MISTREATMENT OF WOMEN DURING CHILDBIRTH IN WEST BANK, PALESTINE: DEVELOPMENT AND VALIDATION OF QUESTIONNAIRE, PREVALENCE AND ASSOCIATED FACTORS, AND ITS RELATIONSHIP WITH SATISFACTION AND PERCEIVED QUALITY OF CARE

DWIKAT IBTISAM M M

UNIVERSITI SAINS MALAYSIA

2022

MISTREATMENT OF WOMEN DURING CHILDBIRTH IN WEST BANK, PALESTINE: DEVELOPMENT AND VALIDATION OF QUESTIONNAIRE, PREVALENCE AND ASSOCIATED FACTORS, AND ITS RELATIONSHIP WITH SATISFACTION AND PERCEIVED QUALITY OF CARE

by

DWIKAT IBTISAM M M

Thesis submitted in fulfilment of the requirements
for the degree of
Doctor of Philosophy

June 2022

ACKNOWLEDGEMENT

In the name of Allah, the most Gracious, the most Merciful. Praise upon Him, whom blessing had helped me through the entire study and gave me the precious opportunity to complete this research.

First of all, special appreciation to my main supervisor, Dr Tengku Alina Tengku Ismail from Department of Community Medicine, School of Medical Sciences for her special efforts, continuous supports encouragement, patience and expert guidance from the initial stages to the completion of this study. Secondly, I would like to deeply thank my co-supervisors, Associate Professor Dr. Mohd Ismail Ibrahim from the same department for his valuable comments, follow up, guidance and encouragements through the whole period of the study. Thirdly, special acknowledgment to Dr Anis Kausar Ghazali from Unit of Biostatistics and Research Methodology for expert advice on statistics. Fourthly, I would like to thank my co-supervisor Dr. Farid Ghrayeb from the Collage of Health Professions, Al-Quds University, Jerusalem for his cooperation and continues supports and encouragement through the whole period of the study. The appreciation also goes to the GIPS- PhD grant of our institution for financial support of this study (grant number: 311/PPSP/4404802). The acknowledgment goes to the Palestinian Ministry of Health for facilitating the data collection, the Palestinian women who participated in this study, and the health care providers who cooperated in data collecting. Special thanks to the experts for their valuable's inputs during the development phase.

Last but not least, I wish to thank my caring husband for his continuous support and help I would finally like to thank my sisters and my brothers for their endless support.

TABLE OF CONTENTS

LIST OF TABLES

Page

LIST OF FIGURES

Page

LIST OF SYMBOLS

Df	Degree of freedom
χ^2	Chi-square
z value	Significant level 5%
σ	Standard Deviation
Δ	Estimated difference from population mean
<	Less than
>	More than
%	Percentage
Df	Degree of freedom
H_O	Null hypothesis
H_A	Alternate hypothesis
χ^2	Chi-square
z value	Significant level 5%
σ	Standard Deviation
Δ	Estimated difference from population mean
<	Less than
>	More than
%	Percentage

LIST OF ABBREVIATIONS

CFA	Confirmatory factor analysis
CFI	Comparative fit index
CVI	Content validity index
D&A	Disrespect and Abuse
EFA	Exploratory factor analysis
FVI	Face validity index
KMO	Kaiser-Meyer-Olkin
MDG	Millennium Developmental Goal
MI	Modification indices
MMR	Mixed Methods Research
MSA	measure of sampling adequacy
NS	Neglect Scale
PCBS	Palestinian Central Bureau of Statistics
PMOH	Palestinian Ministry of Health
RMC	Respectful maternity care
RMSEA	Root mean square error of approximation
ROC	Receiver Operator Characteristic
SPSS	Program for Social Sciences
UNRWA	Unites Nations Relief and Works Agency for refuges
VAS	Verbal Abuse Scale
WHO	World Health Organization
WRA	White Ribbon Alliance
CFA	Confirmatory factor analysis
CFI	Comparative fit index
CVI	Content validity index
D&A	Disrespect and Abuse
EFA	Exploratory factor analysis
FVI	Face validity index
KMO	Kaiser-Meyer-Olkin

MDG	Millennium Developmental Goal
MI	Modification indices
MMR	Mixed Methods Research
MSA	measure of sampling adequacy

LIST OF APPENDICES

PENGANIAYAAN TERHADAP WANITA SEMASA BERSALIN DI TEBING BARAT, PALESTIN: PEMBANGUNAN DAN VALIDASI BORANG SOAL SELIDIK, PREVALEN DAN FAKTOR BERKAITAN, SERTA HUBUNGKAIT DENGAN KEPUASAN DAN TANGGAPAN KUALITI PENJAGAAN

