Orchestrated efforts a must for ending obstetric violence:

A Cross-sectional retrospective study from Gaza

Alaa M. Ismail[1*], Anas Ismail[2], Jane Hirst[3]

[1] Department of Obstetrics and Gynecology, Islamic University, Gaza, Palestine

[2] King's Centre for Global Health and Health Partnerships, London, UK

[3] Professor in Global Women's Health, Nuffield Department of Women's & Reproductive Health, University of Oxford, UK

[*]Corresponding Authors

School of Medicine, Islamic University in Gaza, Gaza Strip

Occupied Palestinian territories

alaa.obgyn2013@gmail.com

Keywords

Obstetric violence, maltreatment and disrespect, delivery, Gaza, Palestine

Abstract

Background

Obstetric violence (OV) is a critical issue that is often overlooked and makes pregnant women reluctant to get proper access to maternity services. In Palestine, and particularly in Gaza strip, there is limited knowledge about the rates or experiences of OV during delivery. This study aimed to assess the prevalence, determinants and common types of OV among women who had given birth during the last four years at different hospitals in the Gaza strip.

Methods

We conducted an online survey through social media and groups in a time period during January and February 2022 to explore women's experiences of giving birth in Gaza Strip. Women who delivered between 2017-2021 in Gaza hospitals were invited to share their experiences by completing the questionnaire. Women were asked to share the experience of their most recent delivery if they had more than one delivery during the period. Consent was taken at the beginning of the questionnaire, which has with a full explanation of the research and the objectives of the study. The confidentiality and anonymity of the data handling were emphasized to encourage women to freely express their feelings and experiences.

Results

A total of 722 women completed the online questionnaire. Most of them (67%) were aged between 21-30 years, and almost half were from low socioeconomic households. Governmental hospitals were the place of delivery for 70% of respondents. One in three women reported they had experienced at least one form of OV. Amongst these women, the types of OV reported were physical (47.8%), psychological (40.8%), verbal (36.4%), and sexual (4.4%). Delivery in private facilities (OR 0.45, 95% CI 0.32-0.74) and the woman knowing their care provider before birth (OR 0.37, 95% CI 0.23-0.59) were both independently protective for OV. In contrast, women who reported they had been aware of OV before birth were more likely to report it happening (OR 3.45, 95% CI 2.37-5.01).

Conclusion

We found a concerningly high prevalence of reported OV among women in Gaza Strip in Palestine. Promoting awareness of these findings and the issue of OV amongst maternity staff, identifying the root causes and developing locally led initiatives to eliminate these practices needs to be a priority.

Keywords

Obstetric violence, quality of care, Delivery, Gaza Strip, Palestine

Introduction

Achieving healthy lives and promoting well-being at all ages is the target of the third Sustainable Developmental Goal (SDG3) adopted by the United Nations and the World Health Organization (WHO) [1]. Achieving this for women means accessing high-quality maternity care, especially during pregnancy and delivery, which is a stressful and painful experience. Laboring women require ample support and empathy during all stages of labor, including dignified care, effective communication, and counselling that respects their choices during pregnancy and delivery [2]. Sadly, many women report various forms of violence or abuse during their labor. Globally, this has necessitated urgent actions that have culminated in progressive healthcare policies in other settings [3].

The context and determinants of disrespect and maltreatment, leading to different forms of violence, during labor vary among nations and cultures. Although there is a wide acknowledgement that obstetric violence is a problem facing women in labor care, there is no consensus over the agreed criteria to define OV. Several organizations supporting and advocating women's rights have adopted different definitions for OV [4,5]. Overall, OV can be attributed to several factors, including inadequate knowledge among laboring women of their rights, over stretched and under-funded health services, and non-adherence to good medical practice among healthcare professionals.

In Palestine, the fertility rate is around 3.9 [6], meaning women spend roughly a third of their reproductive life either pregnant or postpartum. This draws attention the high demand for these services and the need for dignified and high-quality care. Maltreatment and violence during pregnancy, and especially during labor, can make women reluctant to seek medical advice and destroys the trust relationship between women and the health system, resulting in poor access to health care in general. This worsens health outcomes and results in preventable maternal morbidity and mortality.

OV is a sensitive issue in Palestine. Whilst one study has explored OV determinants in Palestine[7], there have been none to date exploring the experiences of women living in the Gaza strip. A recent study[8] explored mistreatment during delivery among Palestinian women but focused on the West Bank (four out of five included hospitals). Women living in Gaza face additional restrictions on their freedoms, such as travel limitations and higher unemployment rate, whilst they also live with the stress of undergoing at least four major military operations in the last 15 years. These stresses combined with socio-economic challenges could affect the health service delivery and women’s perceptions of their care. We aimed to

explore the forms of obstetric violence experienced among laboring women in Gaza and the associations with socio-demographic characteristics.

