Disrespect and Abuse During Facility-Based Childbirth in North Showa Zone, Ethiopia

Yohannes Mehretie Adinew (✉ yohannes.adinew@adelaide.edu.au)
Wolaita Sodo University  https://orcid.org/0000-0002-0171-7789

Helen Hall
Monash Nursing and Midwifery, Monash University, Melbourne, Australia

Amy Marshall
Adelaide Nursing School, The University of Adelaide, Adelaide, Australia

Janet Kelly
Adelaide Nursing School, The University of Adelaide, Adelaide, Australia

Research

Keywords: maternity care, childbirth, Ethiopia

DOI: https://doi.org/10.21203/rs.3.rs-72775/v1

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

**Background:** Respectful maternity care is a fundamental human right, and an important component of quality maternity care that every childbearing woman should receive. Disrespect and abuse during childbirth is not only a violation of a women's rights, it is associated with a reduction in the number of women accessing professional maternity services and increases the risk of maternal mortality. This study investigated women's experience of disrespect and abuse during facility-based childbirth in Ethiopia.

**Methods:** A cross-sectional study was conducted with 435 randomly selected women who had given birth at public health facility within the previous twelve months in North showa zone of Ethiopia. A structured, researcher administered questionnaire was used with data collected using digital, tablet-based tools. Participants’ experiences were measured using the seven categories and verification criteria of disrespect and abuse identified by White Ribbon Alliance. Multivariable logistic regression was used to identify the association between experience of disrespect and abuse and interpersonal and structural factors at p-value < 0.05 and OR values with 95% confidence interval.

**Results:** All participants reported at least one form of disrespect and abuse during childbirth. Types of disrespect and abuse experienced by participants were; physical abuse 435(100%), non-consented care 423(97.2%), non-confidential care 288 (66.2%), abandonment/ neglect (34.7%), non-dignified care 126(29%), discriminatory care 99(22.8%) and detention 24(5.5%). Hospital birth [AOR: 3.04, 95% CI: 1.75, 5.27], rural residence [AOR: 1.44, 95% CI: 0.76, 2.71], monthly household income less than 1,644 Birr (USD 57) [AOR: 2.26, 95% CI: 1.20, 4.26], being attended by female providers [AOR: 1.74, 95% CI: 1.06, 2.86] and midwifery nurses [AOR: 2.23, 95% CI: 1.13, 4.39] showed positive association with experience of disrespect and abuse.

**Conclusion:** The level of disrespect and abuse is high and its drivers and enablers include both structural and interpersonal factors. Expanding the size and skill mix of professionals in the preferred facilities (hospitals), and sensitizing care providers and health managers regarding the magnitude and consequences of D&A are strategies that could possibly promote more dignified and respectful maternity care.

**Plain English Summary**

Disrespect and abuse of women during facility based childbirth includes the way care providers act, behave or treat childbearing women and is against the basic human right of childbearing women. There are seven categories of disrespect and abuse and each category has its own verification criteria. The authors surveyed mothers who have given birth in health facility to share their experience, via face to face interview.

The level of disrespect and abuse reported by the participants is high compared to previous studies.

In conclusion, disrespectful caredeter women from seeking lifesaving professional maternity care.
Background

While motherhood is often considered a fulfilling positive experience, pregnancy and childbirth related complications are a leading cause of death for women of child bearing age in developing countries (1). Developing countries contribute 94% of global maternal deaths and more than half of these deaths occur in sub-Saharan Africa (2). Ethiopia's maternal mortality, 401 per 100,000 live births in 2017, is one of the highest globally (3). Birth outside of a health facility without skilled birth attendants is the major reason behind this loss of life (4, 5).

Ethiopia aims to reduce its maternal mortality ratio to less than 70 per 100,000 live births by 2030 in order to achieve the United Nations Sustainable Development Goal three (6). Ensuring access to quality obstetric care is essential as it has the potential to reduce up to 75% of preventable deaths (7, 8). The proportion of Ethiopian women who report having difficulty accessing health care decreased from 96% in 2005, to 70% in 2016 (9). However, only 48% of women gave birth in health facility in 2019. This highlights the need for maternity care to be accessible, competent, appropriately resourced, and, respectful if women are to use it (10).

Respectful maternity care, is a key element of quality of maternity care (10). It is an approach that stresses positive interpersonal interactions between providers and women, throughout maternity care (11). Women's right to respectful and dignified health care throughout pregnancy and childbirth has become a central focus in intervention strategies that seek to reduce maternal mortality (12); disrespect and abuse (D&A) affects women's trust in care providers and the health system deterring them from seeking and using maternity care (11).

