



Disrespect and Abuse During Child Birth Among Mothers who gave Birth in Public Health Facilities, Ebantu District, East Wollega Zone, Oromia, Ethiopia

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Received: December 13, 2021

Published: April 14, 2022

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Abstract

Becoming an efficient leader is one of the essential qualities to be imparted by a medical student which has also been emphasized in the new Competency Based Medical Education. Developing leadership competencies among the medical students particularly girls, directs them to drive and reform the health care systems. The present study determines the evaluation of the Goleman's 6 types of leadership styles among girls pursuing MBBS. A total of 129 girl students participated in the study. Google forms were shared with them that included demographic data and a Questionnaire for leadership style with 36 questions. There was no question revealing their identity. They were asked to understand each question and answer accordingly. Scores were analyzed. The results were graphically represented and studied for the occurrence of different leadership styles. Democratic leadership was most common type observed in 42 girls (38.8%) followed by visionary type in 27 girls (25%). The least common type of leadership was commanding type reflected in only 3 students (2.7%). Score from 21 students was interpreted and was found to have combined leadership styles. Democratic type was the most common combination observed in 13 students. The present study reports the different types of leadership styles among girls from north coastal Andhra Pradesh. As the number of girls choosing medical profession is on the rise, it is necessary to understand the prevalence of different leadership styles and to motivate them to impart the perfect style suitable for the situation. The study group were addressed after the evaluation and results explained. They were motivated to mould themselves and learn to adapt to the circumstances they face in the future as medical health professionals.

Keywords: Leadership Styles; Medical Girl Students; Health Care; Democratic; Visionary

Introduction

Background

Maternal and child health are priorities and key issues for the government of Ethiopia [1]. Health care services during pregnancy, delivery and after delivery are key points for the wellbeing of

mother and infant. Reducing maternal mortality depends upon ensuring that women have a right to quality care before, during and after delivery [2]. Skilled antenatal care, delivery, and postnatal service are crucial interventions in reducing both maternal and child morbidity and mortality [2].

Every women has seven rights during childbearing including, the right to be free from harm and ill-treatment; the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care, the right to privacy and confidentiality; the right to be treated with dignity and respect; the right to equality, freedom from discrimination, and equitable care; the right to healthcare and to the highest attainable level of health and the right to liberty, autonomy, self-determination, and freedom from coercion [3].

Many women experience disrespectful, abusive or neglectful treatment during childbirth in facilities has been reported to be manifested in different forms and extents worldwide [4]. The main forms of disrespect and abuse reported by different researchers include physical abuse, profound humiliation and verbal abuse, un-consented medical procedures, lack of confidentiality, lack of informed consent for procedures that are undertaken, gross violations of privacy, neglect/abandonment, and detention of women and their newborns in facilities after childbirth due to an inability to pay [5,6].

Disrespect and abusive treatment during childbirth in facilities violates the rights of women to respectful care and threaten their rights to life, health, bodily integrity, and freedom from discrimination. Such practices may have direct adverse consequences for both the mother and infant, since it may increase home delivery and currently only 26% deliveries were facility-based, whereas, ensuring universal access to safe, acceptable, good quality sexual and reproductive health care can significantly reduce global rates of maternal and neonatal morbidity and mortality through increasing home delivery [1,3-5].

Disrespect and abuse are one of the main factors that discourage women from giving birth in health facilities [7]. Lack of respectful maternity care decreases mother's satisfaction with services and mediates lack of access to skilled maternity care by reducing the probability that mothers will return to skilled care for future maternal and child health services through building distrust of facility-based delivery at the community level [8].

Childbirth is a one-day event and women's memory of childbirth experiences stay with her for a lifetime and are often shared with other women and influence their decision to seek care from health facility timely for maternity care [9,10]. Women's experiences with

caregivers at this time have the impact to empower and comfort or to cause long-term emotional suffering, adding to or detracting from women's confidence and self-esteem [10]. Negative experience during childbirth could increase risks of postpartum depression, and may affect mothers' attitude on the future pregnancy and choice place of delivery and will decrease institutional delivery, increased home delivery which may cause mortality and morbidity among child and mothers [9,11].

Globally, far too many women still suffering and dying from serious health problem during pregnancy and childbirth. In 2015, an estimated 303,000 women worldwide died due to maternal causes. Almost all of these deaths (99%) occurred in low and middle-income countries (LMIC), with almost two thirds (64%) occurring in Africa [4].

The impact-level targets of Health Sector Transformational Plan (HSTP) of Ethiopia by 2020 is to reduce reduce Maternal Mortality Ratio (MMR) from 420 to 199 per 100,000 live births and Caring, Respectful and Compassionate (CRC) is incorporated in the current Ethiopian government's health sector transformational agenda to improve quality of health services and reduce mortality [2]. But, the facility-based study undertaken in four rural health centres in Amhara and Southern Nations, Nationalities, and Peoples (SNNP) regions of Ethiopia shows that; one in five respondents (21.1%) are experiencing some form of D&A during child birth including, non-consented care (17.8%), lack of privacy (15.2%) and non-confidential care (13.7%) [12]. Again in Arba Minch 98.9%, Jimma University Medical Center 91.7% and in Western Ethiopia; 74.8% of the respondents are experiencing at least one form of disrespect and abuse during child birth in health facilities [13-15].

The result from Jimma zone hospitals shows that 29% of respondents received not women-friendly during antenatal care, delivery and postnatal care. About 20.2% of them reported disrespect and abuse including shouted/scolded while receiving care and 32.6% of respondents had no need of companionship from family at labor ward in which 10.7% of them were due to the fact that they worried of health staffs may disagree on them and their companionship [16].

Different factors those can contribute to the experiences of disrespect and abuse. Normalization of disrespect and abuse during childbirth, lack of community engagement and oversight, lack of

autonomy and empowerment, supervision for respect and non-abuse in childbirth; lack of accountability mechanisms at care site, provider demoralization related to weak health systems, shortages of human resources, provider status and respect, socioeconomic and demographic factors are factors predisposing to disrespect and abuse during facility-based child birth [5,17].

Even though there were some studies that have been conducted with regard to disrespect and abuse during childbirth in health facilities, majority of the studies were facility-based. Only few community-based studies were undertaken in Pakistan, India, Bahir Dar and Tigray North Ethiopia indicated the prevalence of women’s experiences of disrespect and abuse during childbirth ranged from 22 to 99.7% [11,17-19]. This evidence shows the availability of the problem and needs to be investigated.

Therefore, this study tried to identify the prevalence and factors associated with disrespect and abuse experienced by women during their childbirth in health facility in both quantitative and qualitative methods as a community based. This finding enable health care providers for developing interventions, to customize the respectful maternity care in their facility and encouraging clients’ future facility based child birth.

