Mistreatment of women during childbirth and its influencing factors in maternity hospitals in Tehran, Iran: a formative qualitative multi-stakeholder study

Marjan Mirzania  
Tehran University of Medical Sciences

Elham Shakibazadeh (✉ shakibazadeh@tums.ac.ir)  
Tehran University of Medical Sciences

Meghan A. Bohren  
University of Melbourne

Sedigheh Hantoushzadeh  
Tehran University of Medical Sciences

Farah Babaey  
Ministry of Health and Medical Education

Abdoljavad Khajavi  
Gonabad University of Medical Sciences

Abbas Rahimi Foroushani  
Tehran University of Medical Sciences

Research Article

Keywords: Disrespectful maternity care, Mistreatment, Quality of care, Maternity Ward, Labour and Childbirth, Qualitative multi-stakeholder research, Iran

Posted Date: September 30th, 2022

DOI: https://doi.org/10.21203/rs.3.rs-2083151/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.  
Read Full License

Additional Declarations: No competing interests reported.

Version of Record: A version of this preprint was published at Reproductive Health on May 24th, 2023.  
See the published version at https://doi.org/10.1186/s12978-023-01620-0.
Abstract

Background

Mistreatment during labour and childbirth is a common experience for many women around the world. A picture of the nature and types of mistreatment; and especially its influencing factors has not yet been identified in Iran. This study aimed to explore the manifestations of mistreatment and its influencing factors in maternity hospitals in Tehran.

Methods

A formative qualitative study was conducted using in-depth face-to-face interviews between October 2021 and May 2022 in five public hospitals. Participants included women, maternity healthcare providers, and managers at hospital and Ministry of Health levels. Participants were selected using purposive sampling. Recorded interviews were transcribed verbatim and thematically analyzed with a combined deductive and inductive approach using MAXQDA 18.

Results

A total of 60 interviews were conducted. Women experienced various forms of mistreatment during labour and childbirth, including verbal abuse, frequent and painful vaginal examinations, neglect and abandonment, lack of supportive care, denial of mobility and pain relief, and physical abuse. Four main themes were identified as the drivers of mistreatment: (1) individual-level factors (healthcare providers perception about women's limited knowledge on childbirth process, untrained companions, mismatched expectations of women for care, and discrimination based on ethnicity or low socioeconomic status); (2) healthcare provider-level factors (healthcare provider stress/stressful working conditions, healthcare providers with limited personal experience of pregnancy and childbirth, neglect of midwives' identities by doctors, poor educational contents and curriculum, and low salary and lack of incentive); (3) hospital-level factors (lack of staff, lack of supervision and control, type of hospital, inadequate physical structures); and (4) national health system-level factors (lack of access to pain management during labour and childbirth and perceptions about forced vaginal birth in public hospitals).

Conclusions

There are multiple level drivers for mistreatment which requires multifaceted interventions. These interventions should emphasize training of pregnant women and their companions, training healthcare providers, encouraging and managing work shifts, strengthening the position of midwives in public hospitals. Moreover, continuous monitoring of the performance of providers, increase staff numbers and
improvement of physical space of the maternity wards, as well as implementation of the related guidelines, including painless childbirth, should also be considered.

Plain English Summary

Mistreatment during labour and childbirth is a common experience for many women around the world. A picture of the nature and types of mistreatment; and especially its influencing factors has not yet been identified in Iran. This study aimed to explore the manifestations of mistreatment and its influencing factors in maternity hospitals in Tehran. Semi-structured interviews were conducted with women, maternity healthcare providers, and managers at hospital and Ministry of Health levels between October 2021 and May 2022. Our findings showed that women experienced various forms of mistreatment during labour and childbirth. Four main themes were identified as the drivers of mistreatment: (1) individual-level factors (perception of healthcare providers about women's limited knowledge on labour and childbirth process, untrained companions, mismatched expectations of women for care, and discrimination based on ethnicity or low socioeconomic status); (2) healthcare provider-level factors (healthcare provider stress and stressful working conditions, healthcare providers with limited personal experience of pregnancy and childbirth, neglect of midwives' identities by doctors, poor educational contents and curriculum, and low salary and lack of incentive); (3) hospital-level factors (lack of staff, lack of supervision and control, type of hospital, inadequate physical structures); and (4) national health system-level factors (lack of access to pain management during labour and childbirth and perceptions about forced vaginal birth in public hospitals). These findings can provide a good platform for designing and implementing intervention programs to reduce disrespectful maternity care. It can also be used as a guide for managers and policymakers to improve the quality of services provided to women.

Background

According to the World Health Organization (WHO), approximately 810 women die each day from pregnancy and childbirth-related causes in 2017, and most of these deaths were preventable [1]. Policymakers and health program planners have identified the main strategy for reducing maternal mortality and morbidity as increasing coverage of health care and subsequently improving the quality of care [2]. All women deserve high-quality care during pregnancy and childbirth as a right. Equality and dignity of women and newborns should also be met [1, 3]. The WHO (2015) published the quality of care framework for maternal and newborn health, highlighting the importance of both the provision of care and experiences of care [4]. Three standards of effective communication, respect and dignity, and emotional support - known as respectful maternity care (RMC) - were directly related to the experience of care [4, 5]. Despite significant advancements in maternal and newborn health care worldwide, access to quality care is not guaranteed for many women, especially in low- and middle-income countries (LMICs). Even with availability, care may be compromised by the negative experience of childbirth, including mistreatment [6, 7].
Mistreatment of women during childbirth includes physical, sexual, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health systems conditions and constraints [8]. Mistreatment is important not only in terms of the violation of women's rights but also as a public health and social justice issue [9]. However, increasing evidence suggests that mistreatment during labour and childbirth has become a common experience for many women around the world [10–16]. In a study by Annborn et al., Swedish women reported experiencing psychological and physical abuse during childbirth [10]. In a study by Vedam et al. in the United States, one in six women had negative childbirth experience [11]. A study by Sharma et al. in India showed that all women (n = 275) experienced at least one type of mistreatment [12]. A study in Ethiopia also showed a prevalence of mistreatment of 67.7% [13]. Studies conducted in Iran also show a high prevalence, so that in a study 75.7% of women [14] and in another study all women (n = 357) suffered from mistreatment in maternity wards [15].