Disrespectful treatment ranges from denial of a woman's right to make informed decisions and being scolded for demanding their rights (13), to denial of anaesthesia while performing and repairing episiotomies (14). The White Ribbon Alliance (WRA) categorise D&A in childbirth into seven categories: physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, discrimination, and detention. Each category has more than one verification criteria with “Yes” or “No” dichotomized responses. According to WRA, verification criteria/ manifestations of D&A often fall into more than one category, so that categories are not intended to be mutually exclusive. Rather categories should be seen to be overlapping along a continuum (15). International human rights frameworks highlight D&A of women during childbirth as a key human rights issue, (16–19) and a human rights based approach to birthing care has become a primary concern (20).

Research shows growing evidence of disrespectful and abusive care in Ethiopia (21–33). Thus, understanding D&A will help inform changes in the practice and culture of maternity care. However, the experience of D&A and its determinants are not well understood. Thus, the aim of this study is to gain insight into women's experiences of D&A during facility based childbirth in Ethiopia and thereby contribute to quality and safety in maternity care by creating an evidence base to inform education and training, policy and future research.
Methods

Study design and setting

This survey was conducted as part of a larger mixed methods study that examined disrespect and abuse of women during facility based childbirth in Ethiopia. A community-based cross-sectional study was conducted from 5 October 2019 to 25 January 2020 in North showa zone of Ethiopia. The zone is located 110km to north of the capital Addis Ababa. Based on the 2007 Census conducted by the Central Statistical Agency of Ethiopia, the Zone has a projected total population of 1.5 million in 2016, of whom 48% were women. North Shewa zone has an area of 10,322.48 square kilometers and population density of 138.66 (34). Three hospitals, 62 health centers, 268 health posts are currently functioning in the zone.

Study population and eligibility

Participants were women who had given birth at public health facilities of North showa zone during the last twelve months preceding the survey, regardless of the birth outcome. Women who gave birth at home, those who were acutely unwell physically or mentally and those with disability which would prevent them talking to a researcher were excluded.

Study variables

The dependent variables of this research were specific categories of D&A (physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, discrimination, and detention) women experience during facility based childbirth. The independent variables of this research were sociodemographic variables (age, residence, marital, education, occupation and monthly household income), obstetric history and experience of maternity care utilisation (walking distance of health facility from home, total number of live births, number of birth in health facility, antenatal care (ANC) checkups, ANC and childbirth in same facility, type of health facility visited for birth (health center vs hospital), method of birth and number of baby in most recent childbirth, profession and sex of provider who attended the birth).

Sample size determination and sampling procedures

A single population proportion formula was used to calculate the sample size with assumptions of 78.6% proportion of disrespect and abuse (21), 4% precision, 95% level of confidence and a 10% non-response rate, the final sample size was 443. A list, including contact details, of women who gave birth in public health facility is maintained by local health extension workers (HEWs). Using this list as a sampling frame 443 eligible women were selected by computer generated random numbers in Excel spreadsheet (Microsoft Corporation, 2013). Selection and initial contact was made in person by HEWs and women were invited to choose time and place of interview. HEWs are all female, have a one year formal pre-service training and provide basic health promotion services in health posts. They are not directly connected to the birthing facilities.
Data collection tool and procedures

Data were collected using digital, tablet-based tools, Open Data Kit (ODK) Collect. A validated questionnaire was programed and uploaded to tablets for the survey \((21, 35)\). The questionnaire consisted of three parts. The first part contained seven questions and was used to assess the sociodemographic characteristics of participants. The second part contains 10 questions focusing on the participants’ obstetric history and experience of maternity care utilisation, and the third part includes the seven categories of disrespect and abuse (physical abuse, non-dignified care, abandonment, non-consented care, non-confidential care, discrimination and detention) including the 48 verification criteria used to measure experience of D&A. The questionnaire was designed in English and translated to the local language, Amharic, and then back to English by a third person to check for internal consistency. The Amharic version of the questionnaire was piloted and used to collect data face to face. Participants were surveyed in their homes or another preferred location and were accompanied by person of their choice during the interview.

Measurement

The D&A were categorised in to seven groups and prevalence was calculated for each specific category. Each category has more than one verification criteria with “Yes” or “No” dichotomised responses. A respondent was considered to have been disrespected and/or abused for the specific category if she reported “Yes” in at least one of the verification criteria in that category \((21)\).

Data quality assurance

Digital, tablet-based data collection improves quality of the data as it allows predetermined options only. Local health extension workers with prior experience of tablet-based survey implementation conducted the survey following two days of intensive training. The health extension workers also practiced collecting data using the tablets in order to familiarize themselves with the tool prior to data collection. The enumerators, HEWs, were all females to make sharing ideas easier, as the topic is sensitive. The principal investigator has closely supervised the data collection process.

Data processing and analysis

The data were exported to SPSS Window version 21. Descriptive statistics were used to describe the study population in relation to relevant variables. To identify predictors of each D&A categories bivariate logistic regressions with each potential covariate was conducted and variables that have p-value of \(<0.2\) were included in the final multivariable binary logistic regression models. Then, four multivariable logistic regression models (one model for each category of D&A, except for physical abuse, non-consented care and detention), with a 95% confidence interval were fitted. Physical abuse and non-consented care were reported by too many participants whereas the number of women who reported detention were too small. As a result, these three categories were excluded as we could not perform further statistical analyses.
Adjusted odds ratios and their 95% confidence intervals were computed and statistical significance was declared at p-value of <0.05.