Conceptual frame work

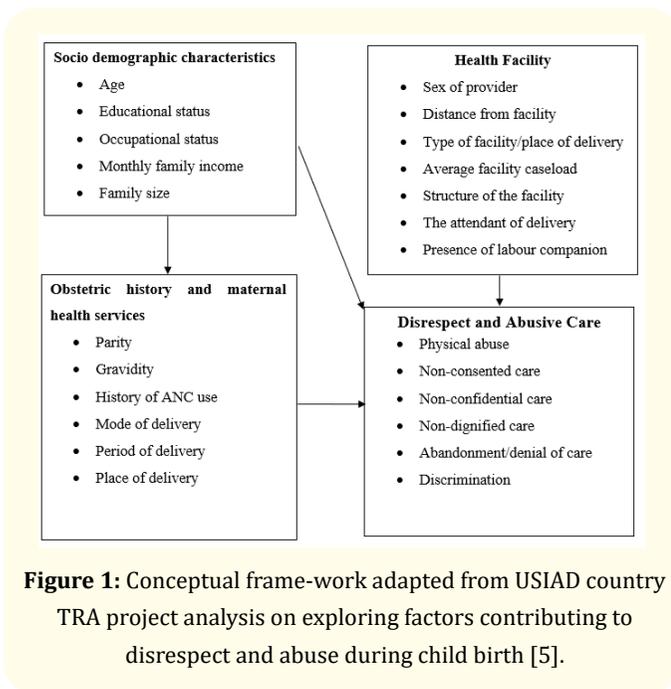


Figure 1: Conceptual frame-work adapted from USIAD country TRA project analysis on exploring factors contributing to disrespect and abuse during child birth [5].

Methods and Materials

Study area

This study was conducted in Ebantu District. Ebantu District is one of the Seventeen (17) districts of East Wollega Zone which is located in Oromia Regional State, North-Western part of Ethiopia at a distance of 466 KM from Addis Ababa the capital city of Ethiopia and 138 KM from Nekemte town the capital city of East Wollega Zone. The total population of the district is estimated to be 51,750 of which 25,933 are males and 25,817 are females according to 2007 Centra Statistical Agency. Out of these, about 11, 437 were expected to be women’s in the reproductive age groups. The district has 21 kebeles of which, 19 are rural kebeles and 2 are urban kebeles. In Ebantu District there are 2 public health centers, 21 health posts and 4 private clinics.

Map of the study area

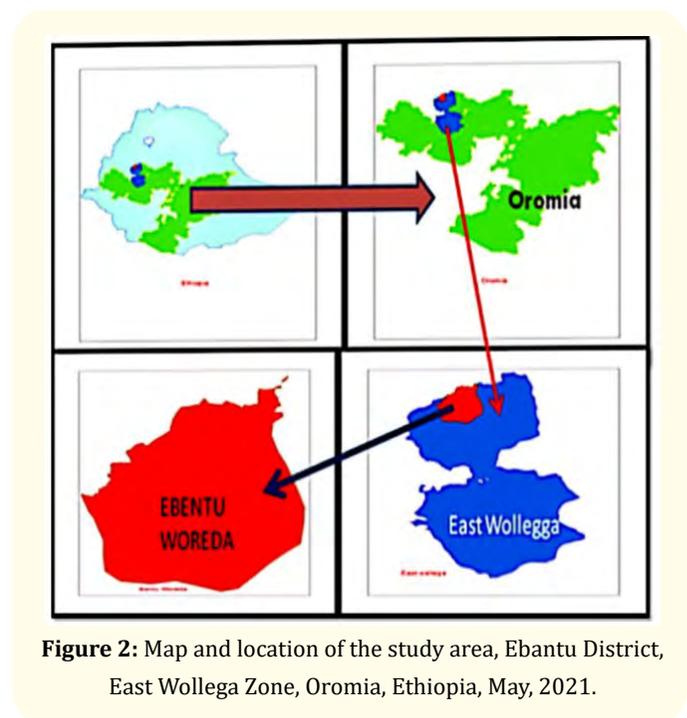


Figure 2: Map and location of the study area, Ebantu District, East Wollega Zone, Oromia, Ethiopia, May, 2021.

Study period and design

A community-based cross-sectional study was conducted from May 1-30, 2021 using both quantitative and qualitative methods.

Population

- **Source population:** All mothers living in Ebantu district and who gave birth in public health facilities.

- **Study population:** All mothers who gave birth in public health facilities in the six months prior to the study period.

Study subjects

Randomly selected mothers living in Ebantu district who gave birth in public health facilities in the six months prior to the study period.

Sampling frame

The list of mothers (registration) who gave birth in the six months prior to the study period in public health facilities from the kebeles was taken from the health extension workers and used.

Eligibility criteria

Inclusion criteria

Mothers living in Ebantu district who gave live birth in public health facilities in the six months prior to the study period for quantitative data and purposely selected key informants for qualitative data.

Exclusion criteria

Mothers those were critically ill and unable to communicate at the time of data collection.

Sample size determination and sampling procedures

Sample size determination

Quantitative part

The sample size required for this study was calculated based on a single population proportions formula as follows.

$$n = \frac{(Z\alpha/2)^2 \cdot (P)(1 - P)}{(d)^2}$$

Where;

‘n’ was sample size,

‘Z’ was critical value for normal distribution corresponding to significance level at $\alpha = 0.05$ which was 1.96,

‘d’ was margin of error assumed to be 5%,

‘P’ was estimated prevalence of women reporting abuse and disrespect while giving birth in health facilities in previous study and 43% was taken from study in Bahir Dar [23].

Thus,

$$n = \frac{(1.96)^2 \cdot (0.43)(0.57)}{(0.05)^2} = 377,$$

Then, adding 10% contingency for the non-response rate (38); the total sample size was 415.

Qualitative part

Purposely selected key informants including 2 primary health care directors, 4 health professionals, 5 community and religious leaders, 1 district health office head and 1 district maternal and child health coordinator and 3 mothers those gave birth in public health facilities and those did not participate in quantitative data collection were participated in in-depth interview until level of idea saturation.

Sampling procedures techniques

A systematic random sampling technique was employed to draw a sample from the target populations. All kebeles of the district (21) was included in the study and the number of respondents was allocated proportionally to child birth services given in the kebeles within the six months prior to the study period based on the registration taken from HEWs from the kebele. The total deliveries registered in the kebeles by HEWs in the six months prior to the study were 795. The data collector’s used list of deliveries conducted in public health facilities and registered by health extension workers. The first respondent was selected from the list by lottery method and the others were selected with the interval of two. Then by going to the selected households or mothers, the data was collected. For household with more than one mother who gave birth, only one person was selected using lottery method.

The interval formula of systematic random sampling was used to know the interval of the respondents. Measurements taken for those who were not present at those times of data collection were, waiting for the next two times by identifying appropriate time and consulting them. For those who were not present again, the next mother from the sampling frame and nearby was asked.

The interval was calculated as;

$$K = \frac{N}{n}, \text{ where } ,$$

N = Total delivery services conducted and registered within the last six months prior to the study period,

n = Sample size required

K = The interval required

So, $K = 795/415 = 1.916 \approx 2$.