Global evidence suggests that mistreatment during childbirth has multiple drivers. These drivers that have been reported from the perspectives of multiple stakeholders (e.g. women, healthcare providers, and health managers) include: women (such as discrimination based on their age, education, socioeconomic status, perceived ‘lack of cooperation’ with healthcare providers), healthcare providers (such as beliefs and attitudes, power imbalances, poor rewards and motivation, poor education), health systems (such as lack of equipment, poor supervision), community (such as social pressure, normalization of mistreatment and violence), and policy (such as lack and/or weakness of policy, high costs of maternity care) [7, 17–22]. Due to the differences in the cultural, social and economic characteristics of societies, it is necessary to explore the drivers of mistreatment in maternity care in different contexts as well as from the perspective of multiple stakeholders. The results of these studies can provide valuable information towards designing effective and context-specific interventions and strategies to reduce mistreatment.

There are limited studies on mistreatment during childbirth in Iran; and most of them have focused on the prevalence [14, 15] and description of women's experiences [23]. To our knowledge, there is no comprehensive study that can shed light on the nature and types of mistreatment and especially its influencing factors in Iran. In order to address this gap, the aim of this qualitative study was to explore the manifestations of mistreatment of women during childbirth and its influencing factors in maternity hospitals in Tehran.

**Methods**

**Study design and setting**

This multi-stakeholder formative qualitative study is part of an implementation research project involving the development and implementation of a context-specific intervention to reduce mistreatment during childbirth and evaluation of implementation improvement strategies. This qualitative study was conducted using in-depth face-to-face interviews between October 2021 and May 2022 in five public teaching hospitals in Tehran, Iran. Tehran has 18 public hospitals, 50 private hospitals, and 28 other hospitals (hospitals that are a subset of a specific organization such as charity, affiliated with Armed
Forces, affiliated with Social Security Organization, and affiliated with Islamic Azad University). In this study, a total of five public teaching hospitals with the highest childbirth rates were selected. The characteristics of these hospitals have been reported in Table 1.

Table 1
Characteristics of study hospitals, based on 2021 data

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Hospital Located in North</th>
<th>Hospital Located in South</th>
<th>Hospital Located in East</th>
<th>Hospital Located in West</th>
<th>Hospital Located in Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total births</td>
<td>641</td>
<td>5630</td>
<td>5332</td>
<td>347</td>
<td>2140</td>
</tr>
<tr>
<td>Number of vaginal births</td>
<td>277</td>
<td>2533</td>
<td>1894</td>
<td>105</td>
<td>454</td>
</tr>
<tr>
<td>Number of caesarean births</td>
<td>364</td>
<td>3097</td>
<td>3438</td>
<td>242</td>
<td>1686</td>
</tr>
<tr>
<td>Number of live births</td>
<td>655</td>
<td>5696</td>
<td>5430</td>
<td>359</td>
<td>2208</td>
</tr>
<tr>
<td>Stillbirths</td>
<td>2</td>
<td>111</td>
<td>77</td>
<td>6</td>
<td>45</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of obstetricians</td>
<td>8</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Number of midwives</td>
<td>18</td>
<td>34</td>
<td>26</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Number of residents</td>
<td>15</td>
<td>36</td>
<td>30</td>
<td>21</td>
<td>31</td>
</tr>
<tr>
<td>Capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of labour and delivery room</td>
<td>3</td>
<td>10</td>
<td>9</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Number of beds in labour and delivery rooms</td>
<td>4</td>
<td>10</td>
<td>10</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Designated waiting room for family members or companions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Resource: Department of Midwifery, Ministry of Health and Medical Education (MOHME), Iran; 2021 [24].

Participants and sampling

The study population consisted of three groups: a) women in the immediate postpartum ward; b) maternity healthcare providers (obstetricians, midwives, and residents); and c) managers at the hospital level (maternity supervisors) and the Ministry of Health and Medical Education (MOHME) (policy-makers of reproductive health programs). The inclusion criteria were as follows: women who had vaginal birth and currently lived in Tehran; obstetricians and midwives with at least one year of work experience;
Residents who had passed at least one semester (six months) in the maternity ward; managers with at least five years’ experience in their role. All participants had willingness to participate in the study.

After initial coordination and getting approvals from the hospitals, the eligible healthcare providers, maternity supervisors, and managers at MOHME were invited to participate. The objectives of the study were explained and confidentiality was ensured. Eligible women were also invited to the study from the postpartum wards. All participants expressed their written consent to participate in the study prior to the interview. They were also aware that their participation was voluntarily and they could withdraw from the study at any time. Purposive sampling method with maximum variation was used to select participants. Women were sampled based on age, level of education and socioeconomic status, and healthcare providers and managers based on age and work experience.