Results

Out of the invited 443 women, 435 agreed to participate in the study yielding a response rate of 98.1%. The mean age of respondents was 28.65 (SD = ± 5.38) ranging from 18 to 46 years. Over two thirds, 304 (69.9%), of respondents were urban dwellers. Most 378 (86.9%) of participants were married and 100 (23%) have attended tertiary level of education, and only 77 (17.7%) of the participants reported monthly household income ≥ 1,644 birr.
Table 1
Sociodemographic characteristics of participants (N = 435)

| Variables          | Frequency | Percentage |
|--------------------|-----------|------------|
| **Age in Years**   |           |            |
| 18–19              | 14        | 3.2        |
| 20–24              | 78        | 17.9       |
| 25–29              | 179       | 41.1       |
| 30–34              | 90        | 20.7       |
| 35+                | 74        | 27.0       |
| **Residence**      |           |            |
| Urban              | 304       | 69.9       |
| Rural              | 131       | 30.1       |
| **Marital status** |           |            |
| Single             | 25        | 5.7        |
| Married            | 378       | 86.9       |
| Divorced           | 24        | 5.5        |
| Widowed            | 8         | 1.8        |
| **Level of education** |       |            |
| No formal education| 105       | 24.1       |
| Primary education  | 124       | 28.5       |
| Secondary education| 106       | 24.4       |
| Tertiary education | 100       | 23.0       |
| **Occupational status** |     |            |
| Housewife          | 201       | 46.2       |
| Government employee| 99        | 22.8       |
| Private employee   | 113       | 26         |
| Farmer             | 22        | 5.1        |
| **Monthly household income** |     |            |
| >= 1,644           | 77        | 17.7       |
| Less than 1,644    | 358       | 82.3       |
| **Spouse occupation** |       |            |
| Unemployed         | 16        | 3.7        |
| Private employee   | 137       | 31.5       |
| Farmer             | 45        | 10.3       |
| Government employee| 180       | 41.4       |
*1 USD was equivalent to 28.85 ETH birr during the study period and then multiplied by poverty line income (1.9/day).

**Participants’ obstetric history and experience of maternity care utilisation**

More than half of the 248 participants (57.0%) walk between 30 to 60 minutes to reach the nearest health facility. The majority, 316(72.6%), had prior experience of giving birth in a public health facility. Most, 395(90.8%), of the study participants have antenatal care follow up for their recent pregnancy, of which, 345 (87.3%) gave birth in same facility where they received ANC checkups. About half 223(51.3%) gave birth in health centres. Midwives/nurses attended 255(58.6%) of the births and 217(49.9%) women reported they were attended by male care providers.
Table 2
Obstetric history of participants (N = 435)

| Variables                                                   | Frequency | Percentage |
|-------------------------------------------------------------|-----------|------------|
| Walking distance of health facility from home in minutes     |           |            |
| <30                                                         | 145       | 33.3       |
| 30–60                                                       | 248       | 57.0       |
| >60                                                         | 42        | 9.7        |
| Total number of live births                                 |           |            |
| 1–3                                                         | 354       | 81.4       |
| >=4                                                         | 81        | 18.6       |
| Number of birth in health facility                          |           |            |
| 1                                                           | 119       | 27.4       |
| >=2                                                         | 316       | 72.6       |
| ANC follow up for recent pregnancy                          |           |            |
| Yes                                                         | 395       | 90.8       |
| No                                                          | 40        | 9.2        |
| ANC and childbirth in same facility for recent birth (N = 395) |           |            |
| Yes                                                         | 345       | 87.3       |
| No                                                          | 50        | 12.7       |
| Type of health facility visited for birth                   |           |            |
| Health Centre                                              | 223       | 51.3       |
| Hospital                                                    | 212       | 48.7       |
| Method of birth for recent childbirth                       |           |            |
| Vaginal delivery                                           | 391       | 89.9       |
| Caesarean section                                          | 44        | 10.1       |
| Number of baby in most recent childbirth                    |           |            |
| One baby (single)                                           | 405       | 93.1       |
| Two babies (twin)                                          | 30        | 6.9        |
| Profession of provider who attended the birth               |           |            |
| Doctor                                                      | 99        | 22.8       |
| Midwifery nurse                                             | 255       | 58.6       |
| I don’t know                                                | 81        | 18.6       |
| Sex of provider who attended the birth                      |           |            |
| Male                                                        | 217       | 49.9       |
| Female                                                      | 218       | 50.1       |

