Magnitude and associated factors of respectful maternity care in Tirunesh Beijing Hospital, Addis Ababa, Ethiopia, 2021

Alemu Basazin Mingude1, Tadesse Mamo Dejene2, Samuel Derbie Habtegiorgis3 and Fiseha Sahle1

Abstract
Objective: The main aim of this research was to assess the magnitude of respectful maternity care and associated factors during labour and delivery in Tirunesh Beijing General Hospital, 2021.
Methods: Facility-based cross-sectional research was employed among 319 postnatal mothers who were selected by systematic random sampling technique. Bi-variable and multi-variable logistic regression analysis was used to identify associated factors. Variables whose p-value < 0.05 in the multivariable model with 95% confidence interval were considered as statically significant.
Results: A total of 319 respondents participated in the research with a response rate of 100%. The overall prevalence of respectful maternity care was 87.8%. Type of delivery in which caesarean section (adjusted odds ratio = 10.4, 95% confidence interval: (1.8, 61) and spontaneous vaginal delivery (adjusted odds ratio = 2.9, 95% CI: 1.4, 6). Getting delivery service by the provider of their preference (adjusted odds ratio = 2.6, 95% CI: 1.3, 5.2), still birth (AOR = 5.8 95% CI: 1.3, 25.8) and sex of delivery attendant (adjusted odds ratio = 3.6, 95% CI: 1.8, 7.5) were associated factors RMC.
Conclusion and recommendation: In our research area, a sizable number of women have received respectful maternity care, but abuse and disrespect are still complaints. Therefore, emphasis should be placed on respectful maternity care by every healthcare professional and health service manager.

Keywords
Respectful maternity care, labour and delivery, Ethiopia

Date received: 3 April 2022; accepted: 18 October 2022

Introduction
All childbearing women have a fundamental right to respectful maternity care (RMC), which goes beyond just guarding against mistreating pregnant women.1,2 Every woman has the right to the highest level of health possible, which includes the right to kind, considerate medical care. But many women around the world experience disrespectful and abusive treatment in facilities when giving birth.3

In order to reduce maternal mortality globally, it is essential to guarantee that all women have access to skilled care prior to, during, and after childbirth. However, the psychosocial aspects of labour and delivery dominate a woman’s birth experience.4-6

Lowering maternal mortality is one of the global objectives outlined in the Sustainable Development Goals. Ethiopia had one of the highest maternal mortality ratios (MMRs) in the world.7,8 In addition, Ethiopia had one of the highest rates of perinatal mortality in sub-Saharan Africa.9,10 Enhancing the standard of care given during childbirth is the most efficient method for reducing perinatal mortality.11

1 Department of Nursing, College of Health Sciences, Debre Berhan University, Debre Berhan, Ethiopia
2 Department of Public Health, College of Health Sciences, Debre Berhan University, Debre Berhan, Ethiopia
3 Department of Public Health, College of Health Sciences, Debre Markos University, Debre Markos, Ethiopia

Corresponding author:
Alemu Basazin Mingude, Department of Nursing, College of Health Sciences, Debre Berhan University, P.O. Box 445, Debre Berhan, Ethiopia.
Emails: alexppx0809b@gmail.com; alemubasazin@dbu.edu.et
Institutional delivery in Ethiopia fell short (48%).

Disrespectful maternity care is also typical (49.4%). The mistreatment, abuse, and neglect of health workers have fueled dissatisfaction, mistrust, and avoidance of facility-based delivery care.

During childbirth, one-fifth of Ethiopian women claimed to have been treated disrespectfully. The most typical forms of mistreatment and disrespect included failing to respect one’s right to information, informed consent, the right to choose one’s childbirth position, and being neglected while in labour.

Despite the fact that assessing RMC during childbirth is crucial for improving the quality of maternity care services and lowering maternal morbidity and mortality rates. In our field of study, there is a lack of evidence. As a result, the primary goal of this study was to evaluate the extent of RMC and related variables during labour and delivery in Tirunesh Beijing Hospital, 2021. The Tirunesh Beijing Hospital, other healthcare organizations, managers of health services, and future researchers may find the study’s findings to be significant.

Material and methods

Research design, period, and area

Institutional-based cross-sectional study design was employed to assess the magnitude of RMC and associated factors during labour and delivery in Tirunesh Beijing General Hospital from 1 May to 30 June 2021. Tirunesh Beijing General Hospital was named after a famous Ethiopian Olympic gold medallist Tirunesh Dibaba during Beijing Olympics (China) and the Hospital is found in Akaki-Kaliti sub-city, Addis Ababa, Ethiopia. The Hospital serves about 2 million people. The hospital renders all MCH, delivery and postnatal care services. Currently, the Hospital has 47 midwives and more than 3500 annual delivery.

Source and study population

The source population was all women who delivered at Tirunesh Beijing General Hospital. The study population was all women who delivered at Tirunesh Beijing General Hospital during the data collection period and selected by systematic random sampling. Women who were referred from another health facility after giving birth were excluded.