Data collection

Pretested semi-structured interview guides were used for data collection (Additional files 1 and 2). All interviews were conducted in Persian by the first author, who is a PhD candidate in Health Education and Promotion and has been trained in qualitative research. She had no prior relationship with the participants. Before starting the interview, study objectives, voluntary participation and confidentiality of data were explained to each participant. Written informed consent and permission for audio recording were also obtained from them. Women were interviewed before discharge in a private room in the postpartum wards of each hospital. Interviews were conducted with healthcare providers and managers at their workplace (in a private room). In the first section of the interviews, the demographic information of the participants were asked as follows: for women: age, education, job, nationality, family income, service provider type, and number of living children; for healthcare providers and managers: age, marital status and work experience. The second section examined their experiences and perceptions of mistreatment during labour and childbirth, with a greater focus on the factors influencing mistreatment. Each interview lasted between 40 and 50 minutes, during which field notes were taken by the interviewer. Each participant was interviewed only once. We achieved data saturation by interviewing 24 women and 36 healthcare providers and managers; until no new data and/or themes were emerged.

Data analysis

Data analysis was performed using a content analysis approach simultaneous to with data collection. First, the first author (MM) transcribed the recorded interviews verbatim in Persian. The transcripts were uploaded to the MAXQDA 18 software for analysis [25]. Then, the third author (ESh; female professor in Health Education and Promotion and expert in qualitative research) checked the transcripts to ensure quality. MM and ESh coded the transcripts independently (investigator triangulation). Finally, the codes were compared and the discrepancies were resolved. In order to coding the data, the typology of mistreatment during childbirth developed by Bohren et al. [8] and the Ratcliffe’s framework of the risk factors of disrespect and abuse during childbirth [26] were used. Based on the mistreatment typology, women’s experiences were in the categories of physical and verbal abuse, failure to meet professional standards of care, and poor rapport between women and providers. Also, based on the Ratcliffe’s
framework of the risk factors of disrespect and abuse during childbirth, the extracted components were classified into four main themes: individual-level factors, healthcare provider-level factors, hospital-level factors and national health system-level factors. Therefore, a combined deductive and inductive (new themes) approach were used for the analysis. We translated the selected quotations in English for providing in this paper.

Lincoln and Guba criteria (1985) were used to ensure the trustworthiness of the study [27]. The lead researcher (MM) had a long relationship with study settings (hospitals) which helped to gain participants' trust as well as understand the research setting and context (prolonged engagement). Coded interviews were returned to three participants for feedback. Furthermore, data collection from multiple stakeholders such as women, healthcare providers, and managers (data source triangulation) provided greater credibility to the data. To ensure dependability, the interviews were analyzed independently by two authors.

Conformability was obtained by reviewing and confirming the data analysis process by a researcher familiar with qualitative studies who did not participate in the study. Variation in participant selection also contributed to the transferability of the findings. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to report this manuscript [28] (Additional file 3).

Results

A total of 60 interviews were conducted (women: 24 interviews; healthcare providers: 29 interviews; and managers: 7 interviews). Tables 2 and 3 show the demographic characteristics of the participants. Three people refused to participate in the study including a manager who did not respond to our invitation and two healthcare providers who expressed concerns about lack of time. The results are presented in two sections: first, an overview of the experiences and manifestations of mistreatment during labour and childbirth, followed by the factors affecting the mistreatment, which is the main focus of this article.
Table 2
Women’s sociodemographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>24 (100.0)</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 20</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td>21–30</td>
<td>16 (66.7)</td>
</tr>
<tr>
<td>31–40</td>
<td>6 (25.0)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td>Primary</td>
<td>7 (29.2)</td>
</tr>
<tr>
<td>Cycle</td>
<td>3 (12.5)</td>
</tr>
<tr>
<td>Diploma</td>
<td>6 (25.0)</td>
</tr>
<tr>
<td>University</td>
<td>6 (25.0)</td>
</tr>
<tr>
<td><strong>Job</strong></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>21 (87.5)</td>
</tr>
<tr>
<td>Employed</td>
<td>3 (12.5)</td>
</tr>
<tr>
<td><strong>Nationality</strong></td>
<td></td>
</tr>
<tr>
<td>Iranian</td>
<td>17 (70.8)</td>
</tr>
<tr>
<td>Afghan</td>
<td>7 (29.2)</td>
</tr>
<tr>
<td><strong>Family income (self-report)</strong></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>8 (33.3)</td>
</tr>
<tr>
<td>Middle</td>
<td>14 (58.3)</td>
</tr>
<tr>
<td>High</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td><strong>Service provider type</strong></td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>20 (83.3)</td>
</tr>
<tr>
<td>Midwife</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Obstetrician</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Do not Know</td>
<td>4 (16.7)</td>
</tr>
</tbody>
</table>
### Table 3

Healthcare providers’ and managers’ demographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Midwives</th>
<th>Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
<td>13</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25–34</td>
<td>12</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>35–44</td>
<td>1</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>45–54</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>≥ 55</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Married</td>
<td>7</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td><strong>Work experience (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 5</td>
<td>12</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>6–10</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>11–15</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>&gt; 15</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

**Types of mistreatment experienced during labour and childbirth**

Four main categories of mistreatment including physical abuse, verbal abuse, failure to meet professional standards of care, and poor rapport between women and providers were emerged from the analysis of data about women's experiences.

