Mistreatment in healthcare: peripartum experience in a Tunisian maternity

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BACKGROUND: Mistreatment in healthcare is defined by the set of behaviors, acts, and omissions committed by the healthcare providers on patients. Pregnant women can be exposed to this behavior during pregnancy, childbirth, and the postpartum period. It can have several aspects and affects the women's mental health, social and professional life, and also their newborns and families.

OBJECTIVE: This study was made to estimate the frequency of mistreatment during the peripartum period in a Tunisian maternity unit, determine its impact on the parturient and her entourage, and draw up recommendations for the prevention of this public health problem.

STUDY DESIGN: We conducted a cross-sectional survey in Department C of the Tunis Maternity and Neonatology Center from July 2022 to September 30, 2022. Our questionnaire encompassed verbal and physical abuse, patient information, consent, unprofessional conduct, poor communication, and discrimination.

RESULTS: This study included 400 patients. The average age was 29.3+−5.65. Single women represented 12.3% of the cases. Seventy-five percent of women reported having been victims of at least one type of violence during childbirth. Verbal abuse was the most frequent type observed. Eighty-two percent of women reported verbal abuse, while 23.25% underwent physical violence. After the delivery, 391 women (97.8%) stated that the delivery was a source of anxiety and that they were not ready to repeat the experience. Six of them were followed up in psychiatry. Mistreatment was expressed by a lack of information and/or respect for consent, unprofessional conduct, or poor communication between the caregiver and the patient.

CONCLUSION: This study emphasizes the significance of including women in decision-making processes regarding their care. Establishing systematic approaches for providing information and obtaining consent is crucial, ensuring a dynamic approach that promotes women's freedom of choice.

Key words: childbirth, consent, obstetric, respect, violence

Introduction

The rights of women during the perinatal period were recognized by the World Health Organization in 2015, which emphasized the importance of assessing and eliminating cases of mistreatment against women during childbirth.[1] In the early 2000s, the term "obstetric violence" (OV), including various concepts of disrespectful and abusive treatment against pregnant women, emerged in Latin America. As a result, some countries (such as Venezuela in 2008 and Argentina in 2009) modified their legislation to include this concept as a type of violence.[2]

In a study that looked at symptoms of anxiety and depression during high-risk pregnancy in Tunisia, the prevalence of depressive symptoms was 20%, and anxiety symptoms 39%.[3] In another Tunisian study, 74.5% of women reported severe anxiety regarding childbirth. Additionally, delivery was perceived as traumatic in 48.2% of cases.[4] At the sub-Saharan level, findings from a Moroccan study indicate that 59.2% of participants reported experiencing adverse events during their most recent childbirth. Among these, the primary grievances included nonconsensual care (86.7%), disregard for privacy (45.4%), and verbal mistreatment (25%).[5]

The High Council for Gender Equality established a report in 2018 on sexist acts during obstetric care, and the National Consultative Commission on Human Rights issued a report in 2018 on mistreatment in the healthcare system. Both institutions recommended conducting surveys on this subject.[6]

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Disclosures:

Ethics Statement: This study was reviewed and approved by the ethical committee of the Maternity and neonatology center of Tunis with the approval number: 2022/17.

All participants provided informed consent to participate in the study.

All participants provided informed consent for the publication of their anonymized case details.

The study complies with all Tunisian regulations.

Data Availability Statements: The data that support the findings of this study are available on request from the corresponding author, Aloui Haithem.

Conflicts of Interest: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this article.

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Why was this study conducted?

To assess the prevalence of mistreatment in healthcare during labor and postpartum periods in a Tunisian maternity unit, understand its impact on women and their families, and develop recommendations for preventing this public health issue.

Key findings

The study of 400 patients revealed that 70.5% experienced mistreatment during childbirth, primarily verbal abuse.

Postdelivery, 97.8% of women felt anxious and unwilling to undergo it again, with 5.5% developing postpartum depression consequently.

What does this study add to what is already known?

This study expands our understanding of mistreatment during labor and postpartum period in Tunisia, emphasizing the importance of improved communication, consent, and women's participation in decision-making.

It advocates for systematic approaches to safeguard women's autonomy and freedom of choice during childbirth.

Given the lack of Tunisian research on mistreatment in obstetric settings, this study aims to investigate the prevalence and impact of such mistreatment. By identifying key risk factors and barriers to quality care, we seek to develop strategies for prevention and intervention, ultimately ensuring a safe and positive experience for women during childbirth.