ABSTRAK

Fenomena penganiayaan terhadap wanita semasa bersalin perlu difahami dalam kalangan wanita Palestin kerana ia masih belum ditangani sewajarnya di Palestin. Kajian ini bertujuan untuk membangun dan mengesahkan satu soal selidik baharu, mengukur prevalen, jenis penganiayaan, faktor berkaitan, serta hubungkaitnya dengan kepuasan penjagaan dan persepsi kualiti penjagaan di Tebing Barat, Palestin. Ia dijalankan dalam dua fasa menggunakan pendekatan pelbagai kaedah. Fasa pertama melibatkan pembangunan dan pengesahan borang soal selidik. Pembangunan borang soal selidik diperoleh melalui tinjauan literatur dan kajian kualitatif secara temubual bersemuka bersama enam orang wanita lepas bersalin dan lima orang kakitangan kesihatan untuk menerokai bagaimana wanita dilayan semasa bersalin. Analisis tematik telah dijalankan. Analisis faktor penerokaan dan pengesahan telah dijalankan bagi validasi domain kepuasan penjagaan dan persepsi kualiti penjagaan. Ia melibatkan 400 orang wanita yang hadir ke klinik ibu dan anak dalam masa 16 minggu pertama selepas bersalin yang dipilh secara persampelan bertujuan. Bagi fasa kedua, satu kajian keratan rentas telah dijalankan dalam kalangan 269 orang wanita dalam masa 16 minggu selepas bersalin daripada enam kawasan di utara Tebing Barat menggunakan pensampelan rawak berstrata secara proporsi. Analisis regresi logistik berganda digunakan bagi mengenalpasti faktor yang berkaitan dengan

penganiayaan. Hubungkait antara penganiayaan dengan kepuasan penjagaan dan persepsi kualiti penjagaan telah dianalisis menggunakan regresi linear mudah. Borang soal selidik baharu ini direka dalam Bahasa Arab dan mengandungi 87 item; pengalaman penganiayaan semasa bersalin (43 item), kepuasan penjagaan (10 item), persepsi kualiti penjagaan (16 item), dan 18 item berkenaan sosiodemografi dan obstetrik. Borang Soal Selidik Penganiayaan, Kepuasan dan Kualiti Penjagaan (MSQ-Q) mempunyai sifat psikometrik dan kesahihan yang baik. Prevalen penganiayaan secara keseluruhan adalah 97.8%; dengan setiap satu adalah 88.5% bagi hubugan tidak baik antara wanita dan pengamal kesihatan, penderaan fizikal (76.6%), gagal memenuhi standard penjagaan yang profesional (75.8%), penderaan secara lisan (24.5%), stigma dan diskriminasi (11.9%), dan keadaan dan kekangan pada sistem kesihatan (22.3%). Faktor yang mempunyai hubungkait signifikan dengan penganiayaan semasa bersalin adalah umur, jenis kelahiran, jenis fasiliti, kaedah kelahiran, tempat tinggal, tempoh kelahiran, tahap pendidikan, penerimaan ubat penahan sakit, dan bilangan anak. Wanita yang mengalami mana-mana jenis penganiayaan kecuali penderaan fizikal, mempunyai skor kepuasan penjagaan dan persepsi kualiti penjagaan yang lebih rendah secara signifikan. Sebagai kesimpulan, majoriti peserta kajian pernah mengalami sekurang-kurangnya satu jenis penganiayaan semasa bersalin. Wanita yang bersalin di fasiliti awam lebih berisiko mengalami kesemua enam jenis penganiayaan. Tambahan pula, limitasi yang terdapat di fasiliti kelahiran, persekitaran kerja yang tidak baik, sesetengah polisi seperti penghalangan peneman semasa bersalin perlu diperbaiki bagi mengurangkan kejadian penganiayaan semasa bersalin.

MISTREATMENT OF WOMEN DURING CHILDBIRTH IN WEST BANK, PALESTINE: DEVELOPMENT AND VALIDATION OF QUESTIONNAIRE, PREVALENCE AND ASSOCIATED FACTORS, AND ITS RELATIONSHIP WITH SATISFACTION AND PERCEIVED QUALITY OF CARE

ABSTRACT

Mistreatment during childbirth phenomenon should be understood among Palestinian women because it has not been adequately addressed in Palestine. This study aimed to measure the prevalence, types of mistreatment, associated factors and its association with satisfaction of care and perceived quality of care in West Bank, Palestine. It was conducted in two phases using a multi-method approach. Phase one involved the development and validation of questionnaire. Development of the questionnaire was achieved through literature review and qualitative study using face-to-face interviews with six purposively selected postpartum women and five healthcare providers to explore how women were treated during childbirth. Thematic analysis was conducted. Exploratory and confirmatory factor analysis was conducted for validation of satisfaction of care and perceived quality of care domains. This validation study involved 400 women attending maternal and child health clinics within the first 16 weeks postpartum who were selected using purposive sampling. For phase two, a cross sectional study was done among 269 women within the first 16 weeks postpartum from the six governorates located in north area of West Bank by using proportionate stratified random sampling. Multiple logistic regression analysis was used to determine factors associated with mistreatment. The associations of mistreatment with satisfaction of care and perceived quality of care were