**Physical and verbal abuse**
Some women complained of pressure on their abdomen by healthcare providers during childbirth, calling it an “agonizing” behavior. While the providers stated that sometimes they had to use fundal pressure to save the baby's life.

“During childbirth, she pressed my abdomen so hard that my abdomen turned blue. I told her 'not to push'. She said 'be quiet and help. My ribs hurt.” (Woman 21, 32 years old)

Judgmental comments and harsh and rude language were the most common forms of mistreatment experienced by women. This verbal abuse took several forms, including judgmental comments about a woman's young age and shaming women for crying out from labour pains.

“During childbirth, when I was screaming, they said: Shut up, shut your mouth.” (Woman 23, 24 years old)

“They said to me: You who given birth before and have birth experience, aren’t you ashamed to shout? You have to endure the pain; you did not come here to have fun.” (Woman 13, 24 years old)

Another woman said: “I was told several times: why are you pregnant as a child? Do not have children anymore. This will be your first and last child.” (Woman 10, 21 years old)

Several women also reported inappropriate behavior of cleaners during childbirth: “Here, the cleaners also yells at us.” (Woman 21, 32 years old)

Some women also described being threatened of poor outcomes by the providers. However, the healthcare providers did not consider these threats to be mistreatment; they believed that it was an important means of getting the women’s cooperation, believing that these threats came from a place of caring and help, rather than malice.

“The doctor said: 'Madam, you do not push, your child will be handicapped.” (Woman 2, 27 years old)

“Yes, yes, we should threaten the mother that 'If you do not push, your baby will die'. Because if we do not threaten her, she will not push at all ... But I do not consider this as mistreatment because I want to help her.”(Midwife 1, 43 years old)

**Failure to meet professional standards of care**

**Painful vaginal exams:** All women interviewed complained of frequent and painful vaginal examinations. They reported that the providers performed the examination without explanation or permission.

“I hate to be examined by them. I think they examined me more than twenty times. With long nails, it really agonizes. They came quickly, put on gloves, and started the examination ... Now I see a nurse wearing gloves and coming towards me, I’m scared.” (Woman 9, 27 years old)

**Neglect and abandonment:** The narrations of the women showed that many suffered from neglect and abandonment by the healthcare providers. The providers refused to sympathize with them during labour
or left them alone after birth.

“In the labour room, no matter how much I shouted. No one paid attention to me until the birth.... When the baby was born, I was left alone again because another woman was in pain and all the doctors and midwives went to take care of her. I was very scared because there was no one by my side to help.” (Woman 6, 18 years old)

**Refusal to provide pain relief:** Ignoring women’s requests for pain relief during childbirth has also been reported by several women:

“She did not use painkillers for me. She said, ‘There will be four stitches; it’s not worth using painkillers. Be patient.’” (Woman 23, 24 years old)

**Poor rapport between women and providers**

Reports from women and some midwives indicated a lack of supportive care for women during labour and childbirth. They stated that healthcare providers do not allocate time for them to have an emotional relationship with women or to provide information throughout labour and birth.

“I was much stressed. My whole body was shaking. She was my first child and was to be born sooner. Instead of explaining or encouraging me, they said, ‘Shut up, does anyone cry because of childbirth?’” (Woman 12, 19 years old)

“We do not have an emotional relationship with the mother at all. She likes us to explain to her, for example, what is going to happen to her and what the delivery process is like, but unfortunately we do not spend time on it at all.” (Midwife 3, 40 years old)

**Denial of mobility** during labour was also an important source of dissatisfaction for women. They were often connected to the monitors and had no right to walk or move. The midwives explained that residents may have to monitor women tightly because of their legal responsibilities to the health of both mother and baby.

“I was not allowed to get out of bed at all. I said let me walk, but they connected that device to me and I had to lie down, and this was kind of torture.” (Woman 14, 38 years old)

**Influencing factors of mistreatment during labour and childbirth**

We identified four main themes for factors influencing mistreatment during labour and childbirth: Individual-level factors, healthcare provider-level factors, hospital level-factors and national health system-level factors (Table 4).

**Theme 1: Individual-level factors**
Our study showed that healthcare providers believed that women’s limited knowledge about labour and childbirth process, and untrained companions caused mistreatment by them. Moreover, mismatched expectations of women for care, and discrimination based on ethnicity or low socioeconomic status were among the most important factors of mistreatment.

**Perception of healthcare providers about women’s limited knowledge on labour and childbirth process**

Prenatal education is a good opportunity to empower women, and increase their self-efficacy and cooperation during labour and childbirth. However, healthcare providers reported poor knowledge of pregnant women about labour and childbirth processes as major factor of mistreatment. They believed that despite being free of charge, most women did not attend childbirth preparation classes, and this lack of knowledge plays an important role in their lack of “cooperation” during childbirth and mistreatment.

“Unfortunately, many women do not have the knowledge of birth processes and are not ready to give birth. They expect to give birth as soon as they arrive at the maternity ward and then return home. If the woman knows what a normal birth is like; how long does it take; what should she do at each stage of labour; I do not need to shout at her.” (Resident 7, 32 years old)

**Untrained companions**

Some healthcare providers reported that the presence of untrained lay companions was another factor contributing to the experience of mistreatment. They believed that the companions should have received the necessary training in order to be able to help the birthing women, while they did not have enough information and interrupt unnecessarily in the childbirth process.