Forms of disrespect and abuse reported by participants

Frequencies of D&A items organised around the Bowser and Hill categories of D&A and presented in the White Ribbon Alliance's Universal Rights of Childbearing Women Framework were calculated. As a result, the prevalence ranged from 100% for physical abuse to 5.5 for detention in health facility.
All women have reported at least one form of D&A during birth care. Physical abuse was found to be the most prevalent (100%) category. Among the verifications of physical abuse, 413 (94.9%) women reported that they were not allowed to give birth in their preferred birthing position; whereas for 381 (87.6%) women an episiotomy was given or sutured without anesthesia. Non-consented care was the second most common D&A reported by 423 (97.2%) of participants. A vast majority of participants, 362 (83.2%) reported that care providers had conducted a vaginal examination without their consent. In addition, 92 (21.1%) participants reported that intrauterine device was inserted without their consent. Two thirds, 288 (66.2%) of participants reported confidentiality of their care was breached, of which, 220 (50.6%) reported absence of curtains/partitions or other measures to provide privacy. Likewise, 204 (46.9%) of participating women said vaginal examinations were not conducted privately. About one third (34.7%) of participants felt abandoned or neglected. More than one in ten (12.9%) women said providers were not present when the baby was born. Non-dignified care was the fifth most common D&A reported by 126 (29%) participants. Among verifications of non-dignified care, 75 (17.2%) of women said providers threatened them if they did not comply and indicated that they or their baby would have a poor outcome. Similarly, 71 (16.3%) of participating women reported that health care providers had shouted/screamed at them during labour or birth. Nearly quarter, 99 (22.8%) of participants reported that they felt discriminated against. Discrimination amongst this group included 51 (11.7%) respondents stating health care providers made negative comments regarding their HIV seropositive status, whereas 37 (8.5%) women received negative comments regarding their age. In addition, 24 (5.5%) of respondents said they were detained in the facility against their will, of which, 17 (3.9%) were detained due to inability to pay hospital bills while 13 (3.0%) were instructed to clean up their own blood or other fluid after birth.
Table 3
Experiences of disrespect and abuse during facility based childbirth, Ethiopia, 2020 (N = 435)

| Types of D&A                                                                 | N  | %   |
|-----------------------------------------------------------------------------|----|-----|
| Experienced at least one form of D&A                                        | 435| 100 |
| Physical abuse                                                              | 435| 100 |
| Pinched/kicked/slapped                                                       | 34 | 7.8 |
| Hit with an instrument                                                       | 12 | 2.8 |
| Gagged to prevent from speaking/making noise                                 | 41 | 9.4 |
| Restrained or tied down during labor                                         | 32 | 7.4 |
| Fundal pressure applied                                                      | 75 | 17.2|
| Preferred birthing position not allowed                                     | 413| 94.9|
| Episiotomy given or sutured without anesthesia                              | 381| 87.6|
| Not allowed to move around during labour                                     | 277| 63.7|
| Had no access to water or other oral fluids                                 | 108| 24.8|
| Not allowed to eat without medical indication                               | 219| 50.3|
| **Non-dignified care**                                                       | 126| 29  |
| Shouted/ screamed at                                                         | 71 | 16.3|
| Insulted/ scolded/ mocked                                                    | 44 | 10.1|
| Received negative comments about your/your baby's physical appearance       | 37 | 8.5 |
| Received negative comments regarding your sexual activity                   | 32 | 7.4 |
| Threatened with a physical violence or unfavorable medical procedures        | 59 | 13.6|
| Threatened with poor outcome to comply                                      | 75 | 17.2|
| Threatened to withhold care                                                  | 55 | 12.6|
| Blamed or intimidated during childbirth                                      | 17 | 3.9 |
| Hissed at                                                                   | 36 | 8.3 |
| **Non-consented care**                                                       | 423| 97.2|
| Vaginal examination not explained                                           | 126| 29.0|
| Non-consented vaginal examination                                           | 362| 83.2|
| Uncomfortable vaginal examinations                                          | 152| 34.9|
| Episiotomy                                                                  | 58 | 13  |
| Types of D&A                                                                 | N  | %   |
|----------------------------------------------------------------------------|----|-----|
| **IUD insertion**                                                          | 92 | 21.1|
| **Augmentation of labor**                                                  | 97 | 22.3|
| **Non-confidential care**                                                  | 288| 66.2|
| Staff discussed private information in a way that others could hear       | 54 | 12.4|
| Lack/misuse of curtains to provide privacy                                 | 220| 50.6|
| Don't have bed during labor                                                | 89 | 20.5|
| Don't have during childbirth                                               | 73 | 16.8|
| Shared bed with another woman or women                                     | 31 | 7.1 |
| Vaginal examinations not conducted privately                               | 204| 46.9|
| **Neglect/ abandonment**                                                  | 151| 34.7|
| Providers not present when the baby came out                               | 56 | 12.9|
| Felt ignored by the health workers or staff                               | 111| 25.5|
| Waited for long before attended by a provider                             | 107| 24.6|
| Felt emotionally unsupported by providers                                 | 64 | 14.7|
| Providers didn't listen to my concerns                                    | 77 | 17.7|
| Providers didn't responded to my concerns                                 | 84 | 19.3|
| Disallowed to have a birth companion                                       | 91 | 20.9|
| **Discrimination**                                                        | 99 | 22.8|
| Received negative comments regarding your ethnicity/ religion              | 7  | 1.6 |
| Received negative comments regarding your age                             | 37 | 8.5 |
| Received negative comments regarding your marital status                   | 11 | 2.5 |
| Received negative comments regarding your level of literacy                | 22 | 5.1 |
| Received negative comments regarding your economic circumstance            | 24 | 5.5 |
| Received negative comments regarding your HIV seropositive status          | 51 | 11.7|
| Denied a language interpreter                                              | 13 | 3   |
| **Detention**                                                             | 24 | 5.5 |
| Detained in the hospital due to inability to pay hospital bills            | 17 | 3.9 |
| Instructed to clean up own blood or other fluid after birth               | 13 | 3.0 |
### Types of D&A