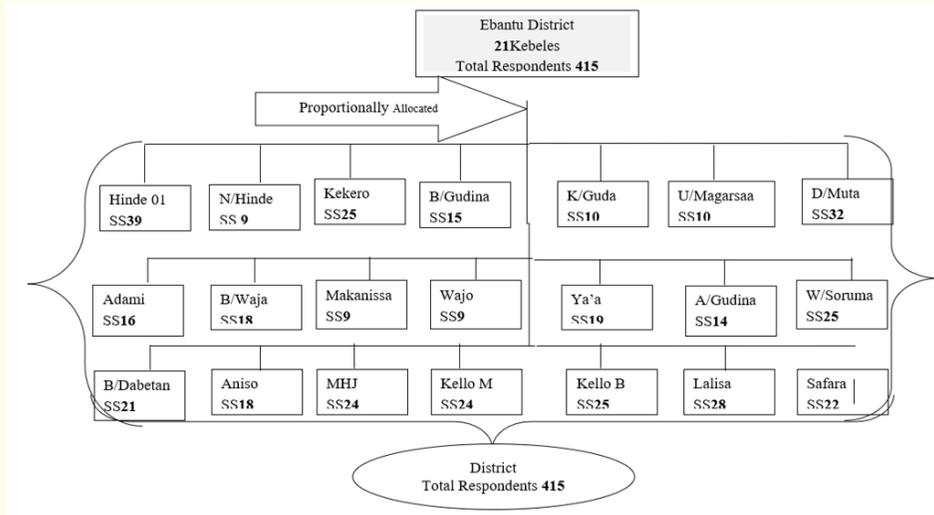


Figure 3: Schematic presentation of sample selection procedures among mothers who gave birth in public health facilities in the past six months prior to the study period, Ebantu District, East Wollega Zone, Oromia, Ethiopia, September 2019.

Operational definitions

- **Physical abuse:** The ‘yes’ responses to at list to one among three options listed under physical abuse (the provider slapped the mother, the provider harshly forced mother’s leg apart and others), was considered as the mother had physically abused during child birth at public health facilities.
- **Non-confidential care:** The ‘yes’ responses to at list to one among the three options listed under non-confidential care (the provider did not use curtains/drape or other visual barriers to protect mother, mother’s history taking findings shared when others could hear or discussed her issues when other clients were listening and auditory privacy not respected during examination) was considered as the mother had experienced non-confidential care during child birth at public health facilities.
- **Non-consented care:** The ‘yes’ responses to at list to one among the four options listed under non-consented care (the provider did not introduce themselves and greeted mother and her support, the provider assesses mother’s abdomen

and reproductive organs without obtaining any consent or permission, the provider conduct episiotomy without informing the mother and others) was considered as the mother had experienced non-consented care during child birth at public health facilities.

- **Non-dignified care:** The ‘yes’ responses to at list to one among the nine options listed under non-dignified (provider did not explain/gives periodic updates on status, progress of labor and what to expect throughout labor and birth, provider talked or used a facial expression that made mother feel uncomfortable and used abusive language, provider made insults, shouted at, intimidates and threats, laughed at mothers, providers made negative comments about mothers, providers did not demonstrate care in a culturally appropriate way and others) care was considered as the mother had experienced non-dignified care during child birth at public health facilities
- **Neglect or Abandonment or denial of care:** The ‘yes’ responses to at list to one among the seven options listed under neglected/abandonment care (left unattended by health

workers when needed help and feel alone or unattended, ignored regarding requests for pain relief, provider did not come quickly when needed, provider did not encourage to call if needed, forget to arrange meal and porridge for the mother, did not give attention to the cleanliness of delivery room and bed sheets and others) was considered as the mother had experienced neglected/abandonment care during child birth at public health facilities.

- **Discrimination:** The 'yes' responses to at list to one among three options listed under discrimination (discrimination due to being younger age, discrimination based on personality and others) was considered as the mother had discriminated during childbirth at public health facilities.
- **Any form of D&A:** The mothers 'yes' responses to at list one of the options from physical abuse, non-consented care, non-confidential care, non-dignified care, neglected care and discrimination, the mother was considered as being experienced any form of disrespect and abuse during childbirth at public health facilities.

Data collection techniques and instruments

For quantitative data

Structured, pre-tested questionnaire and face to face interview was used to collect data from the study participants. The questionnaires have three major parts; socio-demographic characteristics, obstetrics history of the respondents, women's experience of disrespect and abuse during child birth. Five diploma and degree holder's health professionals were selected from other departments except maternal health departments. Data collectors have assured the privacy of the data to the respondents before starting data collection. The questionnaire was designed in English and translated in to local language Afan Oromo by the investigator and then translated back to English to check for consistency.

For qualitative data

An in-depth interview guided by semi-structured questionnaire was used to collect data from the study participants. The trained health officer was the interviewer of the respondents. Notes and tape recorder were used during data collection.

Data quality control

Quantitative data

Before starting the actual data collection; data collectors and supervisors were trained on the objective, benefit of the study,

individual's right, written consent, asset and techniques of the interview for two days.

After data collection, the questionnaire was checked and examined by the principal investigator for completeness and internal consistency. The trained supervisors and principal investigator made close supervision and further clarification was given for those items, which were unclear for the respondents during data collection.

To assure the data quality high emphasis was given to design the data collection instrument. First the questionnaire was pre-tested on 10% of sample size in Ebantu district, Hinde 01 kebele. After pre-tested further adjustments were made to improve clarity, understandability, and simplicity of the messages of the data collection tool.

All parts of the questionnaire were checked for completeness and accuracy before, during and after the period of data collection. The collected data was again reviewed and checked for completeness before data entry.

Qualitative data

In-depth interview conducted with health professionals, community leaders and religious leaders, district health office representatives and mothers who gave birth at public health facilities by the data collector were re-checked with recorded and notes taken and documented.

Data processing and analysis

Quantitative data

After the completion of data collection, the data were analyzed using SPSS version 20. The uni-variable analysis was done for description of explanatory variables. Bi-variable logistic regression was under taken to assess the association between explanatory variables and disrespect and abuse among mothers who gave birth in public health facilities. Variables which had p-value < 0.25 [18], were taken into multi-variable logistic regression. Multi-collinearity statistics was performed to check for confounding effect of one variable over the other variable. Variables with variance inflation factor (VIF) less and equal to 5 were taken to final multivariable logistic regression. Results were compiled, described and presented using texts, tables, graphs.

Qualitative data

In-depth interviewed data was transcribed, translated back to English, thematized under each category of disrespect and abuse and triangulated with quantitative data.

Ethical considerations

Before starting data collection, written ethical clearance and permission letter were secured from Wollega University, Institute of Health Science and permission letter from Ebantu district administration were granted.

The objective of the study was explained to the study subjects. Written consent/thumb print was obtained from individual respondents before the administration of the information gathering tool. Participation in the study was completely voluntary and based on each respondent's ability to give consent. For one respondent with 17 years old age, consent from the respondent and asset from her husband was taken. Before starting the data collection, participants were guaranteed confidentiality and privacy of the information collected through the data collectors. The respondents had given full right to refuse from participation or not to respond at any point of data collection and as non-participation had no negative effect on participants.