“Companions are completely unaware, completely unaware, their interference makes us angry, and this may lead to aggression with the mother. For this reason, we (healthcare providers) do not agree with the constant presence of an untrained companion.” (Obstetrician 5, 33 years old)

**Mismatched expectations of women for care**

Some healthcare providers considered the high levels of women's expectations for receiving high quality services as another factor for their mistreatment. Because this factor often caused women to be abusive to the providers and ultimately to provoke sharp reactions from the providers.

“Some women are very expectant. They expect care like private hospitals, meaning having private doctor and midwife.” (Resident 3, 30 years old)

**Discrimination based on ethnicity or low socioeconomic status**

Both healthcare providers and women believed that being women who were not Iranian may be at higher risk of mistreatment. In Tehran, this was particularly true for Afghan women:
“Many of the women referred to our hospital are Afghan women, some of whom do not understand our language at all and do not cooperate well with us. Usually this causes a sharp reaction from us.” (Midwife 17, 50 years old)

“When I was in the delivery room, they said, ‘Afghans again, these Afghans are everywhere we go’... We were offended by their words. I saw that Iranian women were treated better.” (Woman 16, 23 years old)

Women with low economic status are more likely to experience mistreatment. Because most women who go to public hospitals are in poor financial condition, they inevitably accept any kind of care from a healthcare provider. Furthermore, the level of education of women was so important that illiteracy or low education prevented them from receiving respectful care.

“I think a group of people come here (public hospitals) who are either illiterate or financially compelled. They have no other choice, so they tolerate any situation and their voice is not heard. Otherwise, who would like to be treated like this?” (Hospital level manager, 55 years old)

“Most of my friends told me not to go to X hospital. The behavior of its staff is very bad. They will harass you; it looks like you are a laboratory rat. But because the cost was low, I had to come here.” (Woman 12, 19 years old)

**Theme 2: Healthcare provider-level factors**

Healthcare provider stress and stressful working conditions, healthcare providers with limited personal experience of pregnancy and childbirth, neglect of midwives' identities by doctors, poor educational contents and curriculum, and low salary and lack of incentive were the factors identified at the healthcare provider-level.

*Healthcare provider stress and stressful working conditions*

High anxiety and stressful working conditions of the healthcare providers can play a significant role in their way of behaving as a health staff. Some of them complained of pressure from seniors. Seniors were always under legal pressure of providing healthy childbirth outcome and they transfer the pressure to junior healthcare providers.

“The professors are also pressuring us. I think some of our professors are too sensitive. For example, when I have to take a non-stress test (NST) for a pregnant woman who has no problem at 3 o'clock in the morning, of course I get nervous. Because I can't find the fetus's heart, I vent my anger on the patient. 'Pull down your pants, lady, hurry; you have no right to move until I get a good NST', this happens many times and the reason is that when the senior resident or professor comes, the NST should be in the patient's file.” (Resident 12, 27 years old)

Moreover, the high workload and long hour shifts of healthcare providers, especially residents, were another factor stated by the participants that created the ground for mistreatment of women by creating
physical and mental fatigue.

“A resident who has to spend a 36-hours shift cannot be expected to be kind to patient.” (Resident 10, 28 years old)

Healthcare providers with limited personal experience of pregnancy and childbirth

Lack of provider experience of pregnancy and/or childbirth was identified as a factor influencing the quality of care. Participants emphasized that most providers (especially resident doctors as the primary maternity providers) are young. They are often single or have not experienced pregnancy or childbirth, and both healthcare providers themselves and women believed that this lack of understanding and empathy can be accompanied by mistreatment.

“Most (healthcare providers) are young, maybe they do not have the experience of motherhood and childbirth, and they do not understand what the pain of childbirth is?” (Woman 3, 38 years old)

“I have two children; I had a vaginal delivery, the way I treat a pregnant woman is far different from a single resident because I experienced the pain of childbirth, the pain is really terrible, I am more patient with the sighs and groans she makes.” (Resident 4, 33 years old)

Neglect of midwives’ identities by doctors

Proper communication between healthcare providers plays an important role in providing quality and respectful care. However, midwives indicated that there is no good interaction between the obstetric residents and the midwives.

“The relationship between the resident and the midwife is not very good. How can one expect respect for the patient when they do not value us?” (Midwife 4, 37 years old)

Furthermore, most midwives stated that obstetricians and residents should work mostly in the field of surgery and high-risk clinical activities; and midwives should be responsible for caring for women during labour and birth, particularly involving empathy and low risk timely care for women. Therefore, in order to improve the quality of obstetrics care and respecting pregnant women, it is necessary to review the job descriptions of maternity ward providers in public hospitals.

“Midwives have no place in the teaching hospitals. I only do paper works and have no clinical responsibility as a midwife to give birth. Why shouldn't midwife control labour process?” (Midwife 14, 40 years old)

“Description of midwives duties in a teaching hospital should be clearly defined. We suggested that low-risk delivery be performed by midwives and high-risk delivery by Obstetricians.” (MOHME level manager, 51 years old)

Poor educational contents and curriculum
Training gaps for healthcare providers were reported as an important factor for mistreatment by most participants. They believed that they have not well trained about medical ethics or the way to communicate with women during labour and birth. As a result, they feel that they are not sufficiently prepared to provide respectful care for women. They believed that it should be included in their curriculum as a separate course.

“We do not have enough information about dis/respectful maternity care, I have only passed a communication skills training course during my studies that had not that much information on respectful care.” (Resident 2, 31 years old)

“Doctors or midwives are clinically literate, but they do not know how to treat a patient respectfully. I think it is necessary to hold regular training courses for them.” (Woman 18, 27 years old)

Low salary and lack of incentive

Most healthcare providers believed that low salary, along with a system of punishment, instead of encouragement and reward, affected the quality of care provided by them and the quality of relationship with patients.