Materials and method

We conducted a cross-sectional descriptive and analytical study in Department C of Obstetrics and Gynecology at the Tunis Maternity and Neonatology Center. The study lasted 3 months, from July 1, 2022, to September 30, 2022.

The questionnaires were distributed to women hospitalized in our department on the second day of the postpartum period. The questions were answered in Arabic during a face-to-face interview between the women and the data collection doctor. It was interpreted for women who cannot understand Arabic during the interview. A doctor made the collection from another maternity unit. The team involved in patient care did not participate in data collection to avoid influencing the women's responses. The questions in part 4 (consequences of childbirth) were answered during an interview with the same team at the outpatient clinic during the routine visit on the 40th day of the postpartum period.

The formula for calculating the sample size is $n = z^2 \times p\,(1-p)/m^2$.

z = confidence level according to standard normal distribution. This formula determines the number of people (n) to recruit depending on the margin of error (m) that can be tolerated on a proportion of responses p. In our case, the calculated sample size n was 354.79.

Data was set and analyzed anonymously via SPSS software version 20.0. Quantitative data was presented in means (SD) or medians (IQR) and compared, as suited, by the Student's t test or Mann−Whitney-U test. The chi-square test and Fisher's exact test were used to compare proportions. A P value <.05 was needed for statistical significance.

In this study, inclusion criteria encompassed all women delivering in our maternity ward during the study timeframe, irrespective of gestational age, delivery method (vaginal or cesarean), or the necessity of instrumental extraction, provided they were over 18 years old. Conversely, pregnant women who gave birth in the department during the study period but left against medical advice or absconded were excluded from the analysis.

Mistreatment against women during childbirth was measured using a previous Tunisian questionnaire.[4] The questionnaire, developed by a multidisciplinary team, included 55 questions divided into 4 items (epidemiological and obstetrical characteristics, the experience of pregnancy [25 questions], the experience of childbirth [21 questions], and the experience of the first day of postpartum).[4]

The questionnaire and patient consent were validated by the hospital's ethical committee, medical board, and the National College of Obstetrics and Gynecology of Tunisia. To ensure informed consent, we provided interpretations of the consent form in the Tunisian dialect for patients unfamiliar with Arabic. Participants received no financial or other benefits, and none belonged to ethnic minorities in Tunisia. We affirm that our work is free from conflicts of interest and adheres to ethical and professional standards.

Results

The study comprised 400 patients, with the average age of the parturients at 29.3±5.65 years. Most hailed from rural areas (n=362, 65.8%) and were often primiparous (n=171, 42.8%). Unplanned pregnancies were prevalent (n=357, 89.3%) yet well-monitored in 59.8% (n=239) of instances. Complications arose in 11.3% (n=45) of pregnancies, with premature rupture of membranes occurring in 35.6% (n=142) of all cases.

The median gestational age at delivery was 39 weeks (PW), ranging from 28 to 41 PW, with only 12 premature deliveries.

Epidural anesthesia was administered in 4.5% (n=18) of cases, and spontaneous onset of labor was noted in 46.5% (n=186) of deliveries. Vaginal deliveries predominated (n=354, 88.5%), with forceps used in 9% (n=36) of cases and episiotomy performed in 36.7% (n=147). Cesarean sections were conducted for 46 patients, with manual exploration of the uterine cavity undertaken in 60 cases (15%).

Complications during the perinatal and postpartum periods occurred in 7.5% (n=30) of deliveries.

During delivery, most women (*n*=348, 87%) expressed dissatisfaction with the care conditions due to lack of information, a factor significantly linked to age, origin, and socioeconomic status (*P*=.016). While women generally valued the constant presence of caregivers (*n*=389, 97.3% satisfaction rate), concerns arose regarding the clarity of roles within the medical and paramedical team; notably, 67.3% of women (*n*=269) reported that staff and doctors failed to introduce themselves during delivery. A notable concern was the lack of communication between women and healthcare personnel, highlighted by 386 respondents.

Regarding information and consent, most women (*n*=354, 88.5%) noted a lack of consent during their care, with only (*n*=46, 11.5%) feeling adequately informed.