Dissemination of result of findings

After approval, the results of this finding will be disseminated to Wollega University, Institute of Health Science, Department of Public Health, Ebantu District Health Office and other concerned bodies. Efforts will be made to present the results on scientific conferences and publications will be considered.

Result

Socio-demographic characteristics of the participants

A total of 415(100%) mothers who gave birth in public health facilities within six months prior to the study period with 100% response rate were interviewed after consent and asset form was taken. About 201 (48.4%) age of the mothers were between 25-34 years old with the minimum and maximum age of 17 and 40 years respectively.

All of the mothers (100%) were married and 306(73.7%) were house wife, 193(46.5%) of the respondents' husband were farmers. Almost all of the study participants were Oromo 414(99.8%) and 381(91.8%) were followers of the protestant religion. About

119(28.7%) of the respondents have no formal education, whereas 161(38.8%) of the respondents' husbands have attended college and above.

From the total, 352(84.8%) mothers were rural residents. One hundred fifty (36.1%) of respondents' family size was less than 4 with minimum and maximum family size of 1 and 12 respectively. About 301(72.5%) respondents' monthly family income in Ethiopian birr were less than 3000.00 ETB with minimum and maximum of 100.00 and 8,000.00 ETB respectively. The means of transport to health facilities were on-foot 326(78.6%), whereas the 228(54.9%) respondents distance from place of delivery were less than ten kilometer (Table 1).

| Variables | Categories | Frequency | Percent (%) |
|--|-------------------------|-----------|-------------|
| Age of the respondents in years | Less or equal to 24 | 122 | 29.4 |
| | 25-34 | 201 | 48.4 |
| | 35 and above | 92 | 22.2 |
| | Total | 415 | 100 |
| Educational status of the respondents | No formal education | 125 | 30.1 |
| | Primary school (1-8) | 114 | 27.5 |
| | Secondary school (9-12) | 86 | 20.7 |
| | Collage and above | 90 | 21.7 |
| | Total | 415 | 100 |
| Educational status of the husbands | No formal education | 34 | 8.2 |
| | Primary school (1-8) | 154 | 37.1 |
| | Secondary school (9-12) | 66 | 15.9 |
| | Collage and above | 161 | 38.8 |
| | Total | 415 | 100 |
| Occupational status of the respondents | Housewife | 306 | 73.7 |
| | Government employee | 57 | 13.7 |
| | Merchant | 21 | 5.1 |
| | Student | 31 | 7.5 |
| | Total | 415 | 100 |
| Occupational status of husbands | Farmer | 193 | 46.5 |
| | Private employee | 43 | 10.4 |
| | Government employee | 131 | 31.6 |
| | Merchant | 26 | 6.3 |
| | Student | 22 | 5.3 |
| | Total | 415 | 100 |

| | | | |
|---|---------------------|-----|------|
| The religion of the respondents | Protestant | 381 | 91.8 |
| | Orthodox | 34 | 8.2 |
| | Total | 415 | 100 |
| Respondents residence area | Urban | 63 | 15.2 |
| | Rural | 352 | 84.8 |
| | Total | 415 | 100 |
| Family Size (Including respondent and husband) | ≤ 4 | 150 | 36.1 |
| | 7-May | 148 | 35.7 |
| | ≥ 8 | 117 | 28.2 |
| | Total | 415 | 100 |
| Average family monthly income (in Ethiopian birr) | <3000 | 301 | 72.5 |
| | ≥ 3000 | 114 | 27.5 |
| | Total | 415 | 100 |
| Usual Means of transport to health facilities | On foot | 326 | 78.6 |
| | By public transport | 89 | 21.4 |
| | Total | 415 | 100 |
| Distance from place of delivery in KM | <10 Km | 228 | 54.9 |
| | 10-20K m | 82 | 19.8 |
| | 20*Km | 105 | 25.3 |
| | Total | 415 | 100 |

Table 1: Socio-demographic characteristics of respondents, Ebantu District, East Wollega Zone, Oromia, Western Ethiopia, (n = 415).

Obstetrics history of respondents

One hundred sixty-three (39.3%) of respondent gravidity were 5 and above with minimum and maximum of 1 and 11 respectively. Whereas the 144(34.7%) of respondent parity were 5 and above with minimum and maximum respondents was 1 and 10 respectively.

From the total respondents, 350(84.3%) ever had a history of antenatal care whereas, 347(83.6%) had history of antenatal care for the last pregnancy. About 114(27.5%) of the mothers had four and above antenatal care visits. Around 286(68.9%) of the respondents got regular ANC services from public health centers and 244(58.8%) of the respondents reported that they could not identify the providers those gave ANC services for them.

Majority of the respondents 353(85.1%) of the mothers gave birth at the health center. One hundred thirty-five (32.5%) of the delivery services were attended by midwifery and 168(40.5%) of them reported that they could not identify the attendants of their delivery services. The sex of the attendants of the deliveries was 159(38.3%) male and 155(37.3%) female.

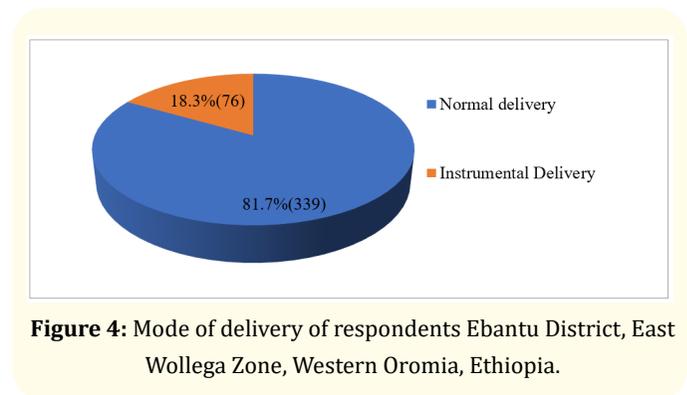


Figure 4: Mode of delivery of respondents Ebantu District, East Wollega Zone, Western Oromia, Ethiopia.

About 139(33.5%) of the respondents reported that they need the presence of labour companion during delivery but, only 5(12.3%) of them had reported as they get labour companion. Regarding the timing of delivery, 217(52.3%) was during night time. Ninety-nine (23.9%) of the respondents faced complications during delivery which includes; bleeding (14%), retained placenta (5.3%), birth asphyxia (1.2%) and headache (1.2%).