analysed using simple linear regression. The new questionnaire was designed in Arabic language and consisted of 87 items; experience of mistreatment during childbirth (43 items), satisfaction of care (10 items), perceived quality of care (16 items), and 18 items related to socio-demographic and obstetric characteristics. The Mistreatment, Satisfaction and Quality of Care Questionnaire (MSQ-Q) had good psychometric properties and reliability. The overall prevalence of mistreatment was 97.8%; with each type was 88.5% for poor rapport between women and providers, physical abuse (76.6%), failure to meet professional standard of care (75.8%), verbal abuse (24.5%), stigma and discrimination (11.9%), and health system conditions and constraints (22.3%). The significant factors associated with mistreatment during childbirth were age, type of labour, type of facility, mode of delivery, residency, duration of labour, education, pain killer received and parity. Women who experienced any types of mistreatment except physical abuse had significantly lower satisfaction of care and perceived quality of care scores. In conclusion, the majority of the participants encountered at least one type of mistreatment during childbirth. Women who delivered at public childbirth facility were more prone to face all the reported six types of mistreatment. Furthermore, the limitations in childbirth facilities, poor working environment, some recent policies such as preventing childbirth companion should be modified especially at public facilities to reduce mistreatment during childbirth.

CHAPTER 1

INTRODUCTION

1.1 History of Mistreatment of Women During Childbirth

Globally, mistreatment of women during childbirth became a common phenomenon irrespective of all initiatives against mistreatment of women in health care facilities, as summarized in formal international conventions on human rights (WHO, 2016). It is considered as a cause of women suffering, as well as a violation of ethical principles and human rights (WRA, 2013).

Therefore, mistreatment is a very old term. Women from developing and developed countries complained of mistreatment since many years ago. Previous study documented since 1990 that Brazilian women were reported being delivered alone, left alone and were prevented to have a companion during childbirth (Misago et al., 2001). Similarly, women in the United States have reported being mistreated since many years, such as receiving surgical procedures without anesthesia during childbirth, strapped down for several hours in lithotomy position, hitting and threatened by the health care providers (Schultz, 1958). Jewkes et al (1998) reported that African women encountered abandon, verbal and physical abuse during receiving care from their nurses in maternity care unit. A review of evidence was conducted by d'Oliveira et al. (2002) to explore violence against women in childbirth facilities and showed four main types of mistreatment experienced by the women; abandon verbal abuse, physical abuse and sexual abuse. Their study also demonstrated other types of abuse such as structural abuse (discrimination), inappropriate care that are not congruent to evidence-based practice such as conducting caesarean sections for economic reason, unnecessary shaving of the pubic area, and routine episiotomy (d'Oliveira et al., 2002).

Additionally, around 7% of Swedish women in a representative study reported experiencing undesirable birth experience that involved loss of control, unsupported care and deficit in information during childbirth (Waldenstrom and Rubertson, 2004). Moreover, women from Ghana reported that they were deprived from services, psychological support and encouragement during childbirth (d'Ambruoso et al., 2005).

1.2 Maternal Health, Childbirth and Respectful Maternity Care

Maternal health is one of the important health issues all over the world especially in developing countries. It refers to health of women during pregnancy, childbirth and postpartum period. Various efforts have been done to achieve maternal health and reduce maternal mortality. Universally, maternal mortality has reduced by approximately 44% between the years 1990 and 2015 (Alkema et al., 2016). Unfortunately, yearly 303,000 women still die during pregnancy and childbirth (Alkema, et al., 2016). Around 99% of these deaths took place in developing countries, particularly in Sub-Saharan Africa (WHO, 2014). As a result of these deaths, special emphasis is required to ensure childbirth with good quality of care; clinically suitable, childbirth with respectful and dignified conditions (WHO, 2014).

The WHO (2014) highlights statement that each childbearing woman has the right to the maximum achievable standard of health, which comprises the right to magnificent, respectful health care during pregnancy and childbirth, in addition to the right to be free from violence and discrimination. Therefore, each woman must find a skilled care during childbirth process with evidence-based practices in a respectful, humanize supporting environment in order to eradicate preventable causes of maternal death and achieving optimal maternal health (WHO, 2016; WRA, 2011).

Respectful maternity care (RMC) is a universal human right for every woman in a childbearing age. There is no standard definition of RMC but it is usually referred to friendly and women-centred care. In seeking and receiving care before, during and after childbirth, every woman is entitled to several rights. They include the rights to; 1) be free from harm and ill treatment, 2) information, informed consent and refusal, and respect for her choices and preferences, including companionship during childbirth, 3) privacy and confidentiality, 4) treatment with respect and dignity, 5) equality, non-discrimination, and equitable care, 6) healthcare and high achievable level of health, and 7) liberty, autonomy, self-determination and non-coercion (WRA, 2011). It is important to fulfil these rights in order to obtain RMC for every woman.

