also included.	25	Mostly hospitals in major city of Mashhad Participants were selected from hospitals and health centers, The hospitals included four governmental hospitals, one social health-care hospital, three non-governmental (private) hospitals and two charity hospitals, members of websites, public places such as parks, and social networks like Telegram and Viber (by sending an invitation letter and an information sheet).						x		
Women's experiences of routine care during labour and childbirth and the influence of medicalisation: A qualitative study from Iran	Pazandeh et al	2017	**Iran**	Descriptive qualitative study, purposeful sampling, interviews (n=26)	26	Four public hospitals in capital city, Tehran with a high rate of births, providing services to low and middle income families.	x	x						
Caring behaviours by midwives: Jordanian women's perceptions during childbirth	Khreshe h et al	2019	**Jordan**	Exploratory and qualitative design utilizing semi-structured interviews (n=21)	21	The main public hospital in Southern Jordan, serving the entire southern region			x	x		x		x
Evaluating the experience of Jordanian women with maternity care services	Hatamleh et al	2013	**Jordan**	Semistructured interviews (n= 460)	460	Three public hospitals in Jordan	x		x	x		x		x

'My pain was stronger than my happiness': experiences of caesarean births from Lebanon	Kabakian-Khasholi et al	2013	**Lebanon**	Inductive qualitative design, using face-to-face semi-structured interviews (n=22)	22	Recruited through perinatal database and selected obstetricians' clinics in the Greater Beirut area in Lebanon (facility-based, urban, most likely private facilities due to contract out mechanisms in Lebanon)	x	x						x
Exploring Women's Personal Experiences of Giving Birth in Gonabad City: A Qualitative Study	Askari et al	2014	**Pakistan**	purposeful approach in-depth interviews (n=21)	21	Gonabad University of medical sciences (tertiary teaching hospital, public and urban)	x	x	x					
Sarah's birth. How the medicalisation of childbirth may be shaped in different settings: Vignette from a study of routine intervention in Jeddah, Saudi Arabia	Scamell et al	2017	**Saudi Arabia**	Ethnographic data collection methods, including participant observation, field notes, and interviews of patients (n=19) and health workers: obstetricians (n=10), midwives (n=12), obstetric nurses (n=6) and nurse/midwives (n = 1). Health workers assisted in recruiting the sample participants.	19	Public hospital in major city, Jeddah	x		x	x	x	x		
WHAT WOMEN HAVE TO SAY ABOUT GIVING BIRTH IN SAUDI ARABIA.	Jahlan et al	2016	**Saudi Arabia**	Cross-sectional/qualitative IDI (n=32) and questionnaire (n=169) 24 hours post-partum in 3 selected public hospitals	201	Three public hospitals in major cities	x	x	x	x		x		x
"Is the doctor God to punish me?!" An intersectional examination of disrespectful and abusive care during childbirth against single mothers in Tunisia	Amrousia et al	2017	**Tunisia**	Qualitative IDI (n=11) recruited voluntarily through two local NGOs	11	Public tertiary hospitals (urban): Seven participants delivered at a University Teaching Hospital in the capital; while the other participants delivered at public healthcare facilities in different cities (3 different regional hospitals and one university teaching hospital in a coastalcity).	x	x		x	x			x
Quantitative														
Factors Affecting Women's Satisfaction During Labor Experience	Elgazzar et al	2018	**Egypt**	Descriptive design using a survey tool (n=214)	214	Large public teaching hospital in urban city center (Mansoura city hospitals)		x		x		x		x