Incase of child birth in the future, 311(74.9%) of the respondents reported as they want to have a child in the future and 252(60.7%) of them want to give birth at health center in the future if become pregnant and 347(83.6%) of the reports to suggest their nearby friends give birth at health centers if pregnant (Table 2).

| Variables | Categories | Frequency (#) | Percent (%) |
|-----------|--------------------|---------------|-------------|
| Gravidity | Less or equal to 2 | 146 | 35.2 |
| | 4-Mar | 106 | 25.5 |
| | 5 and above | 163 | 39.3 |
| | Total | 415 | 100 |
| Parity | Less or equal to 2 | 156 | 37.6 |
| | 4-Mar | 115 | 27.7 |
| | 5 and above | 144 | 34.7 |
| | Total | 415 | 100 |

| | | | |
|---|-------------------------|-----|------|
| Number of antenatal cares for recent child pregnancy | 1 | 15 | 3.6 |
| | 2 | 60 | 14.5 |
| | 3 | 159 | 38.3 |
| | 4 and above | 114 | 27.5 |
| | Total | 415 | 100 |
| Place of ANC services (n = 496)* | Health center | 286 | 68.9 |
| | Hospital | 125 | 30.1 |
| | Health Post | 85 | 20.5 |
| | Total | 496 | |
| ANC providers (n = 530)** | Health Officer | 13 | 3.1 |
| | Nurse | 110 | 26.5 |
| | Midwifery | 102 | 24.6 |
| | HEWs | 61 | 14.7 |
| | Can not identify | 244 | 58.8 |
| | Total | 530 | |
| Place of delivery | Health Center | 353 | 85.1 |
| | Hospital | 62 | 14.9 |
| | Total | 415 | 100 |
| Attendants of the delivery | Nurse | 107 | 25.8 |
| | Midwifery | 135 | 32.5 |
| | Health Officer | 5 | 1.2 |
| | I ca not identify | 168 | 40.5 |
| | Total | 415 | 100 |
| Sex of the main attendants of delivery | Male | 155 | 37.3 |
| | Female | 159 | 38.3 |
| | Both(Where≥2 providers) | 101 | 24.3 |
| | Total | 415 | 100 |
| Time of delivery | Day time | 198 | 47.7 |
| | Night time | 217 | 52.3 |
| | Total | 415 | 100 |
| The place to give birth if pregnant next time (n = 311) | Home | 15 | 3.6 |
| | Health center | 252 | 60.7 |
| | Hospital | 41 | 9.9 |
| | Can not decide now | 3 | 0.7 |
| | Total | 311 | |

| | | | |
|---|---------------|-----|------|
| Where to suggest a nearby friend give birth if pregnant | Home | 8 | 1.9 |
| | Health center | 347 | 83.6 |
| | Health post | 12 | 2.9 |
| | Hospital | 48 | 11.6 |
| | Total | 415 | 100 |

Table 2: Obstetrics history of respondents, Ebantu District, East Wollega Zone, Western Oromia, Ethiopia, (n = 415).

* n = 496 single mother had used different types of health facilities for the recent pregnancy; ** (n = 530) single mother had received ANC services from different health providers for the recent pregnancy.

Prevalence of disrespect and abuse

Out of total respondents, 284 (68.4%, 95% CI: 63.7, 72.8) of them reported that they were experienced any form of disrespect and abuse. About 179 (43.1%, 95% CI: 38.3, 48.1) and 74(17.8%, 95% CI: 14.3, 21.9) of them experienced one and two form of disrespect and abuse respectively (Figure 5). Also, in an in-depth interview result, different types and categories of D&A which was thematized under five dimensions were identified.

Non-consented care was the most common type of disrespect and abuse experienced by the respondents with the prevalence of 240(57.8%, 95%CI: 52.9, 62.6). Among the options of non-consented care, 56.6% (95% CI: 51.7, 61.4) accounts for the option provider did not introduce themselves to the mother and her support. Conducting episiotomy without informing the mother accounts 32(7.7%) and supported within-depth interview result (Table 3).

Neglected care was the second most common type of disrespect and abuse experienced. The prevalence was 107(25.8%, 95% CI: 21.7, 30.3). Left unattended when needed help and feel lonely 48(11.6%, 95%CI: 8.7, 15.5) and 39(9.4%, 95%CI: 6.8, 12.7) ignored regarding requests for pain relief were the categories of neglected care experienced more. The in-depth interview result indicates the presence of neglect care including un arrangement of meal and porridge, do not give pain relief when needed, forgetting to tie a cord tie of the baby and do not respecting the time of service in facilities. One in-depth interview participant mother said “I gave birth at health center and the provider did not tie a cord tie of my baby in an appropriate way. After 2 hours, another health

profession came and tied it again and referred my baby to hospital. I stayed for two weeks at hospital. Due to this I want to give birth at my home in the future”.

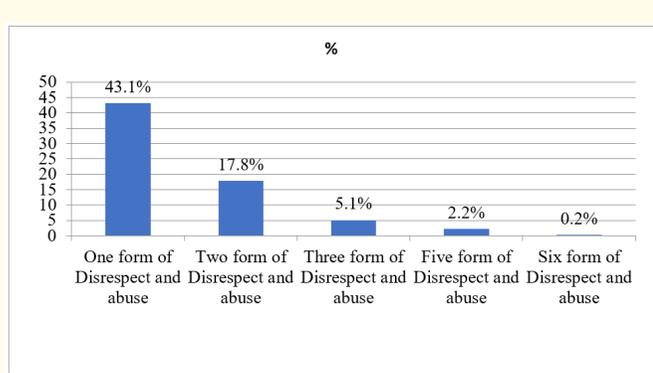


Figure 5: Frequency and forms of Disrespect and abuse reported by respondents, Ebantu District, East Wollega Zone, Western Oromia, Ethiopia.

Non-dignified care was the third type of disrespect and abuse experienced with the prevalence of 50(12.0%, 95% CI: 9.2, 15.7). The respondents reported as 22(5.3%, 95%CI: 3.4, 8.0) of the providers talked or used a facial expression that made them feel uncomfortable and used abusive language. This result was supported by an in-depth interview in which using abusive words, intimidating and threatening the mother using forceps, do not inform the mother the progress and periodic updates were reported. One in-depth interview participant health professional said “Providers some times use abusive words when they feel uncomfortable and demoralized due to weak to the managing system of the facilities”.

Non-confidential care was the fourth types of disrespect and abuse experienced by the respondents with the prevalence of 16(3.9%, 95%CI: 2.3, 6.3) and the providers were not used drape or barriers to protect the respondents 7(1.7%). In-depth interview result shows that there were confidentiality problem and do not use barriers to protect the mother. One in-depth interview participant mother who gave birth at hospital said” I gave birth at hospital and I had seen that one mother had seen when a health provider is assisting another mother through vaginal delivery and she had decided to give birth by cesarean because of the door was not closed/no were protective barrier there”.

Physical abuse was the fifth types of disrespect and abuse experienced by the respondents with the prevalence of 15(3.6%, 95%CI: 2.1, 6.2) and harshly forced their leg apart accounts 9(2.2%). The commonly reported categories of physical abuse were reported again in the in-depth interview including slapping the mother, hitting and harshly leg apart.