Methods and materials

We conducted a cross-sectional study in January and February 2022. The study was conducted in Gaza, a highly condensed area with 2.17 million people in an area of 365 square kilometers. In 2021, the birth rate was 32.9 births per 1000 women. It is an occupied territory where blockade and restriction of movement have been imposed since 2005 after the Israeli withdrawal[9]. Being a closed area for 17 years, it is witnessing prolonged socioeconomic deterioration. This has drastically affected all aspects of life, including health care and facilities. Obstetric care in Gaza is mainly provided by 17 hospitals and health centres. The six main government hospitals account for the majority of deliveries (70%). Al-Shifaa hospital is the tertiary and largest hospital in Gaza strip and is located in the Gaza City. It contributes to nearly 35% of all deliveries[10].

Participants were eligible if they had given birth during the preceding five years in Gaza (January 2017 to January 2022). We excluded women who reported a birth date outside of that period and those who could not read or understand Arabic. Participation was voluntary, and women were approached online, through social media platforms, patient lists from hospitals and the authors' social and professional circles on WhatsApp, Instagram, and Facebook handles. A further snowballing approach was utilized to ensure a wide reach of the questionnaire. Participants were encouraged to circulate the questionnaire among women meeting the inclusion criteria in their social circles.

Women were asked to complete an online, anonymous and self-administered questionnaire that was designed to record their experiences of labor and delivery in Gaza hospitals. The questionnaire was based on previous research on OV[11–13] and comprised 42 questions (7 scale-like questions and 35 closed multiple choice questions)

The questionnaire was divided into four parts: 1) socio-demographic information, 2) antenatal care experiences, 3) intrapartum course and, 4) experiences of OV. If women had more than one child during the study period, clear instructions were given to describe only their most recent birth experience in the questionnaire. The primary outcome was OV of any form. Based on previous literature[13,14], we categorised OV into: physical, psychological, verbal and sexual violence. Physical violence was defined as exposure to any of the following: hitting, spitting, restriction of movement, procedures without analgesia, unconsented examination, unindicted recurrent vaginal exam, examination non-privately,

exposing other parts of the body other than the one examined or training students without consent. We defined Verbal violence as direct cursing, yelling, using offensive terms or non-humane treatment. Psychological violence included any form of threatening, bullying, recurrent negligence, punishment or discrimination. Sexual abuse was defined in our study as any form of direct sexual harassment, threatening the patient to do sexual acts or use of offensive sexual words.

Under each category, women were asked about their experiences of various possible forms of abuse and/or violence. Examples included discrimination, non-consented procedures, breach of confidentiality, negligence, disrespect and inadequate medical care.[5] The prevalence of OV in Gaza was unknown at the start of this study, therefore we used the sample size method described by Martines-Galiano et al in their study of OV in women in Spain[15], where a sample of 667 women was deemed sufficient for a background estimate of OV of 15% and to provide at least 10 events for each independent variable considered.

Statistical Analysis

All the data were analyzed using SPSS version 26. We first performed a descriptive analysis to determine the mean, percentage and standard deviation for all variables. Following this, we performed bivariate and multivariable logistic regression to explore factors associated with OV in this population. We present odds ratios with 95% confidence intervals. All statistical tests were 2-sided with a significance level of <0.05. Owing to the limited sample size, we did not perform any pre-specified sensitivity analyses.

Results

A total of 722 women had completed the questionnaire, comprising 722 deliveries out of nearly 223,251 deliveries[16] in Gaza during the five years. The median age of respondents was 27 (range 14-40 years), with most (67.2%) in the age group 21-30 years. More than 43% of participants (n= 313) lived in Gaza City. Overall, around two-thirds of the participants lived in urban settings (71.1%), and 29% of these were from refugee camps (n=209). Most respondents (n=532, 73.7%) reported their occupation as housewives. Half of the respondents (n=362, 50.1%) were from low-income households with a family income per month of less than 1000 NIS (USD300), and only 7.5% (n=54) reported an income exceeding 3000 NIS (USD $900). The rate of facility birth was high in this sample, with only four women giving birth at home. Most women (n=508, 70.4%) gave birth in government facilities, and 221 gave birth in non-governmental or private facilities. Overall, one in five women delivered by caesarean section whereas

seven out of ten women had normal vaginal delivery, whereas instrumental vaginal delivery contributed to less than 5% (Table 1).