Transitioning to meeting needs and respecting maternal privacy, every woman reported a lack of privacy during their hospital stays, with a significant proportion (*n*=279, 69.8%) expressing concerns about the frequency of vaginal examinations. Furthermore, 87.8% of women (*n*=351) were separated from their newborns after delivery, and immediate breastfeeding, as recommended, was practiced by a minority (*n*=49, 12.2%). Additionally, 36.7% of women (*n*=147) felt inadequately supported during their stays, citing restrictions on companionship and timing of family visits as primary concerns.

Regarding the incidence of types of violence, a significant proportion of women (*n*=282, 70.5%) reported encountering some form of violence during childbirth, with verbal abuse being the most prevalent (*n*=327, 81.8%). This included insults (*n*=110, 27.5%), threats (*n*=56, 14%), judgment (*n*=98, 24.4%), and humiliation (*n*=136, 33.9%). Although direct physical violence was not disclosed, 93 patients (23.2%) experienced force from healthcare providers, particularly during childbirth.

Furthermore, nonconsensual vaginal examinations were perceived as sexual violence by 11.5% of women (*n*=46) in the study.

Reported OV varied significantly with age; the conditions of care (delay and lack of support) were qualified insufficiently by patients under the age of 25 and patients who delivered vaginally. The notion of neglect after delivery was primarily found among patients under the age of 25 (*n*=88, 100% vs *n*=283, 90.7% *P*=.003) and those who delivered vaginally (*n*=334, 94.4% vaginal vs *n*=37, 80.4% cesarian section *P*=.003) (Table 1). Patient satisfaction with the conditions of care was not dependent on their origin or socioeconomic status.

The lack of consent observed in our study varied significantly based on age (*n*=64, 72.7% under the age of 25 years vs *n*=290, 92.9% over 25 years, *P*=.000), socioeconomic level (*n*=332, 88.8% low vs *n*=2, 33.3% high, *P*=.002), mode of delivery (vaginal *n*=308, 87% vs cesarian section *n*=46, 100%, *P*=.003), and parity. Consent was lacking among women aged 25 and older, women from rural backgrounds, primiparous women, and women with low to moderate socioeconomic status. The lack of communication varied with age (*n*=88, 100% under the age of 25 vs *n*=298, 95.5% over the age of 25, *P*=.029), origin (rural *n*=261, 99.2% vs urban *n*=125, 91.2%, *P*=.000), and socioeconomic level (low *n*=382, 97% vs high *n*=4, 66.7%, *P*=.016) (Table 2).

The frequency of violence varied significantly with socioeconomic (low *n*=280, 71.1% vs high *n*=2, 33.3%, *P*=.045) and educational level (low *n*=268, 71.7% vs high *n*=14, 53.8%, *P*=.048), as well as the mode of delivery (vaginal *n*=238, 67.2% vs cesarian section *n*=44, 95.7%, *P*=.000). Women from higher socioeconomic and educational backgrounds were less affected by acts of violence.

Verbal violence varied depending on age (*n*=82, 93.2% under the age of 25 vs *n*=245, 78.5% over the age of 25, *P*=.002), educational level (low *n*=310, 82.9% vs high *n*=17, 65.4%, *P*=.03), and the occurrence of complications (*n*=29, 96.7% yes vs *n*=298, 80.5% no, *P*=.028). Young women under the age of 25 and

TABLE 1
Satisfaction with support conditions based on maternal characteristics

		Delay in medical care	*P*	Preparation for childbirth	*P*	Neglect	*P*
Age	<25 y old	25 (28.4%)	.000	68 (77.3%)	.895	88 (100%)	.003
	≥25 y old	37 (11.9%)		239 (76.6%)		283 (90.7%)	
Origin	Rural	39 (14.8%)	.607	198 (75.3%)	.337	243 (92.4%)	.705
	Urban	23 (16.8%)		109 (79.6%)		128 (93.4%)	
Socioeconomic level	low	60 (15.2%)	.235	303 (76.9%)	.425	367 (93.1%)	.063
	High	2 (33.3%)		4 (66.7%)		4 (66.7%)	
Delivery mode	Vaginal	58 (16.4%)	.175	273 (77.1%)	.628	334 (94.4%)	.003
	C section	4 (8.7%)		34 (73.9%)		37 (80.4%)	

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TABLE 2
Satisfaction with the level of information and consent based on maternal characteristics