Discrimination was the least and the sixth form of D&A reported by the respondents with the prevalence of 9(2.2%, 95%CI: 1.1, 4.2) of which includes did not attend mothers equally based on their personality (1.9%) and their age (0.2%) (Table 3).

| Types and categories of disrespect and abuse | No | % | CI (95%) | |
|--|-----|------|----------|-------|
| | | | Lower | Upper |
| Any form of Disrespect and Abuse | 284 | 68.4 | 63.7 | 72.8 |
| Physical Abuse | 15 | 3.6 | 2.1 | 6.0 |
| The provider slapped them | 1 | 0.2 | 0.0 | 1.6 |
| The provider harshly forcing leg apart | 9 | 2.2 | 1.1 | 4.2 |
| Other physical abuse experienced | 5 | 1.2 | 0.4 | 3.0 |
| Non-confidential care | 16 | 3.9 | 2.3 | 6.3 |
| The provider did not use curtains/drape or other visual barriers to protect them | 7 | 1.7 | 0.7 | 3.6 |
| The mother’s history taking findings shared when others could hear | 9 | 2.2 | 1.1 | 4.2 |
| Auditory privacy not respected during post-natal examination | 1 | 0.2 | 0.0 | 1.6 |
| Non-consented care | 240 | 57.8 | 52.9 | 62.6 |
| The provider did not introduce themselves and greeting mother and her support person | 235 | 56.6 | 51.7 | 61.4 |
| The provider assesses the mother’s abdomen and reproductive organs without obtaining any consent or permission | 9 | 2.2 | 1.1 | 4.2 |

| | | | | |
|---|-----------|----------|-----------------|--------------|
| Conduct episiotomy without informing the mother | 32 | 7.7 | 5.4 | 10.8 |
| Others non-consented cares experienced | 4 | 1.0 | 0.3 | 2.6 |
| Types of disrespect and abuse | No | % | CI (95%) | |
| | | | Lower | Upper |
| Non-dignified care | 50 | 12.0 | 9.2 | 15.7 |
| Provider didn't explain/ gives periodic updates | 12 | 2.9 | 1.6 | 5.1 |
| Provider talked or used a facial expression that made me feel uncomfortable and used abusive language | 22 | 5.3 | 3.4 | 8.0 |
| The provider insults me | 6 | 1.4 | 0.6 | 3.3 |
| The provider shouted at me | 4 | 1.0 | 0.3 | 2.6 |
| The provider intimidates and threats at me | 2 | 0.5 | 0.1 | 1.9 |
| The provider laughed at me | 10 | 2.4 | 1.2 | 4.5 |
| Health providers made negative comments about me | 4 | 1.0 | 0.3 | 2.6 |
| Did not demonstrate care in a culturally appropriate way | 11 | 2.7 | 1.4 | 4.8 |
| Others non-dignified cares experienced | 19 | 4.6 | 2.9 | 7.2 |
| Neglected care | 107 | 25.8 | 21.7 | 30.3 |
| Left unattended when needed help and feel alone | 48 | 11.6 | 8.7 | 15.5 |
| Ignored regarding requests for pain relief | 39 | 9.4 | 6.9 | 12.7 |
| The Provider did not come quickly when needed | 19 | 4.6 | 2.9 | 7.2 |
| The Provider did not encourage to call if needed | 26 | 6.3 | 4.2 | 9.2 |
| Forget to arrange meal and porridge for the mother | 32 | 7.7 | 5.4 | 10.8 |

| | | | | |
|---|----|-----|-----|-----|
| Did not give attention to the cleanliness of the delivery room and bed sheets | 17 | 4.1 | 2.5 | 6.6 |
| Others neglected cares experienced | 18 | 4.3 | 2.7 | 6.9 |
| Any form of Discrimination | 9 | 2.2 | 1.1 | 4.2 |
| Discrimination due to being too young/younger age | 1 | 0.2 | 0.0 | 1.6 |
| Discriminations experienced based on personality | 7 | 1.7 | 0.7 | 3.6 |
| Others discriminations experienced | 1 | 0.2 | 0.0 | 1.6 |

Table 3: Prevalence and Categories of disrespect and abuse reported by respondents, Ebantu District, East Wollega Zone, Western Oromia, Ethiopia (n = 415).

Factors associated with disrespect and abuse

In bi-variable analysis, socio-demographic characteristics including; age of mothers, educational status of both mothers and husbands, occupational status of both mothers and husbands, place of residence, family size, showed p-value of less than 0.25 where as health facility factors including; means of transport to the health facilities, distance from health facilities and obstetrics factors including gravidity, parity, history of ANC for the recent pregnancy, place of delivery, the attendants of the delivery, sex of attendants, mode of delivery, time of delivery and presence of labour companion showed p-value of less than 0.25. Among those, age of the mother, means of transport to the health facilities, distance from health facilities, parity, place of delivery, attendants of the delivery, sex of the main attendants, mode of delivery and presence of labour companion were significantly associated with disrespect and abuse.

In multi-variable analysis, occupational status husbands (AOR = 3.92, 95%CI: 1.04, 14.85; p = 0.04), history of ANC for the recent pregnancy (AOR = 2.36, 95% CI: 1.07, 5.21; P = 0.03), place of delivery (AOR = 3.74, 95% CI: 1.00, 14.00; P = 0.05), the main attendants of the delivery (AOR = 3.20, 95% CI: 1.64, 6.23; P = 0.00) and presence of labour companion (AOR = 4.64, 95% CI: 1.99, 10.82; P = 0.00) were significantly associated with disrespect and

abuse experienced at p-value of <0.05. Being the main attendants of the delivery were other professionals other than nurses and midwifery and presence of labour companion were statistically significant at a p-value of <0.001 (Table 4).

According to the responses of the in-depth interview participants, carelessness of providers and negligence, work

overload and lack of experience from newly arrived providers working environment were the reported contributing factors to disrespect and abuse during facility based child birth. Advising and giving orientation for the providers, follow, arranging the working environment, fulfilling man power as structure were the possible solutions reported by the participants to minimize disrespect and abusive maternal care during child birth at health facilities.