Antenatal Care

Table 2 shows the findings related to antenatal care. Despite most women reporting regular antenatal care from an obstetrician (87.1%), 42% felt the information they received before labor had been inadequate. Two thirds of respondents stated they would be interested in reading and/or watching tutorials about labor symptoms, stages and other related issues.

Knowledge of and Forms of Obstetric violence

Half of women in this sample reported not having any prior knowledge of the term OV. However, upon specific questioning, 41.6% (n=300) reported having experienced at least one form of OV in their most recent birth. One in four women felt they had experienced neglect during their labor. A similar proportion of women also reported they had been yelled at by health staff. One in ten women reported having procedures without analgesia, and 6.6% (n=48) reported some procedures were done without their consent. Fewer women reported experiencing sexual (0.41%) or physical forms of OV (2.9%).

Common problems women experienced in labor and delivery

Initially, women were asked to report the most common struggles they had experienced during labor and delivery. Not allowing a companion (64%), inadequate analgesia during procedures (58%) and inability to find medical staff around when needed (41%) were among the most common issues women experienced at hospitals. Furthermore, one in five women reported having a medical procedure done without having their consent and a third of patients had a concern on privacy measures being inadequate.

Correlates of Obstetric Violence

When considering potential risk factors for OV individually, significant associations were observed with area of residence, type of residency (urban or refugee camp), nulliparity, delivery in a government facility, type of delivery and knowing the obstetric care provider (supplementary table 1). However, after controlling for potential confounding, the only protective factors for OV to remain significant were delivery in a private hospital (AOR 0.49, 95% CI 0.32-0.74) and knowing the medical staff responsible for the delivery (AOR 0.37, 0.23-0.59).

Women with OV were more likely to report they were aware of OV before the survey (AOR 1.86, 95% CI 1.04-3.31). Women living in Khan Younis reported twice the risk of OV than those living in the North

(AOR 2.25, 95% CI 1.13-4.48). None of the other social or care factors were independently associated with OV.

Discussion

We demonstrate that OV is likely to be common in the Gaza Strip, Palestine with around four in ten women who responded to the survey reporting experiencing one or more forms of OV. The most commonly reported forms of OV were medical neglect and being yelled at during labor. Our findings also show the importance of continuity of care between antenatal and delivery care, with higher rates of OV reported when women did not know their delivery provider. Women in government facilities were also more likely to report any form of OV. Reassuringly, rates of sexual and physical abuse were very low, however any report of these forms of abuse needs to be of great concern in a health system and should be investigated.

In Gaza Strip, years of socioeconomic depression, protracted conflict and blockade have left the health sector lacking adequate medical supplies and physical infrastructure[17]. This has been reflected on one hand on workers at maternity centers and hospitals by impacting their motivation and ability to providing adequate, qualified care. On the other hand, mothers find themselves struggle to secure optimal services with special demand arises during pregnancy and labor journey. This warrants joining efforts to better enhance quality of care offered to women throughout different stages of life.

In our study, for most women (58.4%), OV was a new and unfamiliar concept. Though, women with prior knowledge of OV before this study was associated with higher reported rates. Awareness of the issue may be because of a negative birth experience, or it could reflect greater awareness of rights amongst some women, with more awareness when these rights are violated.

The annual report on births in the Gaza Strip for the year 2021, issued by the Palestinian Health Information Center at the Ministry of Health, stated that the number of live births reached (56,658) live births. It also indicated that the number of births in government hospitals (Ministry of Health and Military Medical Services) accounted for (71.5%) of total births[18]. Although total fertility rates in Palestine declined from 7.7 births per woman (BPW) in 2003 to 3.5 BPW in 2020, this remains higher than the average rates among Arab countries (3.1 BPW) [19–21]. Furthermore, given the high birth rate in Gaza, being 28.2 per 1000 population versus 17.4 globally[22,23], obstetric wards in Gaza hospitals are very busy, and sometimes over-stretched beyond capacity, throughout the year. Such a high workload for staff can lead to a fall in the level of care provided. These work pressures may lead medical care workers

to act outside of professional boundaries resulting in OV episodes. Previous studies showed that abusive work environment, health system failure, complications during delivery, unindicted medical procedures and many others, are factors leading to OV [15,24].

The recent study by Abu-Rmeileh et al. explored the mistreatment of women during labor in five health facilities in Palestine, with 36.% of participants from Gaza and the rest from the West Bank.[8] The study reported that nearly 19% of women reported some form of violence or abuse, with women in Gaza reporting higher levels (23%) than the West Bank (16.4%). It is worth noting that Gaza suffers more stressful environment, especially worse working conditions for the health workforce. Another qualitative study from the West Bank on OV showed that shortage in delivery facilities, women and community barriers and factors related to healthcare providers were the main determinants for OV to happen[7].