| Types of D&A                                      | N | %  |
|--------------------------------------------------|---|----|
| Asked for a bribe, informal payment/ gift        | 11| 2.5|

**Predictors disrespect and abuse**

Four logistic regression models were constructed to examine the relationship of interpersonal and structural factors with each of the four different categories of D&A. Three forms (physical abuse, non-consented care and detention) were excluded since bivariate analysis revealed that further statistical analyses could not be performed due to the number of women who reported these categories being too high or too small.

The type of health facility at which childbirth takes place, monthly household income, profession and sex of providers were found to be significantly associated with most of the D&A categories. The type of health facility at which childbirth takes place was found to be the most important statistically significant predictor of all forms of D&A; those who gave birth at hospitals were three times more likely to experience disrespect or abuse [AOR: 3.04, 95% CI: 1.75, 5.27] than those who gave birth at health centers.

Experiences of disrespect or abuse were 1.4 times more likely to be reported by rural women than their urban counterparts [AOR: 1.44, 95% CI: 0.76, 2.71]. Women who have monthly household income less than 1,644 Birr (USD 57) were about two times more likely to experience disrespect or abuse [AOR: 2.26, 95% CI: 1.20, 4.26]. Regarding sex and profession of care providers, those women who were attended by female providers [AOR: 1.74, 95% CI: 1.06, 2.86] and midwives/nurses [AOR: 2.23, 95% CI: 1.13, 4.39] were more likely to report disrespect or abuse compared to those who were attended by male providers and doctors respectively.
Discussion

Disrespect and abuse during facility-based childbirth is a global problem with varying degrees of severity and differing drivers in different contexts (36). It is often a greater problem in developing countries where inadequate number of care providers serve large proportion of clients (37). There is growing evidence in Ethiopia that women are experiencing disrespect and abuse in birthing facilities (38, 39). Thus, this study sought to quantify the frequency and categories of D&A and identify factors associated with reporting D&A among women in north showa zone of Ethiopia.

Respectful maternity care is a universal right of every childbearing women, however this study reveals that disrespect and abuse are common in health facilities. Every women who participated in this study has experienced at least one form of disrespect and abuse, and this rate is higher than for any other study. This disparity is attributed to the comprehensiveness of the current research which used 48 verification criteria for the seven categories of disrespect and abuse, whereas other studies used only 25 or less (21, 23–25, 27, 31, 33), which may have led to under reporting of disrespectful and abusive care. However, two studies from Arbaminch, Ethiopia and Enugu, Nigeria have reported almost similar rate 98.9% (32) and 98% (40) of D&A.
Physical abuse is the most prevailing category with 100% prevalence. From these, 413 (94.9%) women were not allowed to give birth in their preferred birthing position and for 381 (87.6%) women an episiotomy was given or sutured without anesthesia. Whereas 34 (7.8%) and 12 (2.8%) participants were pinched/kicked/slapped and hit with an instrument respectively. Other research from Ethiopia reported level of physical abuse that ranged from 2–75.2% (21, 23–25, 28, 30, 31, 33).

When interventions become necessary, service providers should provide the mother sufficient information in a language she can comprehend so that she can knowingly refuse or consent to the intervention (41). However, this study found that 97.2% of participating women reported non-consented care. This finding is higher than findings of previous research across all contexts (25, 31, 42). Best practice is that providers respect the privacy and confidentiality of every childbearing women during counseling, physical examinations, and clinical procedures, as well as in the handling of patients’ medical records and other personal information. However, two thirds of women who participated in this study had experienced a breach in confidentiality. Studies from other parts of the country have similarly revealed a high level of non-confidential care; common examples include the lack of privacy curtains and women not being appropriately covered during intimate examinations and/or labor and birth (21, 23, 31).