Through childbirth process, women faced various biological, emotional and social changes (Blaaka and Eri, 2008). Attention and care to women is very vital during this period, as childbirth experience can affect the women future lives, relationships with their babies and families (Goodman et al., 2004; Srivastava et al., 2015). The woman's childbirth experience may empower, reassure her or it may cause long lasting damage to her life (WRA, 2011). Consequently, emotional trauma may stay in a woman's memory for a long time (Bowser and Hill, 2010; Okafor et al., 2015). In addition, relationships between health care providers and women during childbirth directly affect their physical, psychological, and emotional status at that period (RMC, 2011; WRA, 2011). The presence of supportive, kindness attitudes from health care providers and availability of childbirth companion could raise the women's trust on hospital childbirth (Theuring et al., 2018). Usually, physical security of the women is the main concern of the health care providers, but more

attention is needed to the women's rights, preferences, respect, autonomy and emotional aspects (d'Oliveira et al., 2002; Bowser and Hill, 2010).

1.3 The Relationship Between Mistreatment of Women During Childbirth and Maternal Health

Globally, there is noticeable improvement in maternal health and a decrease in maternal mortality through the improvement in the quality of the maternal health services. In spite of this improvement and accessibility of the services, the care is still compromised by mistreatment of women during childbirth (Reis et al., 2012). Enormous efforts have been done to accomplish the Millennium Development Goal 5 (MDG)," Improve maternal health" but mistreatment of women during childbirth prevents the achievement of this goal and deprives women from receiving good care (Reis et al., 2012).

Unfortunately, global researches have confirmed that women are experiencing mistreatment during childbirth with various types (Bowser and Hill, 2010; WHO, 2014; Bohren et al., 2015; Bohren et al., 2018; Bohren et al., 2019). Mistreatment can also be referred as obstetric violence, dehumanized care, or disrespect and abuse. It contributes to a huge violation of woman's fundamental rights (WHO, 2014; Khosla et al., 2016) as well as it intimidates women's wellbeing, health, freedom of discrimination and right to respectful treatment (WHO, 2014). Mistreatment may result from minor violations like failure to make payments, failure to attend recommended prenatal visits, or getting pregnant at a younger age (Bazant et al., 2009).

Mistreatment of women during childbirth may cause immediate and long-term negative effects on women's health (Makumi, 2015). It can also lead to negative psychological impact such post-traumatic stress symptoms, sleeping difficulties, poor self-

care (Chadwick et al., 2014; Makumi, 2015), feelings of humiliation (Schroll et al., 2013), low self-esteem and anxiety (Schroll et al., 2013). Such phenomenon makes women prefer home deliveries, and avoid or delay seeking childbirth facilities (Okafor et al., 2015). Therefore, mistreatment of women may indirectly increase maternal morbidity and mortality (Bowser and Hill, 2010; Schroll, et al., 2013; Sando et al., 2016) and prevents accomplishment of MDG 5 "Improve maternal health" (Reis et al., 2012).

1.4 Childbirth Conditions and Maternal Health in Palestine

According to the Palestinian Centre Bureau of Statistics (2016), the fertility rate was 4.1 births per woman in Palestine; 4.5 in Gaza Strip and 3.7 in West Bank (Annual Health Report, 2016). The total fertility rate in Palestine is reducing but it is still high in Gaza strip. A high number of births had been registered in 2016 in Palestine, which was 130,497. Around 55.4% of those births took place in West Bank and 44.6% in Gaza strip (Annual Health Report, 2016). Around 99.9% of those childbirths occurred at childbirth facilities (53.6% in governmental childbirth facilities and 46.3% in non-governmental ones), while 0.1% occurred at home (Annual Health Report, 2016). This high percentage of childbirth facilities utilization is explained by the Palestinian authority policy of hospitalization during childbirth (Giacaman, et al., 2005). Additionally, most of the women chose the governmental childbirth facilities because of the availability of the health insurance coverage. Unfortunately, the governmental childbirth facilities in Palestine still have chronic deficiency of medical supplies and vital medical disposable which will interfere with certain areas and treatment pathways (WHO, 2018).

The available evidences showed that governmental childbirth facilities in Palestine were lacking of good quality services because of shortage of staff and crowded labour

rooms (Wick et al., 2005; Rahim et al., 2009). Additionally, there were presence of dangerous practices such as wide use of lithotomy position and extensive use of episiotomy (Wick et al., 2005).