		Lack of consent	*P*	Lack of communication	*P*
Age	<25 y	64 (72.7%)	.000	88 (100%)	.029
	≥25 y	290 (92.9%)		298 (95.5%)	
Origin	Rural	236 (89.7%)	.284	261 (99.2%)	.000
	Urban	118 (86.1%)		125 (91.2%)	
Socioeconomic level	low	352 (89.3%)	.002	382 (97%)	.016
	High	2 (33.3%)		4 (66.7%)	
Educational level	low	332 (88.8%)	.349	360 (96.3%)	.384
	High	22 (84.6%)		26 (100%)	
First childbirth	No	221 (96.5%)	.000	226 (98.7%)	.006
	Yes	133 (77.8%)		160 (93.6%)	
Delivery mode	Vaginal	308 (87%)	.003	342 (96.6%)	.493
	C section	46 (100%)		44 (95.7%)	

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those who had complicated deliveries were more affected by this type of violence. Women with higher educational levels were less affected by this type of violence. Sexual violence varied based on educational level (low *n*=46, 12.3% vs high *n*=0, 0%, *P*=.037). None of the women with higher educational levels experienced sexual assault (Table 3).

The occurrence of postpartum depression varied according to socioeconomic level (low *n*=7, 1.8% vs high *n*=2, 33.3%, *P*=.006). It was more frequently observed in women giving birth for the first time (primiparous *n*=7, 4.1% vs nonprimiparous *n*=0, 0.9%, *P*=.035). Post-traumatic stress occurred mainly when the delivery was complicated (*n*=5, 16.7% yes vs *n*=17, 4.6% no, *P*=.018) (Table 4).

Discussion

Our study highlights a concerning prevalence of mistreatment during the peripartum period, with 70.5% of women reporting some form of violence, particularly verbal and physical abuse. These findings align with previous research conducted in France, where verbal abuse was the most frequently observed form of violence (73.7% of violence was verbal, 40.8% physical, and 23.9% sexual).[7] This consistency suggests that verbal abuse during childbirth is a widespread issue across different healthcare systems, warranting further investigation into its root causes.

The high levels of anxiety expressed by women postdelivery (97.8%) emphasize the long-term psychological impact of OV. Anxiety about future childbirth is not only a reflection of their recent experiences but also suggests that healthcare environments are not providing adequate emotional support during labor. This gap in care can significantly contribute to negative birth experiences, influencing future reproductive decisions and overall well-being.

Apart from OV, childbirth itself can be a traumatic event. The attitude and listening skills of healthcare professionals are particularly appreciated by patients.[8] In our work, women were generally satisfied with the constant presence of caregivers.

Patient information is essential for obtaining informed consent for every medical procedure.[8] In obstetrics, where maternal or fetal complications can arise suddenly, even when no risk factors are present at the start of labor, the importance of clear and ongoing communication cannot be overstated.[9]

The dynamic nature of childbirth underscores the need for healthcare providers to update and involve patients in decision-making continuously. Failing to provide timely and adequate information not only compromises patient autonomy but can also lead to increased anxiety and dissatisfaction with care, as women may feel excluded from critical decisions during a highly vulnerable time.

Maternity care affects women's autonomy and integrity, such as women's right to codetermination and their right to feel free about their bodies and their sexuality. Ensuring their participation in decision-making regarding the treatment should be a fundamental part of midwifery. This should include mutual agreements and written birth plans.[10] Some studies conducted in developing countries have highlighted higher rates of mistreatment, often accompanied by nonconsensual actions.[11,12]

In our study, the striking lack of information (96%) and absence of consent (88.5%) reported by most women highlight a significant gap in communication between patients and healthcare providers. This raises critical concerns about the quality of information provided, even in cases where women actively request cesarean sections. The decision-making process surrounding such a major procedure must be rooted in comprehensive and transparent information, yet our findings suggest this is not consistently happening.[13] Moreover, the distress caused by post-childbirth procedures, such as uterine examinations, is exacerbated when women are not informed. While the urgency of specific medical situations may justify immediate action, it should not come at the expense of basic patient communication. Even in fast-moving scenarios, brief explanations can alleviate distress and foster trust between patients and healthcare providers. In our study, despite 60 uterine examinations being performed after vaginal deliveries, only 3 patients were informed beforehand, which underscores the need for improved communication protocols during and after labor.