Parturient needs during labor : Egyptian women's perspective toward childbirth experience, a step toward an excellence in clinical practice	Abdel Ghani et al	2011	**Egypt**	Cross sectional study(n=400); each interviewed using a structured questionnaire	400	Major public teaching hospital in capital city, Cairo (El Kasr- Aini, -Cairo- University Maternity Hospitals)	x		x	x		x		x
Quality of care in the delivery room: Focusing on respectful maternal care practices	Mousa et al	2018	**Egypt**	Cross-sectional retrospective study, purposeful sampling, using structured questionnaire as survey tool (n= 501)	501	Large public teaching hospital in urban city center (Minia University Maternity and Child Health Hospital in Minia, Egypt.)	x			x	x	x		
Quality of delivery care in Assiut University Hospital, Egypt: mothers' satisfaction	Monazea et al	2015	**Egypt**	Cross-sectional, (n=435) interviewed using a semistructured questionnaire	435	Large public teaching hospital in major urban city center (Assiut University Hospital)		x	x	x		x		x
Predictors of traumatic birth experience among a group of Iranian primipara women: a cross sectional study	Ghanbari-Homayi et al	2019	**Iran**	Cross-sectional study, cluster sampling (n=800), structured questionnaire used; Data were collected through face to face interviews and analysed mainly by multivariable logistic regression.	800	64 health centres (public) in Tabriz, the second largest city in Iran.	x	x						x
Service Quality of Delivered Care from the Perception of Women with Caesarean Section and Normal Delivery.	Tabrizi et al	2014	**Iran**	Cross-sectional study (n=200) using survey tool	200	One large teaching hopsital in major city, Tabriz			x	x				x
Maternal satisfaction regarding quality of nursing care during labor and delivery in Sulaimani teaching hospital	Atiya	2016	**Iraq**	Purposive sample of (200) postpartum women, structured questionnaire and interviews	200	Large teaching hospital in capital, Baghdad				x				x
Role of verbal and non-verbal communication of health care providers in general satisfaction with birth care: a cross-sectional study in government health settings of Erbil City, Iraq	Ahmed	2020	**Iraq**	Cross-sectional study was conducted on a convenient sample of 1196 women who were directly interviewed using a structured questionnaire	1196	Erbil City (urban) and recruited from: Maternity Teaching Hospital is the biggest specialized public hospital for women's Health care especially labor and delivery care with 300 hundred beds and 30 beds in delivery room. Rezgary Hospital is a general hospital including a unit for women's health care services with capacity of 6 beds and Malafandy Primary Health Center has a small unit with capacity of 5 beds for labor and delivery care of women with low risk and normal		x	x	x				x

						health conditions. All of these institutions are **public** health settings.									
Women's satisfaction with Intrapartum Services in Basrah-Iraq	Asadi et al	2018	**Iraq**	Descriptive cross-sectional study using a structured questionnaire (n=459)	459	14 primary health care centers (public, urban)	x	x	x	x		x	x	x
Exposure to verbal abuse and neglect during childbirth among Jordanian women	Alzyoud et al	2018	**Jordan**	Retrospective cross-sectional descriptive design, using structured questionnaire/survey tool (n=390)	390	4 governmental Maternal and Child Health Centers (MCHCs) in Zarqa, Jordan selected due to their size and diversity (urban, public, facility-based)	x	x		x	x	x		x
Disrespect and abuse during childbirth in district Gujrat, Pakistan: A quest for respectful maternity care	Azhar et al	2018	**Pakistan**	Cross sectional household based study, interview based structured questionnaire (n = 360).	360	Household based study was conducted in tehsil Kharian of district Gujrat. (Community-level, semi-urban, public facility)	x	x	x	x	x	x	x	x
Obstetric violence experienced during child birth in Taif city, Saudi Arabia	Alnemari	2020	**Saudi Arabia**	Cross-sectional study (n=358), recruited after thorough non-probability consecutive sampling technique, using structured questionnaire	358	(Tertiary hospitals, urban, public) Post-natal clinics of maternity hospital of King Faisal medical complex and Al-Hada armed forces hospital, Taif city, Saudi Arabia.	x	x	x	x		x	x	x
Saudi womens acceptance and attitudes towards companion support during labor: should we implement an antenatal awareness program?	Al-Mandeel et al	2013	**Saudi Arabia**	Prospective cohort study (n= 402) using a structured standardized translated questionnaire with fixed-choice questions	402	Three governmental tertiary hospitals within capital city, Riyadh, including a university hospital (King Khalid University Hospital, KKUH), a Ministry of Health Hospital (King Fahd Medical City, KFMC), and a military hospital (Riyadh Military Hospital, RMH).						x		x

An Assessment of Intra Partum Care Provided to Women in Labor at Omdurman Maternity Hospital in Sudan and Their Level of Satisfaction with It	Handady et al	2015	**Sudan**	Cross sectional (n=284), hospital based study, participants selected through systematic random sampling and structured questionnaire	284	One large teaching hospital in major city, Omdurman (Omdurman Maternity Hospital)	x	x	x	x				x
Proportion of Disrespectful and Abusive Care during Childbirth among Women in Khartoum State-2016	Altahir et al	2018	**Sudan**	Descriptive cross-sectional study in 3 hospitals proportionally sampled based on the number of clients who received childbirth services at each facility, semi-structured interviews (n= 263) using structured survey tool	263	Three public teaching hospitals in the capital and urban city-centers. Omdurman Maternity Hospital, Saad Abu-Aleila teaching hospital and Khartoum north teaching hospital were randomly selected for this study.	x	x	x	x	x	x	x	x