Sample size and sampling procedure

The sample size was calculated by using single population proportion formula considering the following assumptions. The prevalence of RMC, p = 74.8%, confidence interval (CI) = 95%, and none response rate = 10%. The final sample size was 319. Systematic random sampling technique was used to collect data using women registration numbers from the delivery logbook and k = 2. Data were collected from every other woman who gave birth during the research period. The first client was selected by simple random sampling (lottery method).

Data collection instrument, procedure and data quality assurance

Interviewer-administered structured questionnaire was used to collect the data. The tool was adapted from similar studies conducted in Ethiopia. This assessment tool was developed using English language and then translated to Amharic language and back to the English language to ensure convenient information was retrieved. Questionnaires we used to assess RMC have Cronbach’s alpha value of 0.845. Pre-test was done in Debre Berhan comprehensive specialized Hospital which was out of our actual data collection site among 5% of the sample to assess the internal consistency and repeatability of the tool. Four BSc midwives were recruited for data and authors were supervised the overall data collection process. Mothers were interviewed after 4 hours of delivery and before discharge. Data were collected in a calm and separate room.

Operational definition

Respectful care was measured by four performance standards (friendly care, timely care, discrimination-free care, and abuse-free care). In each performance standard, there were items to measure each category 7 items from friendly care, 3 items from abusive free care, 2 items from timely care, and 4 items from discrimination-free care. During analysis, the responses of ‘Yes’ for positive meaning questions and ‘No’ for negative meaning questions were considered as received RMC, and the responses of ‘No’ for at least one positive meaning question or response of ‘Yes’ for at least one negative meaning item were considered as disrespected and abused. Finally, women were considered as respected during labour and delivery services when the responses for the four performance standards were classified as ‘Yes’.

Statistical analysis

Data were checked for completeness and entered into Epidata version 3.1 and then exported to SPSS version 25 for further data cleaning and analysis. Frequency distributions were obtained to check for data entry error (missing/unrecognized values and codes). Descriptive statistics was done and presented by Tables and Graph. The presence of an association between the independent and outcome variable was checked by the Pearson chi-square test. In addition, each independent variable was fitted separately into bivariable logistic analysis to evaluate for the degree of association with RMC. Variables with p-values less than 0.25 in bivariable model was candidate variable for multivariable logistic regression analysis.
In multivariable model, backward stepwise regression was used and variables with p-value $<0.05$ in 95% CI were considered independent predictors of RMC.

Ethical approval for this study was obtained from Institutional Review Board (IRB) of Debre Berhan University with protocol number Po 27. Then, permission letter to conduct the study was obtained from the hospital administration office. The respondents were informed about the purpose of the study, and data were collected after obtaining oral informed consent from the study participants. This method of obtaining informed consent was approved by the Institutional Review Board of Debre Berhan University.

Results

Socio-demographic characteristics of research subjects

From the total eligible post-natal mothers, everyone gave a voluntary consent to participate in the research, and there was a 100% response rate. The mean age of respondent’s was 28.17 with a standard deviation of (SD $\pm 4.381$) and the minimum and maximum ages were 19 and 40 years, respectively. Two hundred seventy-two (85.3%) of participants were married and about half 167 participants (52.4%) of participants were Amhara ethnicity, and 168 (52.7%) of participants were followers of Orthodox Christian religion (Table 1).

Ethical approval for this study was obtained from Institutional Review Board (IRB) of Debre Berhan University with protocol number Po 27. Then, permission letter to conduct the study was obtained from the hospital administration office. The respondents were informed about the purpose of the study, and data were collected after obtaining oral informed consent from the study participants. This method of obtaining informed consent was approved by the Institutional Review Board of Debre Berhan University.

| Type of variables | Frequency | Percent (%) |
|-------------------|-----------|-------------|
| Age |
| $<$25 | 92 | 28.8 |
| 25–29 | 113 | 35.4 |
| 30–34 | 84 | 26.3 |
| $>$34 | 30 | 9.5 |
| Marital status |
| In marital union | 272 | 85.3 |
| Nonmarital union | 47 | 14.7 |
| Religion |
| Orthodox | 168 | 52.7 |
| Catholic | 12 | 3.8 |
| Protestant | 75 | 23.5 |
| Muslim | 64 | 20.0 |
| Ethnicity |
| Amhara | 167 | 52.4 |
| Oromo | 112 | 35.1 |
| Tigray | 31 | 9.6 |
| Other’s | 9 | 2.9 |
| Mother’s education level |
| No formal education | 48 | 15.1 |
| Primary-secondary school | 153 | 47.9 |
| College and above | 118 | 37.0 |
| Mother’s occupation |
| House wife | 80 | 25.1 |
| Employee | 160 | 50.1 |
| Self-employee | 61 | 19.2 |
| Student | 18 | 5.6 |
| Family income |
| $\leq$2000 | 76 | 23.8 |
| $>$2000 | 243 | 76.2 |

| Table 1. Sociodemographic characteristic of women (n=319) in Addis Ababa Tirunesh Beijing Hospital. |

In our study, more than 85% (87.8%) of study participants received respectful maternity care. From categories of RMC, 99.1% of women received care in kind approach and 312 (97.8%) received friendly care. The other most commonly reported is abuse-free care from the respected maternity care category as a result, 302 (94.7%) women were assisted without physical abuse (slaps, hitting), and 216 (67.7%) women were assisted during childbirth without screaming/shouting (Table 3). Evidence from our study indicated that still, some health care workers did not treat well their clients due to personal attributes, 258 (80.9%) women reported prompt treatment, while 313 (98.3%) reported non-discriminatory treatment (Figure 1).