“When you are not paid well and you are not satisfied financially, this can automatically affect your behavior.” (Hospital level manager, 55 years old)

Theme 3: Hospital-level factors

Factors of disrespectful maternity care at hospital level include: lack of staff, lack of supervision and control, type of hospital, and inadequate physical structures.

Lack of staff

All healthcare providers complained about staff shortages. For them, performing the clinical routine tasks and paper work was a priority, and caring for women with respect was not prioritized. They also noted that the patient-to-staff ratio increases their job demands, meaning that the resident or midwife is forced to perform tasks that are not defined in their area of responsibility.

“The patient input is very high; for example, each midwife has to cover 6 or 7 patients, which means that we are just running here to do the patient’s clinical and paper works correctly. So, we cannot treat all of them properly.” (Midwife 3, 40 years old)

Lack of supervision and control

The women’s report showed that maternity ward managers did not monitor the performance of healthcare providers. They believed that continuous monitoring of providers’ performance was required to reduce disrespectful maternity care. This issue was also emphasized by some managers.
“There is no management and supervision. If they punish the provider who mistreated, the rest will definitely perform better.” (Woman 19, 25 years old)

“A person, for example, maternity supervisor, should be responsible for monitoring the behavior of staff with women and have the authority to warn if someone disrespects them.” (MOHME level manager, 55 years old)

**Type of hospital**

Women believed that the type of hospital was important in receiving quality care. They thought that women in public teaching hospitals were more likely to experience mistreatment due to high work load of staff and lower costs.

“The more money you pay, the better they will treat you. I think a private hospital is better.” (Woman 9, 27 years old)

**Inadequate physical structures**

Good quality care requires sufficient physical infrastructure. Healthcare providers stated that the lack of physical space in some maternity wards poses a challenge to the privacy of pregnant women as well as the presence of a companion. Moreover, the providers complained about the lack of adequate space for their rest during long shifts.

“We do not have a good space here. The women were separated by the curtain, which is either torn or we have to constantly push it aside so we can see the fetal heart monitor, so privacy is not respected.” (Resident 6, 27 years old)

“Unfortunately, we do not have space for companions; even our residents do not have a suitable place to rest in this hospital.” (Obstetrician 13, 43 years old)

**Theme 4: National health system-level factors**

In this study, poor implementation of existing policies and guidelines was identified as another factor in the mistreatment of women.

**Lack of access to pain management during labour and childbirth**

Midwives and residents reported that pregnant women did not have sufficient options for pain management during labour, including use of epidurals.

“In our hospital, almost no painless normal delivery is performed. It is very difficult for us to coordinate a painless normal delivery. Sometimes an anesthetist is so late that the woman gave birth. Thus, pain causes women not to cooperate. If a painless normal delivery is performed, women will definitely have a better experience of childbirth.” (Resident 9, 32 years old)
Perceptions about forced vaginal birth in public hospitals

Some women also complained about forced vaginal birth in public hospitals. They believed that public hospitals limited women's abilities to express preferences for caesarean birth, and that by giving birth in a public hospital, doctors would force them to have a vaginal birth.

“The doctor told me that this is a public hospital, we do not perform Cesarean sections. Even if you are in pain for five days, you have to endure to give birth vaginally ... one of them tore my amniotic sac, forcing me to give birth normally.” (Woman 7, 28 years old)

“The doctor shouted at me and said, ‘Vaginal delivery is painful. If you could not stand it, you would go to a private hospital for a Cesarean section.” (Woman 4, 29 years old)

Table 4 Themes and sub-themes of influencing factors of mistreatment during labour and childbirth reported by the multi-stakeholders

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1: Individual-level factors</td>
<td>Perception of healthcare providers about women’s limited knowledge on labour and childbirth process</td>
</tr>
<tr>
<td></td>
<td>Untrained companions</td>
</tr>
<tr>
<td></td>
<td>Mismatched expectations of women for care</td>
</tr>
<tr>
<td></td>
<td>Discrimination based on ethnicity or low socioeconomic status</td>
</tr>
<tr>
<td>Theme 2: Healthcare provider-level factors</td>
<td>Healthcare provider stress and stressful working conditions</td>
</tr>
<tr>
<td></td>
<td>Healthcare providers with limited personal experience of pregnancy and childbirth</td>
</tr>
<tr>
<td></td>
<td>Neglect of midwives' identities by doctors</td>
</tr>
<tr>
<td></td>
<td>Poor educational contents and curriculum</td>
</tr>
<tr>
<td></td>
<td>Low salary and lack of incentive</td>
</tr>
<tr>
<td>Theme 3: Hospital-level factors</td>
<td>Lack of staff</td>
</tr>
<tr>
<td></td>
<td>Lack of supervision and control</td>
</tr>
<tr>
<td></td>
<td>Type of hospital</td>
</tr>
<tr>
<td></td>
<td>Inadequate physical structures</td>
</tr>
<tr>
<td>Theme 4: National health system-level factors</td>
<td>Lack of access to pain management during labour and childbirth</td>
</tr>
<tr>
<td></td>
<td>Perceptions about forced vaginal birth in public hospitals</td>
</tr>
</tbody>
</table>

Discussion
This was a formative qualitative study that investigated the experiences on and influencing factors of mistreatment during labour and childbirth in public teaching hospitals in Tehran from the perspective of multiple stakeholders. Our findings showed that there were multiple level drivers for mistreatment in the hospitals. These findings can provide a good platform for designing and implementing intervention programs to reduce disrespectful maternity care. It can also be used as a guide for managers and policymakers to improve the quality of services provided to women.