| Variable | Category | Experience of D&A | | COR(95%CI) | AOR (95%CI) | P-value |
|--|-------------------------|-------------------|-----|------------------|------------------|---------|
| | | Yes | No | | | |
| Age of mother in years | Less or equal to 24 | 93 | 29 | 1.55(0.85,2.84) | 0.70(0.23, 2.19) | 0.54 |
| | 25-34 | 129 | 72 | 0.87(0.51,1.46) | 0.42(0.18, 1.01) | 0.05 |
| | 35 and above | 62 | 30 | 1 | 1 | |
| Respondents Educational status | No formal Education | 82 | 43 | 0.78(0.43, 1.39) | 2.27(0.53, 9.61) | 0.27 |
| | Primary school (1-8) | 75 | 39 | 0.78(0.43,1.42) | 1.74(0.48, 6.28) | 0.40 |
| | Secondary School (9-12) | 63 | 23 | 1.11(0.57,2.15) | 1.82(0.58, 5.71) | 0.30 |
| | Collage and above | 64 | 26 | 1 | 1 | |
| Partners Educational status | No formal Education | 27 | 7 | 1.59(0.65,3.90) | 0.80(0.14, 4.48) | 0.80 |
| | Primary school (1-8) | 102 | 52 | 0.81(0.50,1.30) | 0.38(0.09, 1.62) | 0.19 |
| | Secondary School (9-12) | 41 | 25 | 0.68(0.37,1.24) | 0.44(0.11, 1.80) | 0.25 |
| | Collage and above | 114 | 47 | 1 | 1 | |
| Respondents Occupational status | Unemployed | 226 | 111 | 0.66(0.35,1.26) | 0.45(0.14, 1.48) | 0.19 |
| | Private employed | 15 | 6 | 0.81(0.27,2.50) | 0.80(0.14, 4.59) | 0.81 |
| | Government employed | 43 | 14 | 1 | 1 | |
| Partner Occupational status | Unemployed | 157 | 63 | 1.18(0.74,1.88) | 3.92(1.04,14.85) | 0.04* |
| | Private employed | 38 | 26 | 0.69(0.37,1.28) | 2.39(0.69, 8.22) | 0.17 |
| | Government employed | 89 | 42 | 1 | 1 | |
| Place of residence | Rural | 246 | 106 | 1.53(0.88,2.66) | 1.60(0.68, 3.76) | 0.28 |
| | Urban | 38 | 25 | 1 | 1 | |
| Means of transport to HFs | On foot | 211 | 115 | 0.40(0.22,0.72) | 0.58(0.26, 1.27) | 0.17 |
| | By public transport | 73 | 16 | 1 | 1 | |
| Distance from the place of recent delivery in KM | Less than 10 KM | 145 | 83 | 1 | 1 | |
| | 10-20 KM | 54 | 28 | 1.10(0.65,1.88) | 0.70(0.31, 1.57) | 0.38 |
| | Above 20 KM | 85 | 20 | 2.43(1.39,4.25) | 0.90(0.35, 2.26) | 0.81 |
| Parity | Less or equal to 2 | 116 | 40 | 1 | 1 | |
| | 3-4 | 80 | 35 | 0.79(0.46,1.35) | 1.37(0.59, 3.16) | 0.46 |
| | 5 and above | 88 | 56 | 0.54(0.33,0.89) | 0.44(0.16, 1.20) | 0.11 |

Table 4a: Socio demographic characters and disrespect and abuse Ebantu District, Ethiopia, (n = 415).

* P-value< 0.01 is very significant

** P-value between 0.01 and 0.05 is significant

*** includes Health officers and others health professionals those mothers could not identify except physicians.

| Variable | Category | Experience of D&A | | COR(95%CI) | AOR (95%CI) | P-value |
|---------------------------------------|---------------|-------------------|-----|------------------|------------------|---------|
| | | Yes | No | | | |
| ANC for last pregnancy | No | 51 | 17 | 1.47(0.81,2.66) | 2.36(1.07, 5.21) | 0.03* |
| | Yes | 233 | 114 | 1 | 1 | |
| Place of delivery | Hospital | 57 | 5 | 6.33(2.47,16.20) | 3.74(1.00,14.00) | 0.05* |
| | Health Center | 227 | 126 | 1 | 1 | |
| The main attendant of delivery | Nurse | 55 | 52 | 1 | 1 | |
| | Midwifery | 83 | 52 | 1.51(0.90,2.52) | 1.22(0.65, 2.29) | 0.55 |
| | Others*** | 146 | 27 | 5.11(2.92,8.94) | 3.20(1.64, 6.23) | 0.00** |
| Sex of the main attendant of delivery | Male | 97 | 58 | 1 | 1 | |
| | Female | 103 | 56 | 1.10(0.69,1.74) | 1.34(0.74, 2.41) | 0.34 |
| | Both | 84 | 17 | 2.96(1.60,5.46) | 1.16(0.52, 2.57) | 0.72 |
| Mode of delivery | Instrumental | 65 | 11 | 3.24(1.65,6.37) | 2.59(0.95, 7.07) | 0.06 |
| | Normal | 219 | 120 | 1 | | |
| Time of delivery | Night time | 141 | 76 | 0.71(0.47,1.08) | 0.84(0.48, 1.47) | 0.54 |
| | Day time | 143 | 55 | 1 | 1 | |
| Labour companion | No | 263 | 101 | 3.72(2.03,6.08) | 4.64(1.99,10.82) | 0.00** |
| | Yes | 21 | 30 | 1 | 1 | |

Table 4b: Maternity related explanatory variables disrespect and abuse.

* P-value < 0.01 is very significant

** P-value between 0.01 and 0.05 is significant

*** includes Health officers and others health professionals those mothers could not identify except physicians.

Discussion

The findings of this study show that nearly two-third of the respondents (68.4%, 95% CI: 63.69, 72.83) experienced any form of disrespect and abuse. This finding is inline with the study conducted in Bahir Dar town which indicates the prevalence of D&A is 67.1% [11]. But, it is lower than that of the study conducted in Pakistan (99.7%), district of Aligarh, North India (84.3%) and higher than that of Tigrai, Northern Ethiopia (22%) [17-19]. This difference may be due to the socio-demographic characteristics, difference in study area, recall bias and questionnaires used to capture the data.

In this study, more than 5 out of 10 (57.8%, 95% CI: 52.9, 62.6) of mothers were experienced non-consented care. This result is lower than that of the study conducted in Rural Gujrat, Pakistan (97.5%), district of Aligarh, North India (71.1%) and comparable

with the result of studies conducted in Enugu, southeastern Nigeria (54.5%), Western Ethiopia (54.1%) and Bahir Dar (57.6%) [11,13,17,19,21]. This may be due to socio-demographic factors and provider perspectives since in-depth interview indicates the presence of conducting episiotomy without informing the mother.

Neglected/abandonment care was the other category of disrespect and abuse experienced by women with the prevalence of 107(25.8%, 95% CI: 21.70, 30.33). This result is higher than the study done in North India (10.2%), Kenya (14.3%) and Bahir Dar (7.1%) [11,19,27]. But, inline with study conducted in Western Ethiopia (25.2%) [13]. This inconsistency may be due to the difference in study area, lack of experiences of health care provider and work overload. In-depth interview result from primary health care units and woreda health office manager shows that the presence of neglected care dueto lack of experiences and

work overload; also health providers and mothers indicates issue of conducting delivery as easy as for the provider rather than for the mother and forgetting cleanliness of delivery room and beds sheets.

Non-dignified care was experienced with the prevalence of 50(12.0%, 95% CI: 9.15, 15.67). This result is inline with the result of study undertaken in Rural Gujrat, Pakistan of which non-dignified care were 12.2% and Aligarh, North India (9.2%) [19]. But, higher than that of Bahir Dar (8.5%) and lower than that of low income country (29.6%) and Western Ethiopia (34.6%) [11,13,19,21]. This difference may be due to provider's demoralization related to weak managing issues of health facilities and shortages of man power and provider status since the in-depth interview result from community leaders, district health office manager indicates the presence of work overload, lack of experience and negligence of the providers.