Female doctors are sometimes not available to meet the women's preference in childbirth services. A Palestinian study showed that there were limited women's childbirth preferences including female doctors. Furthermore, there was absence of birth companion in governmental hospital due to the present policy of preventing birth companion during childbirth (Wick et al. 2005). Giacaman et al. (2007) conducted another study in Palestine about women's preferred place for childbirth, and found that 20.5% of them mentioned that the place they gave birth was not the preferred childbirth place. Likewise, a quarter of the women whose last childbirth took place in governmental hospitals showed dissatisfaction about their childbirth setting. Around 40% of them reported that they chose the governmental hospitals for childbirth due to the availability of health insurance and low cost of the services.

Regarding the maternal mortality rate in Palestine, it is still under estimation due to poor reporting system. According to Annual Health Report (2016), the maternal mortality rate in Palestine was 13.8 deaths per 100,000 live births. There was a slight difference between the two parts of Palestine, in which 12.4 deaths per 100,000 live births occurred in West Bank while 15.5 deaths per 100,000 live births happened in Gaza Strip. The most common causes of maternal death in West Bank were cardiovascular diseases and haemorrhage. Around 69% of those maternal deaths could be classified as preventable (Al-Adili et al., 2006).

A study which was conducted in one of the main governmental childbirth facilities in West Bank revealed that the maternal morbidity was high (Hassan et al., 2015). Around 27% of the women encountered one or more maternal morbidities, with 0.96% faced a dangerous complication (near miss). It was also noted that 16.5% of all women who faced morbidities had vaginal deliveries and 14.6% had caesarean sections. Bleeding during pregnancy, labour and childbirth was identified as the most extensive morbidity.

1.5 Problem Statement

Mistreatment of women during childbirth is one of the important obstacles that prevent women from seeking good care and achieving MDG5 improving maternal health. Furthermore, it considers a major violation of a woman's basic human rights and a frequent cause of women suffering during childbirth. Furthermore, it becomes a barrier for women to seek childbirth facilities because it negatively affects women satisfaction of care and the evaluation of the care provided to them. The issues of not seeking care from childbirth facilities when needed is very dangerous to maternal health and it may increase maternal morbidity and mortality.

Mistreatment of women during childbirth is prevalent in low- and high-income countries. The prevalence of mistreatment women encountered during childbirth has been fluctuated from 11% to 98% (Sando, Abuya et al., 2017). New evidence from WHO confirmed that more than a third of women encountered mistreatment during childbirth at around the time of deliveries especially in the form of verbal and physical abuse (Bohren et al., 2019).

It is important to explore the issues of mistreatment during childbirth, and understanding the factors influencing it, satisfaction of care and perceived quality of care.

However, the majority of the available quantitative studies focused on the measurement of prevalence and types of mistreatment. Very few studies reported the factors associated with mistreatment and its association with satisfaction of care and perceived quality of care. Moreover, most of them used Bowser and Hill (2010) types of mistreatment as a building block for their studies. Additionally, the lack of unified definitions, tools, and study methods used in those researches to measure mistreatment in childbirth facilities presented the possibility for systematic error in the reported prevalence, and affected their generalizability and comparability (Sando et al., 2017). Therefore, it is a need for a validated assessment tool to measure the prevalence of mistreatment and understand the scope of problem globally (WHO, 2014).

Currently, little evidence exists to describe mistreatment during childbirth in Arab countries and particularly in Palestine. A few published qualitative studies in Palestine expressed the women's complaint during childbirth but there is no such a study available regarding the prevalence and types of mistreatment and its associated factors. Meanwhile, mistreatment is a multidimensional social phenomenon, which is still not clearly identified, for instance, there are lacking of information on the national prevalence in Palestine, types and manifestations of mistreatment and associated factors of mistreatment of women during childbirth.

Moreover, absence of proper questionnaire to assess mistreatment contribute to poor measuring it, aggravate the problem and delay in improving childbirth conditions. In fact, there is no validated questionnaire corresponds to the Palestinian culture, women preferences pertaining to the measurement of the prevalence and types of mistreatment and associated factors. Most of the pre-existing questionnaire that focused on mistreatment of

women did arise from the western country but it is not suitable to be applied to our Palestinian context. There are significant differences in the educational, socioeconomic, and cultural backgrounds, preferences of Palestinian women as compared to the women in Western countries. Therefore, the adoption of such questionnaires is not suitable and not practical to Palestinian women. Furthermore, some of the existing questionnaires are not well validated and need to re-validate according to our context. Thus, development and validation of a new questionnaire is necessary to gain more information that is necessary to inform the evidence for policy maker to improve the childbirth conditions in the future.

1.6 Rationale of The Study

This study is significant because it addresses the mistreatment of women during childbirth, and there is no clear picture about this subject in Palestine. Thus, it provides important information concerning the actual prevalence, types and associated factors of mistreatment during childbirth in Palestine. A few researches reported that some women complained and suffered during childbirth but they did not directly tackle these issues. This study quantitatively measured the burden of mistreatment, which will provide important insights to the policy makers and other relevant parties. Subsequently, it is hoped that the occurrence of mistreatment during childbirth may be reduced, and maternal health is improved.