- Annex 3: Examples of Sub-themes from systematic review compared to study findings

Title	Author	Year	Country	Type of Study	1. Physical abuse	2. Non-consented care	3. Non-confidential care	4. Non-dignified care	5. Discrimination	6. Abandonment	7. Detention
Exploring OV in the EMR (Baseline)	**Khalil**	**2020**	**EMR**	**Review**	**a. Overuse of routine interventions b. Hitting c. Insufficient pain medication**	**a. Hierarchical care and limited decision-making power b. Limited information for decision-making and consent c. Unconsented routine interventions**	**a. Privacy in the physical environment b. Overcrowding (by other patients, too many health workers, and students)**	**a. Verbal abuse b. Dehumanized care**	**a. Personal characteristics b. Language**	**a. Lack of companionship b. Inadequate attention by staff**	**a. Informal payments and culture of bribes**
The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother–baby friendly birthing facilities initiative	Miller et al	2015	Global	Review	Hitting, roughly forcing legs apart, fundal pressure for normal delivery	No informed consent for procedures, such as when provider elects to perform unnecessary episiotomy	No privacy (spatial, visual, or auditory)	Humiliation by shouting, blaming, or degrading	HIV status, ethnicity, age, marital status, language, economic status, educational level, etc.	Facility closed despite being 24/7, or if open, staff can't attend delivery	Not releasing mother until bill is paid
The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review	Bohren et al	2015	Global	Systematic Review	Use of Force (beaten, kicked, slapped, pinched) OR physical restraint OR sexual abuse (rape)	Lack of informed consent and confidentiality Painful vaginal exams, Refusal to provide pain relief, Performance of unconsented surgical operations	Loss of autonomy, treated passively as participants during childbirth, Denial of food, fluids, or mobility, Lack of respect for preferred birth positions, Denial of safe	Verbal Abuse (harsh, rude language or accusatory comments) OR Threats/blaming OR (Poor communication, Dismissal of women's concerns, Language and interpretation	Discrimination and Stigma (based on age, ethnicity/race/religion, SES, HIV status)	Neglect, abandonment, or long delays Skilled attendant absent at time of delivery, OR Lack of supportive care (from health workers or	Detainment

							traditional practices, Objectification of women	issues, Poor staff attitudes)		Denial or lack of birth companions)	
Methods used in prevalence studies of disrespect and abuse during facility based childbirth: lessons learned	Sando et al	2017	SSA Sub-Saharan Africa includes 4 African Countries (Kenya, Ethiopia, Tanzania, Nigeria)	Systematic Review	Restrained or tied down during labor; Episiotomy given or sutured without anesthesia; Beaten, slapped, or pinched; Sexually abused by health worker	Denied right to information, consent, choice not protected as provider did not: introduce themselves; encourage me to ask questions; respond to my questions with promptness, politeness, and truthfulness; explain to me what is being done and what to expect throughout labor and birth; give me periodic updates on status and progress of my labor; allow me to move about during labor; allow to assume position of choice during birth; obtain my consent or permission prior to any procedure	Age disclosure without consent; Provision of care without privacy; Medical history disclosure without consent; Disclosure of HIV status without consent OR uncovered during delivery or examination; no screens blocking view during delivery or examination OR discussed her issues when other clients were listening.	Blamed or intimidated during childbirth; Threatened with cesarean delivery to discourage patient from shouting; Received slanderous remarks (aspersions) from birth attendant; Scolded, shouted at, or called stupid	The provider spoke to me in a language and at a language-level that I cannot understand; The provider showed disrespect to me based on any specific attribute (age, ethnicity, low SES, HIV status)	Denied companionship by the husband or close relatives; Birth attendant failed to intervene in a life-threatening situation; Not granted requested attention because staff was exhausted, Ignored when sought help for pain relief or left unattended by heath workers when they needed help.	Discharge postponed until her hospital bills are paid; Detained in the hospital until infant's bills are paid, Request for Bribe