Non-confidential care was the fourth categories of disrespect and abuse experienced by the respondents with a prevalence of 3.9% (95%CI: 2.29, 6.32). This result is comparable with study conducted in Kenya (5%) and lower than that of Aligarh, North India (62.3%), Enugu, southeastern Nigeria(26%), Arba Minch town, South Ethiopia (17.1%), Bahir Dar (11%) and Western Ethiopia (40.4%) [11,13,14,19,21,27]. In this study 2.2% of the respondents reported as their history taking findings was shared when others could hear, whereas in Tanzania (19%) and Western Ethiopia (7.2%) of mother's history findings shared when others could hear [13,26]. This was supported with in-depth interview in which mothers participated indicates lack of visual barriers and drapes to protect birth giving mothers in hospital. Thus, this inconsistency might be due to arrangements of infrastructures and negligence of health providers as reported in in-depth interview.

Physical abuse was experienced by the respondents with a prevalence of 3.6% (95%CI: 2.11, 6.02). This finding was comparable with studies conducted at Aligarh, North India (5.9%) and Kenya (4.2%), while lower than that of Uttar Pradesh, India (7.6%), Enugu, southeastern Nigeria (35.7%), Ethiopian public health facilities (9%), Arba Minch (29.5%), Bahir Dar (57.6%), Western Ethiopia (22.2%) [11,13,14,19,21,27-29]. This difference might be due to mother's perception and normalization of disrespect and abuse and mothers lack of empowerment during childbirth.

In this study discrimination was the least type of D&A reported by the respondents with a prevalence of 2.2% (%CI: 1.06, 4.22). This finding was inline with studies conducted in Aligarh, North India(3.9%), Bahir Dar (2.2%) and lower than that of Enugu, southeastern Nigeria(20%), Arba Minch (18.1%) and Western Ethiopia (13.2%) [11,13,14,19,21]. This difference may be due to socio-demographic factors, the study being community and facility-based and provider perspectives since 1.9% of respondents feel they were not attended equally based on their personal attributes.

The finding of this study shows that, respondents of which their husbands were unemployed were 3.92 times more likely disrespected and abused than those governments employed (AOR = 3.92, 95%CI: 1.04, 14.85; p = 0.04).

Again, respondents who had no history of ANC for recent pregnancy were 2.36 times more likely disrespected and abused than respondents with a history of ANC for recent pregnancy (AOR = 2.36, 95% CI: 1.07, 5.21; P = 0.03). This may be due to exposure and familiarities to health facilities and lack of awareness since nearly half of the respondents had educational status of secondary school and above.

As the level of health facility increases, the quality of health service increases and quality of care is assumed to be better. This result shows that, respondents who gave birth in hospitals were 3.74 times more likely reported disrespect and abuse than those mothers who gave birth in health centers (AOR = 3.74, 95% CI: 1.00, 14.00; P = 0.05). This result has similarity with the study conducted in Western Ethiopia in which women delivering in a hospital were 1.6 times more likely to experience any type of D&A than women delivering in health centers [13]. This could be due to high load of patients and presence of complications that needs urgency making it difficult for providers to adequately provide care for mothers.

Mothers those gave birth by the assistance health professionals including health officers and those the mothers could not identify them during their deliveries other than midwifery were 3.20 times more likely disrespected and abused than those mothers who gave birth by the assistance of nurse professionals (AOR = 3.20, 95% CI: 1.64, 6.23; P = 0.00). This has somewhat similarity with that of RMC in Ethiopian public health facilities in which midwives were more likely to have higher total RMC score compared to other providers

[29]. This may be due to midwifery and nurses assigned to the delivery room might have on job training or orientation or got supportive supervision on respectful maternity care, because there were nurses assigned and delegated as midwifery in maternity care services in the study area due to shortages of midwifery.

Similarly, those mothers without the presence of labour companion were 4.60 times more likely disrespected and abused than those mothers who gave birth with the presence of labor companion (AOR = 4.60, 95% CI: 1.99, 10.65; P = 0.00). This is also similar with that of Tigrai, northern Ethiopia and western Ethiopia in which women who were not permitted to have support persons in the delivery room reported a significantly higher rate of D and A during labour and delivery compared with those women who were allowed to have support persons in delivery room. A result from western Ethiopia shows, mothers without a labour companion were almost 10 times more likely to experience disrespect or abuse than those having labour companion [13,28]. The protective effect of having a companion with the mother during child birth could indicate that companions provide an important role as supporter for the birth-giving mother.

Strengths of the study

To measure D&A, the study has used quantitative data supported with in-depth interview. Since the study was community based, the actual data was obtained from respondent.

Limitations of the study

Since the study depended on self-report of the respondents it may include the subjective report of the respondents. Recall and social desirability bias may exist since the respondents were mothers who gave birth in the six months prior to the study period. Also, the structural, provider perspectives and policy related factors were not included in this study.

Conclusion

In this study, two-third of respondents had experienced any form of disrespect and abuse during childbirth at public health facilities. Disrespect and abuse in this study was reported by the respondents both quantitatively and qualitatively. This is in violation of women's right, against compassionate and respectful care, and quality of services during maternity services and can be a barrier to the utilization of facility for childbirth. Occupational status of husband, history of ANC for the recent pregnancy, place

of delivery, main attendants of delivery and presence of labour companion were very statically significant with D&A.

Recommendation

Preventing disrespect and abuse is important to increase facility based child birth and mothers should be free from any form of disrespect and abuse.

Health sector's administrative level and stake holders have to train and orient providers on standards of care; empower health centers through fulfilling necessary infrastructures including equipment's and qualified man power to minimize hospital load can reduce presence of disrespect and abuse during child birth at health facilities.

Health Centers and hospitals have to strengthen patient-centered approach, apply respectful maternity care approach, transfer skill for newly arriving health professionals and follow up and give feedbacks to capacitate their knowledge, ensure presence of labour companion in the delivery room to preventing disrespect and abuse during child birth at facilities.

Further research is needed to assess disrespect and abuse on maternal continuum of care using both community and facility-based study supported with both quantitative and qualitative method for policy making minimize disrespect and abuse during child birth at facilities and increase facility based child birth.

Acknowledgement

Above all, we praise my God for strengthening my hands, never set me aside in all my ups and downs, and during my happiness and sorrow times, and despite all other constraints, brought me to this time. We would like to thank Wollega University Institute of Health Sciences Department of Public Health for all-rounded support and Oromia Regional Health Bureau for sponsoring me. We would like to forward my deepest appreciation and thanks to my advisors Mr. Firew Tekle and Mr. Worku Dechassa for their constructive advice, support, valuable comments and suggestions in conducting this research.

Authors' Contribution

Availability of data and materials

The finding of this study is generated from the data collected and analyzed based on stated methods and materials. The original

data supporting this finding are available from the corresponding authors on reasonable request.

Ethics approval and consent to participate Ethical clearance was obtained from institutional ethical review board of Wollega University before the actual data collection process was started and brought to the administrative bodies of Gimbi town to get permission for the stud. Brief explanation of the study objective was given for participants and the process of data collection was started after the willingness of the participant was asked, and then verbal informed consent was obtained from the study participants. All the information obtained from the study participants were kept confidential throughout the process of study, and the name of the participant was replaced by code. Withdrawal from the study at any point if they wished was assured.

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