Every woman is a person of value and is worthy of respect. All words, actions, and non-verbal communication of providers must honor the dignity of each woman. Unfortunately, in this study, 29% of women reported non-dignified care. Previous studies have documented similar result elsewhere in Ethiopia (21, 23, 31, 33). Non-dignified care and insults may drive women away from healthcare facilities towards less trained providers who treat them with dignity and respect (40). Service providers must acknowledge that women have the right to be treated with respect and consideration. In this study, a number of women reported negative comments regarding their HIV seropositive status, age and literacy were 11.7%, 8.5% and 5.1% respectively.

Attentive care is the right of each client and a woman should never feel abandoned during labour or immediately after birth. However, our study demonstrates that 40% of participating women felt ignored/abandoned and 12.9% of women reported healthcare providers were not present when the baby was born. This finding is in line with a study conducted in the southwest of Ethiopia (31). Furthermore, women should be able to have a birth companion of their choice. However, more than half of the women in this study reported that this was disallowed. The mere presence of a birth companion can ensure respectful care (43) whereas restricting the presence of a birth companion is reported to be a significant barrier to humanized birth care (25, 44, 45). This suggests that health care providers know the way they behave in the absence of a companion is inappropriate and treat a client differently when a companion of the client is present (46).

Freedom from detention is the right of each childbearing woman and a woman or her baby should never be forcibly kept in a facility. Detention is the least reported category by participants, and this is similar to rates reported in other studies from Ethiopia (21, 23, 25, 29, 31–33) possibly because, maternity services are free of charge in Ethiopia and detention due to unaffordable service bills are rare. The economic
status of women has been identified as a significant barrier to quality care. Unlike financially secure families, poor women are more likely to experience disrespectful birthing care (47). Similarly, women of low economic status were more likely to experience D&A in the current research. This indicates the prevailing social attitudes towards people from lower socioeconomic backgrounds. Studies from different contexts have also revealed likewise (25, 48).

Women who gave birth at hospitals reported higher level of D&A compared to those who gave birth at health centers. Hospitals generally belong to the secondary and tertiary levels in Ethiopian three-tier health care system. They serve as referral sites for health centers, which are primary level. Many women prefer hospitals over health centers as they are higher-level and are expected to give better quality of care (26). Increased client volume and insufficient staffing may impede the provision of respectful maternity care in hospitals (49). Previous studies have identified that working in under-equipped and overwrought health systems affects provider enthusiasm and is often labelled as significant contributor to D&A in facilities (50). Local studies have similarly reported higher incidence of D&A among women who gave birth at hospitals (21, 24, 25, 30, 32).

Women who were attended by midwives/nurses were more likely to experience disrespect and abuse compared to those who were attended by doctors. A study from Nigeria revealed that midwives found more of the presented scenarios of mistreatment to be acceptable practices, compared to doctors (13). Middle and lower level care providers, midwives/nurses, work the entire shift whereas higher level (doctors) are mostly called to the labor ward to handle complications or cesarean delivery. Attending to the highly eventful and sensitive process of labor and delivery for long hours in poor working conditions may lead to providers burnout (51) and increase their likelihood of inappropriate treatment of mothers. Negative attitudes of providers towards women is attributed in part to being overworked (52). Evidence shows that if lower level providers are the victims of D&A by managers or higher level providers, then it is more likely that they will use D&A as a tool to ascertain power (53).

Female care providers are presumed to treat women better. Unexpectedly, women who were attended by female providers had a greater likelihood of experiencing D&A in this study. Similar findings have been indicated in a study from Mozambique where higher odds of D&A were reported among women attended by female care providers (54). On the other hand, rural residence was associated with increased likelihood of experiencing D&A. Similarly, in study from Mozambique, the occurrence of disrespect and abuse was much higher in the district hospitals compared to the central hospital (54).

Conclusion

The level of disrespect and abuse reported by participants is high. Structural and interpersonal factors were identified to have positive association with women's experience of disrespect and abuse. Expanding the size and skill mix of professionals in the preferred facilities (hospitals), and sensitizing care providers and health managers regarding the magnitude and consequences of D&A are responses that could possibly mitigate D&A during childbirth.
Abbreviations

ANC
Antenatal Care
D&A
Disrespect and Abuse

Declarations

Acknowledgements

We would like to express our gratitude to the women who participated in this study. We are sincerely grateful to the dedicated team of research assistants, without their tireless efforts, this project would not have been possible.

Funding

This project is funded by a PhD scholarship to YMA from The University of Adelaide.

Availability of data and materials

Not-applicable

Authors’ contributions

YMA conceived the proposal and collected, and analyzed the data and wrote the manuscript. HH, AM and JK approved the proposal with some revisions, reviewed subsequent drafts of the manuscript for their scientific content. All authors read and approved the final manuscript.