TABLE 3
Variation in the frequency and types of violence according to maternal characteristics

		Violence victim	*P*	Sexual violence	*P*	Physical violence	*P*	Verbal violence	*P*
Age	<25 y	58 (65.9%)	.285	8 (9.1%)	.422	24 (27.3%)	.312	82 (93.2%)	.002
	≥25 y	224 (71.8%)		38 (12.2%)		69 (22.1%)		245 (78.5%)	
Origin	Rural	179 (68.1%)	.138	26 (9.9%)	.161	54 (20.5%)	.075	218 (82.9%)	.414
	Urban	103 (75.2%)		20 (14.6%)		39 (28.5%)		109 (79.6%)	
Socio-economic level	low	280 (71.1%)	.045	44 (11.2%)	.144	91 (23.1%)	.425	321 (81.5%)	.296
	High	2 (33.3%)		2 (33.3%)		2 (33.3%)		6 (100%)	
Educational level	low	268 (71.7%)	.048	46 (12.3%)	.037	92 (24.6%)	.015	310 (82.9%)	.03
	High	14 (53.8%)		0 (0%)		1 (3.8%)		17 (65.4%)	
First childbirth	No	160 (69.9%)	.749	6 (2.6%)	.000	49 (21.4%)	.31	180 (78.6%)	.059
	Yes	122 (71.3%)		40 (23.4%)		44 (25.7%)		147 (86%)	
Delivery mode	Vaginal	238 (67.2%)	.000	43 (12.1%)	.193	78 (22%)	.11	285 (80.5%)	.075
	C section	44 (95.7%)		3 (6.5%)		15 (32.6%)		42 (91.3%)	
Complicated delivery	Yes	21 (70%)	.95	3 (10%)	.539	7 (23.3%)	.991	29 (96.7%)	.028
	No	261 (70.5%)		43 (11.6%)		86 (23.2%)		298 (80.5%)	
Abdominal expression	Yes	-	-	46 (12.6%)	.01	88 (24.2%)	.163	307 (84.3%)	.000
	No	-		0 (0%)		5 (13.9%)		20 (55.6%)	

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TABLE 4
Variation in the repercussions according to maternal characteristics

		Postpartum depression	*P*	Post-traumatic stress	*P*
Age	<25 y	1 (1.1%)	.375	6 (6.8%)	.349
	≥25 y	8 (2.6%)		16 (5.1%)	
Origin	Rural	6 (2.3%)	.628	12 (4.6%)	.255
	Urban	3 (2.2%)		10 (7.3%)	
Socioeconomic level	low	7 (1.8%)	.006	22 (5.6%)	.711
	High	2 (33.3%)		0 (0%)	
Educational level	low	9 (2.4%)	.543	22 (5.9%)	.219
	High	0 (0%)		0 (0%)	
First childbirth	No	2 (0.9%)	.035	8 (3.5%)	.042
	Yes	7 (4.1%)		14 (8.2%)	
Delivery mode	Vaginal	7 (2%)	.277	19 (5.4%)	.475
	C section	2 (4.3%)		3 (6.5%)	
Complicated delivery	Yes	0 (0%)	.492	5 (16.7%)	.018
	No	9 (2.4%)		17 (4.6%)	
Abdominal expression	Yes	5 (2.2%)	.611	10 (4.4%)	.294
	No	4 (2.3%)		12 (6.9%)	

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In addition to information and consent, respecting maternal preferences such as skin-to-skin contact is crucial for promoting positive birth experiences. Skin-to-skin contact has well-documented benefits for both mother and newborn, yet in our study, only 12.2% of women reported that this practice was observed, while the majority were separated from their newborns immediately after delivery.[14–16]

The practice of skin-to-skin contact, an important aspect of postpartum care, was reported by only 12.2% of the women in our study, while the majority stated that they were separated from their newborns immediately after delivery. This gap between recommended practices and actual care highlights the need for greater emphasis on patient-centered care and communication. Furthermore, the timing of obtaining consent was a critical issue raised by participants, as women during childbirth are often not in a position, both mentally and physically, to fully process new information being presented to them.[17] This emphasizes the

importance of obtaining informed consent at an appropriate time, well before labor begins.

In developing countries, women face additional challenges during childbirth, including being denied the presence of a companion (14.5%), privacy concerns that vary from 6.3% to over 50%, and feelings of neglect by healthcare providers (8.53%).[11,12] These figures illustrate systemic issues that undermine the quality of care women receive. In our study, 36.7% of women reported a lack of sufficient support and accompaniment, consistent with these findings. Restrictions on the number of companions allowed and visiting hours were among the most frequent complaints.