The results of our study showed that women experienced various forms of mistreatment during labour and childbirth. While this type of care was unacceptable to all women, some healthcare providers justified it and did not consider it as mistreatment. Our findings are consistent with previous studies conducted in other settings globally, in which women experienced verbal abuse, neglect and abandonment, lack of supportive care [29–31], frequent vaginal examinations [29, 32], and denial of pain relief [29].

In Iran, the MOHME has been promoting childbirth preparation classes in health centers and public hospitals since 2008 with the aim of empowering pregnant women and their families. These eight-session classes are held for free of charge, in which the presence of a chosen companion (especially family members and/or spouse to prepare them for labour companionship) in two sessions is allowed [33, 34]. However, in our study, healthcare providers’ statements indicated that women's “lack of cooperation” during childbirth due to poor attendance at childbirth preparation classes led to limited knowledge about labour and childbirth process. They believed that the limited knowledge was a reason for mistreatment. First, all women have the right to respectful care regardless of their age, social, economic, ethnic, racial or other factors. Women are often called “uncooperative” when in reality their own needs, bodies and preferences are not taken care of within the health system or by healthcare providers; and it’s more about lack of effective communication than that women acting poorly. Because at the same time providers are saying women are uncooperative, but acknowledge that they aren't educating women about what to expect. Second, failure to hold the childbirth preparation classes routinely and poor supervising of their implementation could have provided the ground for poor attendance of women in classes, as well as the presence of untrained companions. The importance of attending routine antenatal care (ANC) and accessing information and preparing for childbirth to prevent mistreatment is highlighted in other studies too [7, 20, 35, 36]. Halil et al. reported in their study that attending ANC visits and existence of companion during childbirth reduced the risk of experiencing mistreatment by 50% and 60%, respectively [13].

The findings of our study showed women who expected high quality services were more exposed to disrespect due to communication tensions with healthcare providers. Moreover, non-Iranian women - and particularly Afghan women - experienced discrimination in the maternity care settings. With three million Afghan immigrants, Iran is known as the second host country for Afghan refugees. Despite Iran's support for providing free medical care to registered Afghan refugees, illegal immigrants cannot have access to essential health services. Low quality care for Afghan women, including limited access to ANC and mistreatment during childbirth (especially discrimination) has been confirmed in other studies in Iran [37, 38]. The experience of unfair and disrespectful care for refugee pregnant women in low-income settings
[18, 29] and high-income settings [39, 40] has also been documented. Also, poor socioeconomic status and low education of women were other factors that contributed to their experience of mistreatment. These findings were consistent with studies conducted in Kenya [18], Tanzania [41], Nigeria [42] and Palestine [19].

In our study, training gaps for healthcare providers were one of the most important factors of mistreatment that most participants emphasized on. They believed that their educational content focused on issues of ethics rather than issues of respect, independence, and patient choice. The results of our previous study also showed that healthcare providers had poor knowledge and attitudes about disrespectful maternity care [43]. Therefore, it is necessary to review the curriculum of obstetrician and midwifery education as well as in-service continuing training based on the concept of dis/respectful maternity care. Implementing interventions based on educating healthcare providers has been suggested as an important strategy to respect patients’ rights and reduce disrespectful maternity care in other studies [9, 44, 45].

Healthcare provider stress and stressful working conditions were identified as another important factor for mistreatment. For example, some providers described how a resident might be questioned by obstetricians and a senior resident or pressured to have a healthy childbirth outcome. Simultaneously, long shifts and low salary not only discouraged residents from providing respectful care, but also reinforced feelings of anger towards the patients and the health care system. In the study by Burrowes et al., stress, high workload, and low remuneration of the providers were also described as factors for mistreatment [46].

Neglect of midwives’ identities by doctors was another factor identified in our study. Conflict between obstetricians and midwives might be due to unclear roles, poor management, hierarchy issues, and lack of sufficient skills and knowledge [47]. Despite the fact that according to the job description of the MOHME of Iran, midwives are trained for vaginal delivery, obstetricians have deprived them of this right due to financial benefits [48]. The statements of the participants in the study by Gharibi et al. showed that obstetricians and residents disrespected the women during labour and childbirth, while midwives behaved more appropriately [48]. Consistent with our findings, a systematic review about the perspective of midwives in sub-Saharan Africa showed the low position of midwives in the health system hierarchy as a driver for disrespectful maternity care [49]. Also, provider’s limited personal experience of pregnancy and childbirth were important factors raised by our participants. This situation increased the likelihood of mistreatment due to the lack of understanding the situation and empathy of healthcare providers with women. Also, provider’s limited personal experience of pregnancy and childbirth were also important factors raised by our participants. This situation increased the likelihood of mistreatment due to the lack of understanding the situation and empathy of healthcare providers with women.

Lack of supervision and control in mistreatment emerged as an important factor in our findings. Women and managers believed that the performance of healthcare providers was not monitored and that deterrent mechanisms should be considered to reduce maternity mistreatment. Similarly, Taghizadeh et
al. in Iran reported that there was no legal protection for women being mistreatment in maternity wards, and this influenced their decision for future births, and they preferred never to have another birth [23]. The study by Dwekat et al. showed that the lack of accountability mechanisms and monitoring system deprived Palestinian women of their right to respectful care [19].