Ethics approval and consent to participate

Ethical approval was obtained from The University of Adelaide human research ethics committee H-2019-153 and Salale University College of health sciences research ethics review committee A/G/H/S/C/768/11. Women meeting the eligibility criteria were provided with information about the study and those who agreed to participate consented and were enrolled. All women provided written consent. Participants were provided contact details of the study coordinator for any questions or concerns. No personal identifiers were used in the analysis to ensure anonymity.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no competing interests.
References

1. Exavery A, Kanté AM, Njozi M, Tani K, Doctor HV, Hingora A, et al. Access to institutional delivery care and reasons for home delivery in three districts of Tanzania. International journal for equity in health. 2014;13(1):48.

2. Alkema L, Chou D, Hogan D, Zhang S, Moller A-B, Gemmill A, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. The Lancet. 2016;387(10017):462-74.

3. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization. 2019.

4. Fikre AA, Demissie M. Prevalence of institutional delivery and associated factors in Dodota Woreda (district), Oromia regional state, Ethiopia. Reproductive health. 2012;9(1):33.

5. Amano A, Gebeyehu A, Birhanu Z. Institutional delivery service utilization in Munisa Woreda, South East Ethiopia: a community based cross-sectional study. BMC pregnancy and childbirth. 2012;12(1):105.

6. Callister LC, Edwards JE. Sustainable Development Goals and the ongoing process of reducing maternal mortality. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2017;46(3):e56-e64.

7. Harvey SA, Ayabaca P, Bucagu M, Djibrina S, Edson WN, Gbangbade S, et al. Skilled birth attendant competence: an initial assessment in four countries, and implications for the Safe Motherhood movement. International Journal of Gynecology & Obstetrics. 2004;87(2):203-10.

8. Koblinsky MA, Campbell O, Heichelheim J. Organizing delivery care: what works for safe motherhood? Bulletin of the World Health Organization. 1999;77(5):399.

9. Central Statistical Agency, ICF. ETHIOPIA Demographic and Health Survey 2016.

10. Sheferaw ED, Mengesha TZ, Wase SB. Development of a tool to measure women's perception of respectful maternity care in public health facilities. BMC pregnancy and childbirth. 2016;16(1):67.

11. Miller S, Lalonde A. The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother– baby friendly birthing facilities initiative. International Journal of Gynecology & Obstetrics. 2015;131(S1).

12. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS medicine. 2015;12(6):e1001847.

13. Bohren MA, Vogel JP, Tunçalp Ö, Fawole B, Titiloye MA, Olutayo AO, et al. Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers. Reproductive health. 2017;14(1):9.

14. Center for Reproductive Rights and Federation of Women Lawyers–Kenya. Failure to Deliver, Violations of Women's Human Rights in Kenyan Health Facilities. 120 Wall Street, 14th Floor New York, NY 10005 United States: Center for Reproductive Rights; 2007.
15. White Ribbon Alliance. RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF WOMEN AND NEWBORNS. One Thomas Circle NW, Suite 200 Washington, DC 20005; 2019.

16. UN GA. Universal declaration of human rights. UN General Assembly. 1948.

17. UN GA. Declaration on the Elimination of Violence against Women. UN General Assembly. 1993.

18. UN GA. International covenant on economic, social and cultural rights. United Nations, Treaty Series. 1966;993(3).

19. UN GA. Convention on the elimination of all forms of discrimination against women. Retrieved April. 1979;20:2006.

20. Pillay N. Maternal mortality and morbidity: a human rights imperative. The Lancet. 2013;381(9873):1159-60.

21. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reproductive health. 2015;12(1):33.

22. Asefa A, Bekele D, Morgan A, Kermode M. Service providers’ experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. Reproductive health. 2018;15(1):4.

23. Banks KP, Karim AM, Ratcliffe HL, Betemariam W, Langer A. Jeopardizing quality at the frontline of healthcare: prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia. Health policy and planning. 2018;33(3):317-27.

24. Bekele W, Bayou NB, Garedew MG. Magnitude of disrespectful and abusive care among women during facility-based childbirth in Shambu town, Horro Guduru Wollega zone, Ethiopia. Midwifery. 2020:102629.

25. Bobo FT, Kasaye HK, Belachew Etana MW, Feyissa TR. Disrespect and abuse during childbirth in Western Ethiopia: Should women continue to tolerate? PloS one. 2019;14(6).

26. Garedew M, Kerie M, Walle A. Choice of Healthcare Providing Facility and Associated Factors among Government Employees in Nekemte Town, Western Part of Ethiopia. Health Syst Policy Res. 2019;6(1):83.

27. Gebremichael MW, Worku A, Medhanyie AA, Berhane Y. Mothers’ experience of disrespect and abuse during maternity care in northern Ethiopia. Global health action. 2018;11(1):1465215.

28. Mihret MS. Obstetric violence and its associated factors among postnatal women in a Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia. BMC research notes. 2019;12(1):600.

29. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, et al. Respectful maternity care in Ethiopian public health facilities. Reproductive health. 2017;14(1):60.