This study involved a proper construction and validation of a new questionnaire that corresponds to the Palestinian culture. It produced a well validated questionnaire to understand the scope of mistreatment of women during childbirth and its association with satisfaction and perceived quality of care. Inclusion of the two domains as factors associated with mistreatment helped enriched the questionnaire. Thus, it can be utilized to

determine the prevalence of mistreatment, as well as its association with satisfaction of care and perceived quality of care, which are two important aspects in childbirth care. In addition, the questionnaire is developed following the new evidence-based types of mistreatment which is recommended by Bohren et al (2015). It is more inclusive and given its broader scope of categories. This questionnaire can later be used by other researchers to describe the phenomenon and make the necessary adjustments to meet women's needs during childbirth.

Moreover, this study highlights the human side of childbirth practices in Palestine. The current trend in quality-of-care improvement in governmental childbirth facilities is more focused on medical issues and physical safety of the women. Less attention is paid to women's preferences and emotional side, but these issues are similarly important in maternal health. Therefore, the focus of this study is more widen, and covers various aspects of women's right during childbirth. Mistreatment of women during childbirth is a hot topic and one of the priorities in research area in Palestine (Abu-Rmeileh et al., 2018), as well as in Africa and the eastern Mediterranean region for development of quality of care and safe motherhood (Ali et al., 2018). The results of this study will enrich the literature in the field of prevalence of mistreatment, types, manifestation and associated factors in Palestine, as well as the association of each type of mistreatment of women with the satisfaction of care and quality of care. Furthermore, the results of this study will provide baseline data for upcoming researchers in designing and developing educational intervention programs to promote respectful care and eradicate mistreatment. Consequently, this will contribute to improve maternal health in the future.

1.7 Research Questions

1. Is the new questionnaire valid to measure mistreatment during childbirth, and its association with satisfaction of care and perceived quality of care in West Bank, Palestine?
2. What is the prevalence of mistreatment of women during childbirth at childbirth facilities in north area of the West Bank, Palestine?
3. What are the types and manifestations of mistreatment that women faced during childbirth at childbirth facilities in north area of the West Bank, Palestine?
4. What are the factors associated with each type of mistreatment during childbirth at childbirth facilities in north area of the West Bank, Palestine?
5. Are there associations between types of mistreatment during childbirth and the women's satisfaction of care and perceived quality of care at health facilities in north of the West Bank, Palestine?

1.8 Research Objectives

This part will highlight general and specific objectives of the study.

1.8.1 General Objective

To determine the prevalence, types of mistreatment, associated factors and its association with satisfaction of care and perceived quality of care in West Bank, Palestine using a newly developed questionnaire.

1.8.2 Specific Objective

(a) Phase 1

1. To develop and validate a structured questionnaire assessing mistreatment during childbirth, and its association with satisfaction of care and perceived quality of care in West Bank, Palestine

(b) Phase 2

2. To determine the prevalence of mistreatment of women during childbirth at childbirth facilities in north area of the West Bank, Palestine
3. To identify the types and manifestations of mistreatment that women faced during childbirth at childbirth facilities in north area of the West Bank, Palestine
4. To determine factors associated with each type of mistreatment during childbirth at childbirth facilities in north area of the West Bank, Palestine
5. To determine the associations of mistreatment during childbirth with women's satisfaction of care and perceived quality of care in north area of the West Bank, Palestine.

1.9 Research Hypotheses

1. The newly developed questionnaire is valid and reliable to be used in assessing mistreatment during childbirth and its association with satisfaction of care and perceived quality of care in West Bank, Palestine.
2. There are significant associations between socio demographic characteristics, obstetrics characteristics, providers characteristics, and types of facilities with mistreatment of women during childbirth at childbirth facilities in north area of the West Bank, Palestine.

3. There are significant associations between mistreatment of women during childbirth with satisfaction of care and perceived quality of care at childbirth facilities in north of the West Bank, Palestine.

CHAPTER 2

LITERATURE REVIEW

This chapter explains the literature review focusing on mistreatment of women during childbirth. Qualitative and quantitative articles that written in English were included in the review. The databases used included the Cochrane Library, PubMed, Scopus, and Google scholar. Key words used in database search were “mistreatment of women during childbirth”, “disrespect and abuse, childbirth”, “satisfaction of care” and “quality of care.”

The existing questionnaires to assess mistreatment in various settings are reviewed, and the needs to develop a validated local culturally-adapted questionnaire are discussed. It also covers the information on global burden of mistreatment and the situation in Palestine. The types of mistreatment that the women encountered during childbirth and the associated factors, their satisfaction of care and perceived quality of care are also included in this chapter. This chapter ends with theoretical and conceptual framework of the study.