Participants in our study also identified mistreatment as a shortage of staff, because it limited the provision of quality care due to increased job demands. Moreover, the possibility of respecting women's privacy and sometimes labour companionship was not realized due to lack of physical space in some maternity hospitals. Also, none of the hospitals we studied had a waiting room for family members or companions. These findings are similar to the previous studies that have shown that staff shortages and poor infrastructure contributed to unintentional mistreatment [18, 19, 35, 42]. On the other hand, women in this study reported that they were more likely to experience mistreatment in public hospitals. This is in line with the results of other studies that have shown that women viewed public facilities as a place to provide low-quality care [50] and believed that they should go to private hospitals to receive quality and respectful care [51].

Since 2014, Iran MOHME has launched the policy of “promoting vaginal childbirth” as one of the nine programs of the Health Transformation Plan with the aim of promoting maternal and infant health. One of the important strategies to achieve this goal was to provide methods to relieve labour pain in public hospitals. However, the statements of the providers in our study showed that painless childbirth is not performed in any of the studied maternity wards. Due to the lack of necessary infrastructure such as equipment and space, human resources, cooperation of anesthetists and gynecologist, and training of the women and her choice, painless childbirth is not operational in Iranian hospitals and women are deprived of this right [52, 53].

Our study findings can provide a launching point for identifying and designing interventions to reduce disrespectful maternity care in Iran. To date, interventions to reduce mistreatment and/or promote RMC have been designed and implemented in different settings across the globe [9, 44, 45, 54]. However, there is poor understanding of the implementation aspects of these interventions. In “real-world” settings for the implementation of an intervention or a program, there are always a range of barriers and contextual factors that reduce the effectiveness and success of that intervention or program. So, future research studies should focus on providing strong evidence on potential barriers and facilitators to implementing these interventions and explore appropriate strategies to improve their implementation; in a way that helps the planners and implementers of dis/respectful maternity care interventions to achieve the greatest effectiveness and sustainability with the least challenges.

**Strengths And Limitations**

One of the important strengths of this study was the use of multiple stakeholders' perspectives that provided a deeper understanding of the factors affecting maternity mistreatment in hospitals in Tehran, Iran. Second, interviewing women immediately after delivery reduced the likelihood of recall bias.
However, interviews in hospitals might have hindered women from freely expressing their experiences and views. To reduce this limitation, interviews were conducted in a private room (in the postpartum ward). Furthermore, all women were reassured that this study would have no effect on the care they receive. This study was conducted in public teaching hospitals in Tehran and the results may not be generalizable to all hospitals in Iran. Further studies are suggested throughout the country, as well as in non-public hospitals.

**Conclusions**

Our study showed that women experienced various forms of mistreatment in maternity hospitals. The drivers of the mistreatment were comprehensively identified at different levels of individual, healthcare provider, hospital and national health system. Addressing these factors requires multifaceted interventions. These interventions should emphasize the training of pregnant women and their companions by strengthening childbirth preparation classes (awareness of labour and childbirth process and coping strategies with labour pain), training healthcare providers, encouraging and motivating and managing work shifts, strengthening the position of midwives in public hospitals and improving their communication with doctors. Moreover, continuous monitoring of the performance of providers, increase staff numbers and improvement of physical space of the maternity wards, as well as the implementation of the related guidelines, including painless childbirth, should also be considered.

**Abbreviations**

WHO: World Health Organization; RMC: Respectful Maternity Care; LMICs: Low and Middle Income Countries; MOHME: Ministry of Health and Medical Education; COREQ: Consolidated Criteria for Reporting Qualitative Research; NST: Non-stress Test; ANC: Antenatal Care.

**Declarations**

**Ethics approval and consent to participate**

Written informed consent was obtained from all participants. This manuscript was conducted in accordance with the principles set out in the Helsinki Declaration, and was approved by the Ethics Committee of Tehran University of Medical Sciences (code number: IR.TUMS.SPH.REC.1400.169).

**Consent for publication**

Not applicable.

**Availability of data and materials**

The datasets generated and analyzed during the current study are not publicly available due to privacy restrictions of the participants but are available from the corresponding author on reasonable request.
Competing interests

The authors declare that they have no competing interests.

Funding

This study is funded by Deputy for Education at Tehran University of Medical Sciences (TUMS) (9811108001) and Health Information Management Research Center, TUMS (1401-3-208-62407). The roles of the funders are to monitor the corresponding study planning and progression.

Authors’ contributions

E.Sh., M.M., M.B., A.Kh., F.B., S.H., and A.RF. designed the study. M.M. conducted the interviews, and M.M. and E.Sh. analyzed the data. M.M. and E.Sh. drafted the manuscript. M.B., A.Kh., and F.B. contributed in the revision of the manuscript. All authors have read and approved the final manuscript.

Acknowledgements

We would like to sincerely thank the officials and staff of Taleghani, Mahdieh, Arash, Hazrat Rasoul Akram and Valiasr hospitals in Tehran, as well as all the women’s and managers who helped us in this study.

References


24. Ministry of Health and Medical Education (MOHME). Maternal Health Department. Tehran; 2021:


28. Tong A, Sainsbury P, Craig J: Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007, **19**:349-357. 10.1093/intqhc/mzm042


Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Additionalfile1.docx
- Additionalfile2.docx
- COREQChecklist.pdf