30. Sheferaw ED, Kim Y-M, Van Den Akker T, Stekelenburg J. Mistreatment of women in public health facilities of Ethiopia. Reproductive health. 2019;16(1):130.

31. Siraj A, Teka W, Hebo H. Prevalence of disrespect and abuse during facility based child birth and associated factors, Jimma University Medical Center, Southwest Ethiopia. BMC pregnancy and childbirth. 2019;19(1):185.
32. Ukke GG, Gurara MK, Boynito WG. Disrespect and abuse of women during childbirth in public health facilities in Arba Minch town, south Ethiopia—a cross-sectional study. PloS one. 2019;14(4).
33. Wassihun B, Deribe L, Worede N, Gultie T. Prevalence of disrespect and abuse of women during child birth and associated factors in Bahir Dar town, Ethiopia. Epidemiology and health. 2018;40.
34. CSA. Summary and statistical report of 2007 population and housing censes. Federal Democratic Republic of Ethiopia Census Commission. Addis Abeba.: Central Statistics Authority; 2007.
35. Bohren MA, Vogel JP, Fawole B, Maya ET, Maung TM, Baldé MD, et al. Methodological development of tools to measure how women are treated during facility-based childbirth in four countries: labor observation and community survey. BMC medical research methodology. 2018;18(1):1-15.
36. Sando D, Abuya T, Asefa A, Banks KP, Freedman LP, Kujawski S, et al. Methods used in prevalence studies of disrespect and abuse during facility based childbirth: lessons learned. Reproductive Health. 2017;14(1):127.
37. WHO. The prevention and elimination of disrespect and abuse during facilitybased childbirth: WHO statement. 134588/1/WHO_RHR_14.23_eng.pdf. Accessed 25 Feb 2019 2015 [Available from: http://apps.who.int/iris/bitstream/10665/.
38. Molla M, Muleta M, Betemariam W, Fesseha N, Karim A. Disrespect and abuse during pregnancy, labour and childbirth: a qualitative study from four primary healthcare centres of Amhara and Southern Nations Nationalities and People's Regional States, Ethiopia. Ethiopian Journal of Health Development. 2017;31(3):129-37.
39. Gebremichael MW, Worku A, Medhanyie AA, Edin K, Berhane Y. Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from Women's perspective. BMC pregnancy and childbirth. 2018;18(1):392.
40. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. International Journal of Gynecology & Obstetrics. 2015;128(2):110-3.
41. Jansen L, Gibson M, Bowles BC, Leach J. First do no harm: interventions during childbirth. The Journal of perinatal education. 2013;22(2):83-92.
42. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. The Lancet. 2019;394(10210):1750-63.
43. Hales DR, Johnson TR. Intensive Caring: New Hope for High-risk Pregnancy: Three Rivers Press; 1990.
44. Behruzi R, Hatem M, Fraser W, Goulet L, Li M, Misago C. Facilitators and barriers in the humanization of childbirth practice in Japan. BMC pregnancy and childbirth. 2010;10(1):25.
45. Behruzi R, Hatem M, Goulet L, Fraser W. The facilitating factors and barriers encountered in the adoption of a humanized birth care approach in a highly specialized university affiliated hospital. BMC women's health. 2011;11(1):53.
46. Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, et al. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PloS one. 2015;10(4).

47. Adinew YM, Assefa NA. Experience of Facility Based Childbirth in Rural Ethiopia: An Exploratory Study of Women's Perspective. Journal of pregnancy. 2017;2017.

48. Bayo P, Belaid L, Tahir EO, Ochola E, Dimiti A, Greco D, et al. "Midwives do not appreciate pregnant women who come to the maternity with torn and dirty clothing": institutional delivery and postnatal care in Torit County, South Sudan: a mixed method study. BMC Pregnancy and Childbirth. 2020;20:1-14.

49. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. The Lancet. 2014;384(9948):e42-e4.

50. CRR W. Broken Promises: Human Rights, Accountability, And Maternal Death in Nigeria. Center for Reproductive Rights/Women Advocates Research and Documentation Centre, United States. 2008.

51. Ruotsalainen JH, Verbeek JH, Mariné A, Serra C. Preventing occupational stress in healthcare workers. Cochrane Database of Systematic Reviews. 2014(11).

52. Semachew A, Belachew T, Tesfaye T, Adinew YM. Predictors of job satisfaction among nurses working in Ethiopian public hospitals, 2014: institution-based cross-sectional study. Human resources for health. 2017;15(1):31.

53. Mumtaz Z, Salway S, Waseem M, Umer N. Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. Health policy and planning. 2003;18(3):261-9.

54. Galle A, Manaharlal H, Cumbane E, Picardo J, Griffin S, Osman N, et al. Disrespect and abuse during facility-based childbirth in southern Mozambique: a cross-sectional study. BMC pregnancy and childbirth. 2019;19(1):369.

Figures
Figure 1

Categories of disrespect and abuse reported by women (N=435)