In terms of OV prevalence, a cross-sectional study from Ethiopia, which has similar poor living conditions as Gaza, concluded that three in four women endured at least one form of OV[25]. A further qualitative study from Ethiopia included 415 women found that more than 80% of participants had neglected and non-consented care during delivery[26]. OV was less commonly experienced by women in USA[27], Mexico[28] and Spain[15], 16%, 33%, 38%; respectively.

Strengths and Limitations

The study has several strengths that make its findings significant and a first building block towards more research and policy in the area of OV in Palestine. First, the study is only one of a few tackling the issue of OV in Palestine, and it is the first scientific effort to describe experiences of women and explore their pregnancy and labor experiences in the Gaza Strip.

Second, the online survey was made anonymous to encourage women to participate with honesty and frankness. Patients might be skeptical to report a negative experience in receiving care fearing that their chances of receiving the care in the future. So, providing such sensitive experience through an online, anonymous forms helps ease such fear in comparison to face-to-face data collection.

Third, the questions contained an explanation of what OV and its types are, and what might constitute OV. By merely posing the questions and providing explanations, the study helps in raising the issue of OV in a context with relatively high fertility rate, high need and uptake for maternity services, and little knowledge and awareness of OV among women.

The study also has some limitations. The sampling method was voluntary and not random, which could introduce bias. Women who knew about OV, or had a negative pregnancy experience, may have been more motivated to participate. Therefore, we would exercise caution about making generalization of the study findings about the maternal care in Gaza. Extensive efforts were made to seek a range of experiences from women from different backgrounds in Gaza, however ultimately participation was voluntary.

The method of approach (digital) and questionnaire format (webpage) could also have introduced a potential bias against women lacking access to the internet or who were digitally illiterate. Women who have no or limited access to the internet or smartphone may have not been properly represented as the study only utilized online survey to collect data.

A third limitation is that the study only reported the experience of the women and didn't include the perspectives of the healthcare providers. The incidents of OV reported by the participants cannot be verified and their details inspected. However, we sought to describe women's perceptions of their care. Whilst it is important to also consider the health worker's perspective, this was not the objective of this study. Further work will require a more detailed study of expectations, behaviours and responses from healthcare providers.

Conclusion

We present the first study to document the occurrence of OV among pregnant women in Gaza and to explore the associated factors. Many women in Gaza felt they received inadequate and suboptimal counselling services during ANC visits. Moreover, due to several factors, the care provided during labor fell short of the acceptable standards of care. Several factors were found to be significantly associated with occurrence of OV among women, and these include being a primiparous, giving birth at a governmental hospital, and having previous knowledge of OV and its different forms. Lack of support and companion, inadequate pain killers during labor, and unavailability of medical staff when needed were among the common problems reported by women. Further research is required to guide health policies that increase women's awareness of their rights during labor and that reduce the incidence of OV by addressing the factors the more likely lead to it.

Authors contributions

AlI conceived the main idea of the research, designed the questionnaire, analyzed the data and wrote the initial draft. AA shared the questionnaire and writing the article. AnI contributed significantly to the writing of the subsequent drafts and the final paper. JH reviewed the questionnaire and data analysis and contributed to the final paper.

Collaborators

Hala Shoman, Amani Alsatari, Enas Jendia, Eman abu Naser, Shahd Alrantisi, Doaa Aldahoudi, Esraa Alnaqeeb, Eman Abuwarda and Duha Elbari helped and participated in the data collection for this study.

Author/s agreement

AI confirms that the work contained in this paper is the author/s original work; the article has not received prior publication and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted.

Ethical statement

The research involved the participation of human participants. The participants gave their consent before completing questionnaire.

This study was approved by the ethical committee of research “HELSINKI” no. PHRC/HC/970/21. The ethical approval was received in October 2021.

Funding

This research has not received external funding.

Conflicts of interest

Authors declare no conflict of interests.

References

1. United Nations. Goal 3: Ensure healthy lives and promote well-being for all at all ages. https://sdgs.un.org/goals/goal3.

2. WHO. *STANDARDS OF CARE TO IMPROVE MATERNAL AND NEWBORN QUALITY OF CARE IN FACILITIES Background*. https://cdn.who.int/media/docs/default-source/mca-documents/qoc/quality-of-care/standards-for-improving-quality-of-maternal-and-newborn-care-in-health-facilities.pdf (2016).