2.1 Definition of Mistreatment of Women During Childbirth

Mistreatment of women during childbirth has been categorized and defined in several ways. The most frequent terms used in previous published researches were; “mistreatment of women,” “obstetric violence,” “disrespect and abuse,” “institutional violence,” and “dehumanized birth.” However, there is still no consensus by the researchers on the comprehensive definition of mistreatment (Savage and Castro, 2017). The term “mistreatment” can be used instead of “disrespect and abuse”, but “mistreatment” is a more comprehensive term than “disrespect and abuse”. It gives comprehensive scope of categories and stress on different sources of mistreatment (Bohren et al., 2015).

According to the Cambridge dictionary, the term mistreatment is defined as “the act of treating a person or animal badly, cruelly, or unfairly”. Additional definition includes “dehumanisation, abuse, objectification, severely unkind and unpleasant causing harm to people or animal intentionally” (Cambridge Dictionary, 2018). The definitions of mistreatment have been widened in other countries. In Nordic countries for instance, researchers have defined mistreatment in Health Care which they named Abuse in Health Care (AHC) as “any act perceived as abusive by the child or adult patient in any health care setting” (Brüggemann and Swahnberg, 2012). Another definition of AHC is “the violation of ethical principles of physical abuse, sexual abuse, autonomy, justice and integrity during the provision of healthcare service” (Brüggemann and Swahnberg, 2012).

Bowser and Hill (2010) identified the definition of disrespect and abuse in their landscape analysis which include seven types: physical abuse, non-consented care, non-confidential care, non-dignified care, stigma and discrimination, abandonment of care, and detention in facilities. These types have constituted the conceptual framework for most previous studies related to this issue. Despite the extensive use of Bowser and Hill’s types of abuse, several researchers have highlighted significant limitations to those definitions (Freedman et al., 2014; Bohren et al., 2015; Savage and Castro, 2017). They claimed that the seven types do not adequately distinguish between the forms of abuse that arise from individual behaviors and those from health system insufficiencies (Freedman et al., 2014). Other limitations are the lack of operational definitions that are consistent and comparable between researchers, as well as those types are overlapping (Bohren et al., 2015).

Freedman et al. (2014) defined disrespect and abuse during childbirth as “interactions or facility conditions that local consensus deem to be humiliating or

undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified.'' Bohren et al. (2015) in their systematic review recommended seven evidenced-based types, which include (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) failure to meet professional standards of care, (5) stigma and discrimination, (6) poor rapport between women and providers, and (7) health care system conditions and constrains. These seven evidenced-based types of mistreatment had a clear operational definition. They were recommended to be used for development of new tools in measuring prevalence of mistreatment to avoid overlapping of types and under estimation of this prevalence. Additionally, Bohren et al. (2015) highlighted that mistreatment may come from both intended and unintended actions of health providers, as well as from conditions within health systems and childbirth facilities. WHO recommended the researchers to use these types of mistreatment for better measurement of the prevalence globally.

2.2 Tools for Measuring Mistreatment During Childbirth, Satisfaction of Care and Perceived Quality of Care

There is shortage of unified definitions, tools and study methods used in research to measure mistreatment during childbirth in childbirth facilities (Sando et al., 2017). Moreover, there is absence of universal consensus at a level on how mistreatment is measured in maternity services (Bohren, et al., 2015). The absence of unified tool and definition increase the possibility for systematic error in the reported prevalence of measurement, and affected their generalizability and comparability (Sando et al., 2017).

Accordingly, WHO (2014) recommended researchers to conduct new studies on defining and measuring mistreatment in public and private facilities all over the world. Bohren, et al., (2015) suggested seven evidence-based types of mistreatment with clear

operational definitions. This new typology is recommended to be used in developing a new tool for measurement of the prevalence of mistreatment in order to overcome overlapping of types and under estimation of mistreatment and fluctuation of prevalence. Thus, the mistreatment types were used by the WHO researchers as the basis for their tool in the study that examined mistreatment in Ghana, Guinea, Nigeria, and Myanmar (Bohren., 2019). Looking forward to considering the mistreatment types used in the development of assessment tools that can be standardized for measuring of mistreatment all over the world (Bohren et al., 2016).

There are a few pre-existing questionnaires for assessing mistreatment of women during childbirth. The majority of these questionnaires' construction were based on Bowser and Hill, 2010 types of disrespect and abuse and most of such questionnaires were used in Africa. A few of them were applied in Asia. Most of the questionnaires are not properly validated and not appropriate to Arab culture because they were prepared to be used among different target groups. Those groups are different from Arab women, so they are not suitable to be applied in Arab countries. Moreover, in Arab countries there is a lack of quantitative and qualitative studies which are related to mistreatment of women during childbirth. There is absence of relevant questionnaires prepared in Arabic language. Therefore, it is essential to develop and validate a new questionnaire that is culturally suitable and applicable to Palestinian women. Additionally, the pre-existing questionnaires measuring mistreatment did not include satisfaction of care and perceived quality of care components. Some of the questionnaires only contained two items for evaluating the overall satisfaction of care during childbirth and the perceived quality of care. There are

also separate questionnaires for measuring the satisfaction of care and perceived quality of care domains.