Age and prior obstetric experience also emerged as influential factors in the psychological experiences of women, especially during the prepartum period. Younger, less experienced women were found to be more vulnerable to feelings of powerlessness, which in turn heightened their risk of experiencing certain forms of mistreatment or violence during labor. This dynamic of immaturity and perceived authority by healthcare providers may facilitate the use of power imbalances, further contributing to the mistreatment of women during childbirth.[18]

The presence of mistreatment against women during childbirth is associated with the delivery mode, which is more common in vaginal deliveries where the practitioner and midwife are required to communicate, advise, and clarify decisions made at different stages.[9] Contrary to this observation, the incidence of violence in this study, as well as lack of consent, were mainly observed in women undergoing cesarean section. In the 21st century, the care provided to patients in obstetric services has significantly improved, especially in developed countries, reducing complications for both the mother and the newborn during labor and delivery.[19] The verbal violence experienced by the women in this study was mainly reported in situations of complicated delivery.

Some research has shown that women's fear of childbirth is mainly related to the fear of pain and that this fear is strongly correlated with the risk of post-traumatic stress.[20] The practice of uterine fundus pressure can also be highly distressing. Despite the lack of scientific legitimacy, this procedure is still performed during childbirth. As early as 2007, the High Authority of Health recommended abandoning this practice due to "the traumatic experiences of patients and their families and the existence of rare but sometimes serious complications."[21] In our study, uterine fundus pressure was performed without well-informed consent in 56.2% of cases. Only 4.4% of these women experienced post-traumatic stress. Having a negative memory of childbirth at day 2 is strongly associated with post-traumatic syndrome one year after delivery.[22] Roughly 10% of women who undergo vaginal deliveries exhibit symptoms of postpartum depression, as determined by a depression scale score of $\geq$13 assessed at 2 months postdelivery.[23] In this study, depression, and post-traumatic stress were mentioned in only 2.3% and 5.5% of all patients, respectively. This depressive state was more pronounced in women of higher socioeconomic status and in women giving birth for the first time or having a complicated delivery.

Potential biases in the retrospective data collection include underreporting of OV due to social stigma or fear of repercussions. Additionally, the study's findings may not be generalizable to all regions of Tunisia or other countries with different healthcare systems and cultural contexts.[24]

Our study highlights the need for greater awareness of mistreatment in obstetric care within the broader context of healthcare abuse. The term "mistreatment in healthcare" may be more encompassing, capturing unprofessional behavior across medical specialties. However, obstetric care remains a critical area where patient autonomy and dignity are frequently compromised, suggesting that more targeted interventions are required.[25]

Strengths and limitations

This study benefits from a large sample size, which enhances the statistical power and improves the reliability of the findings. The inclusion of diverse variables, such as verbal, physical, and psychological violence, provides a comprehensive understanding of obstetric mistreatment. Additionally, the study is one of the few in the region to examine OV, offering valuable insights into a largely understudied area. The high response rate due to direct interaction with participants also reduces nonresponse bias and increases the credibility of the results. Furthermore, the findings have practical implications for healthcare policy, improving patient communication, informed consent, and respectful maternal care practices.

However, the cross-sectional design limits the ability to establish causal relationships between the variables, as it only provides a "snapshot" of experiences at one point. This may hinder the understanding of long-term effects, such as whether mistreatment during childbirth leads to persistent psychological issues. Another limitation is the potential for recall bias, as participants may have trouble accurately remembering their childbirth experiences, especially if the events were traumatic. Moreover, since the study was conducted in one department, its findings may have limited generalizability to other regions or countries with different healthcare systems and cultural practices.

Conclusion

Alarmingly, 70.5% of patients in this study reported experiencing some form of violence during childbirth, with verbal abuse being the most common, followed by physical violence at 23.25%. Postdelivery, 97.8% of women expressed anxiety and hesitancy about undergoing childbirth again. OV, evident in instances of lack of consent, nonadherence to nursing standards, and strained caregiver-patient relationships, underscores the urgent need for reform in obstetric practices in Tunisia to safeguard patient well-being. ■

CRediT authorship contribution statement

Haithem Aloui: Writing – original draft, Methodology, Investigation.

Hatem Frikha: Supervision. **Rami Hammami:** Software. **Amal Chermiti:** Investigation. **Hassine Saber Abouda:** Conceptualization. **Mohamed Badis Channoufi:** Validation. **Abir Karoui:** Visualization.

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