3. Stanton, M. E. & Gogoi, A. Dignity and respect in maternity care. *BMJ Glob. Heal.* **5**, e009023 (2022).

4. Bowser, D. & Hill, M. P. H. K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis. (2010).

5. Reis, V., Deller, B., Senior, M., Advisor, M. & Carr, C. Respectful Maternity Care Country experiences Survey Report. (2012).

6. Palestinian Central Bureau of Statistics. Main Indicators. https://www.pcbs.gov.ps/statisticsIndicatorsTables.aspx?lang=en&table_id=901 (2021).

7. Dwekat, I. M. M., Tengku Ismail, T. A., Ibrahim, M. I. & Ghrayeb, F. Exploring factors contributing to mistreatment of women during childbirth in West Bank, Palestine. *Women Birth* **34**, 344–351 (2021).

8. ME Abu-Rmeileh, N. *et al.* Exploring women's experiences during childbirth in health facilities during COVID-19 pandemic in occupied palestinian territory: a cross-sectional community survey. *BMC Pregnancy Childbirth* **22**, 957 (2022).

9. Gaza Strip | The humanitarian impact of 15 years of the blockade - June 2022 | United Nations Office for the Coordination of Humanitarian Affairs - occupied Palestinian territory.

10. Palestinian Ministry of Health. *Health Sector Strategic Planning Southern Governorates, 2021-2025*. https://www.moh.gov.ps/mohStatL/E_Strategic_Plan_2021-2025.pdf (2021).

11. Mena-Tudela, D., Cervera-Gasch, A., Alemany-Anchel, M. J., Andreu-Pejó, L. & González-Chordá,

V. M. Design and Validation of the PercOV-S Questionnaire for Measuring Perceived Obstetric Violence in Nursing, Midwifery and Medical Students. *Int. J. Environ. Res. Public Health* **17**, 1–12 (2020).

12. WHO. *The prevention and elimination of disrespect and abuse during facility-based childbirth*. (2015).

13. Safeguarding Adults. Types of abuse: Safeguarding adults | SCIE. https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse (2015) doi:https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse.

14. Perera, D., Munas, M., Swahnberg, K., Wijewardene, K. & Infanti, J. J. Obstetric Violence Is Prevalent in Routine Maternity Care: A Cross-Sectional Study of Obstetric Violence and Its Associated Factors among Pregnant Women in Sri Lanka's Colombo District. *Int. J. Environ. Res. Public Health* **19**, (2022).

15. Martínez-Galiano, J. M., Martinez-Vazquez, S., Rodríguez-Almagro, J. & Hernández-Martinez, A. The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study. *Women and Birth* **34**, e526–e536 (2021).

16. Palestinian Central Bureau of Statistics. State of Palestine Palestinian Central Bureau of Statistics. (2021).

17. UNRWA. Health in the Gaza Strip | UNRWA. https://www.unrwa.org/activity/health-gaza-strip#:~:text=Through 22 centres%2C UNRWA provides,in all our health centres.

18. Palestinian MoH. *Palestinian Ministry of Health Annual Report 2021*. https://www.moh.gov.ps/portal/wp-content/uploads/2022/05/التقرير-السنوي-2021-مع-الجداول-1.pdf (2022).

19. The Fertility of Palestinian Women in Gaza, the West Bank, Jordan and Lebanon | Cairn International Edition.

20. UNFPA. UNFPA Palestine | PCBS-UNFPA Joint Press Release on the occasion of World Population Day. https://palestine.unfpa.org/en/news/pcbs-unfpa-joint-press-release-occasion-world-population-day (2021).

21. Ali-Masri, H. Y. *et al.* Evaluation of Accuracy of Episiotomy Incision in a Governmental Maternity Unit in Palestine: An Observational Study. (2018) doi:10.1155/2018/6345497.

22. Fertility rate, total (births per woman) | Data.

23. UNdata | record view | Crude birth rate (births per 1,000 population).

24. Faheem, A. The nature of obstetric violence and the organisational context of its manifestation in India: a systematic review. *Sex. Reprod. Heal. Matters* **29**, (2022).

25. Mihret, M. S. Obstetric violence and its associated factors among postnatal women in a Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia. *BMC Res. Notes 2019 121* **12**, 1–7 (2019).

26. Berhe, E. T., Gesesew, H. A., Ward, P. R. & Gebremeskel, T. G. Neglected and non-consented care during childbirth in public health facilities in Central Tigray, Ethiopia. *BMC Pregnancy Childbirth* **22**, 1–11 (2022).

27. Vedam, S. *et al.* The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod. Health* **16**, (2019).

28. Castro, R. & Frías, S. M. Obstetric Violence in Mexico: Results From a 2016 National Household Survey. (1983) doi:10.1177/1077801219836732.