Table 2.1 summaries the available published articles in relation to the questionnaire measuring mistreatment of women during childbirth, the satisfaction of care and perceived quality of care.

Table 2.1 Pre-existing studies that used questionnaire on measuring mistreatment of women during childbirth.

Study	Questionnaire development and concept measures	Total items	Measurement scale used in study
Kruketal., 2014, Tanzania	Assessment of the frequency of reported disrespect and abuse during childbirth in rural areas of Tanzania and investigate the associated factors.	14 items measuring the experiences of disrespect and abuse.	Woman considered abused if she answered yes to one or more of the 14 items
Africa	Questionnaires were developed in English, and translated into Swahili, questions were constructed according to Bowser and Hill .2010 types of disrespect and abuse. The questionnaire comprised demographic data, health history, recent health care utilization, delivery characteristics, quality of care and satisfaction, experiences of disrespect and abuse during childbirth and future health care utilization.	Yes/No answers were used for them. As for quality of care (one item was used) which is evaluated by a scale of excellent, very good, good, fair and poor. Satisfaction with delivery one item was used)	Tool was adjusted and validated for the Tanzanian circumstances by content validation and face validation.

		Evaluated by a scale of satisfied, somewhat satisfied, somewhat dissatisfied and very dissatisfied	
Asefa, 2015 **Ehiopia** **Africa**	Determining the level and types of disrespect and abuse women encountered during childbirth at childbirth facilities. Questionnaire developed based on seven categories of abuse identified by Bowser and Hill (2010), translated to Amharic and the verification criteria were developed as part of the Maternal and Child Health Integrated Program (MCHIP) Socio-demographic variable, obstetric characteristics, past history of institutional birth, sex of providers, length of stay in health facility, self-	23 items	The verification criteria used yes or no option in response to categories of disrespect and abuse.

	report of disrespect and abuse added to the questionnaire.	
Okafor et al., 2015, Nigeria	Determining the prevalence of disrespect and abuse of women during childbirth at a large teaching hospital in Nigeria. Structured and pretested questionnaire was used. Questions regarding disrespect and abuse based on seven categories of abuse identified by Bowser and Hill (2010) First part of the questionnaire included socio demographic characteristics data, and parity. The second part included the seven categories of abuse. Self –administered and structured questionnaire.	Yes or no answers were used

Abuya etal., 2015, Kenya	Description of the manifestation and measuring disrespect and abuse (D&A). The questionnaire was developed through a series of discussions with the research teams from Kenya and Tanzania, also through qualitative study (FGD with women and men). Types of disrespect and abuse that were used depend on Bowser and Hill categories and focus of the current measurement, based on Fredman, 2014 definitions. The questionnaire comprises several modules: demographics, household characteristics including socio-economic status, past service utilization, delivery characteristics, perceived quality and satisfaction, and D&A experience.	11 items	Yes or no options were used Questionnaire was validated by a survey conducted among 75 participants. As for reliability testing for estimation of the prevalence of D&A, follow-up case narratives conducted 2 weeks later among 25 participants who reported any form of D&A in the exit survey and 25 others who did not report any form of D&A. The outcome enabled the author to improve the tools for measuring the prevalence of D&A.

Sheferawi, 2016. Ethiopia	Building a scale to measure women's perception of respectful maternity care provider in public heath sectors and determine its reliability and validity. Questioner developed by 3 phases; generating items in first phase (literature review, in-depth-interviews with 8 postpartum women) Second phase (pilot study with 40 postpartum women, 5 expert review) Third phase concluded by a draft RMC scale with 37 items and two additional measures of global satisfaction items, The seven dimensions of RMC identified by Bowser and Hill (2010). The RMC components were labeled as friendly care, abuse-free care, timely care, and discrimination-free care.	15 items	The RMC items and 2 items of global satisfaction measured on a five-point Likert scale (with 5–strongly agree, 4–agree, 3–I don 't know, 2–do not agree, and 1– strongly do not agree) was used Exploratory factor analysis (EFA) using a principal component analysis (PCA) The final scale with 15-item, the reliability was α=0.845.

	The final RMC scale correlated strongly with the global satisfaction measures		
Sando et al.,2016 Tanzania	Assessment of the prevalence of D&A as reported by women who delivered in a large, urban referral hospital in Dar es Salaam. Study questionnaire were adopted from similar project conducted in Kenya. Types of D&A identified by Bowser and Hill (2010). Self- report questionnaire The variables that were used; demographic and household characteristics, previous care history, and perceived quality of care during labor and delivery, instances of disrespect and abuse the experienced and overall satisfaction with services.	11 items	Yes or no answers were used
Sheporna ,2015			Very good, Good, Fair, Poor for overall perceived quality of care.