Factors associated with respectful maternity care

When testing the bivariable association, factors with a p-value of 0.25 or less were considered potential variables for the multivariable regression model. The variables that went into the final model were the type of delivery, the gender of the primary care provider, the sex of the delivery staff, the history of stillbirth, access to the desired health care provider, and the type of women’s birth. The type of delivery (caesarian delivery and spontaneous vaginal delivery), getting service by the provider of their preference, history of still birth and sex of delivery attendant (male attendant) were significantly associated with respectful maternity care with a p-value $<0.05$.

Respectful maternity care varies depending on the delivery method. Compared to mothers who gave birth by instrument, mothers who delivered by caesarian section were 10.4 times more likely to receive respectful maternity care (RMC): adjusted odds ratio (AOR)=10.4, 95% CI: 1.8, 61, and mothers who gave birth naturally were 2.9 times more likely to receive RMC: AOR=2.9, 95% CI: 1.4, 6.
Women who chose the provider of their choice for delivery had a 2.6-fold increased chance of receiving respectful maternity care compared to those who did not (AOR = 2.6, 95% CI: 1.3, 5.2). Contrarily, mothers who had a male delivery attendant were found to be 3.6 times more likely than those who had a female delivery attendant to receive respectful maternity care (AOR = 3.6, 95% CI: 1.8, 7.5).

Another factor that has been linked to receiving respectful maternity care is a mother’s history of stillbirth. Accordingly, mothers with a history of stillbirth were 5.8 times more likely to receive such care than mothers without such a history. AOR = 5.8, 95% CI: 1.3, 25.8 (Table 4).

**Discussion**

Our study primarily focuses on evaluating the level of respectful maternity care and its contributing factors in the Tirunesh Beijing Hospital, which was named after the well-known Ethiopian Olympic runner Tirunesh Dibaba. According to the study’s findings, 87.8% of maternity care was provided in a respectful manner. This finding was higher than the research conducted at Harar (38.4%),18 Benishangul Gumuz (12.6%),20 Debre Berhan (35.7%),21 Bahir Dar Town (57%),22 Iran (24.3%),23 and Egypt (80%).24 These variations might be due to the difference in the sampling methods, for example, research conducted in Debre Berhan used consecutive sampling, but this is not the case in our study. The other difference might be due to the difference in sample size, study period and area.

According to this research abuse-free care is the most commonly experienced category of RMC, and its provision was 83.6%. This result was higher than the research conducted in Bahir Dar Town (14.4%),22 and Harar, Eastern, Ethiopia (45%).18 This deviation may be due to difference in staff training (on job training) on compassionate respectful care (CRC) and organizational working culture. The other possible explanation for the difference might be due to the difference in frequency of antenatal care visit because respectful maternity care is associated with the presence of maternal ANC follow-up in many studies.18,21,25,26 On the other hand, the result is lower than the research conducted at west Shewa zone Oromia region, Ethiopia (89.2%) this might be due to the difference in a research setting and sample size.27

The other category of RMC was timely care during the provision of services, 80.9% of mothers receive timely care. This finding was higher than research carried out in Bahir Dar (1.4%),18 and Harar, Eastern, Ethiopia (45%).18 This deviation might be due to the difference in organizational work culture and attitude of professionals towards their work.

The other category of RMC experienced during labour and delivery was discrimination-free care. More than 98.3% of mothers received discrimination-free care. This result was higher than research conducted at Harar (45.4%), and Bahir Dar (32.4%).18,22 The reasons might be due to the difference in measurement of outcome variables, for example, the research conducted in Harar used previous studies and it was categorized as ‘disrespect care’ if there is 1 response from 15 items to determine cut-off-point for respectful maternal care but our research used the mean score value of responses from the criteria to determine the cut of points the other reason might be due to the study settings.

**Table 2. Obstetric characteristic of women at Addis Ababa Tirunesh Beijing Hospital (n = 319).**

| Type of variables | Frequency | Percent (%) |
|------------------|-----------|-------------|
| History of ANC follow-up (n = 319) | | |
| Yes | 308 | 96.6 |
| No | 11 | 3.4 |
| Place of receive ANC visit (n = 308) | | |
| Health centre | 174 | 56.5 |
| Hospital | 120 | 39 |
| Private clinics | 14 | 4.5 |
| ANC care provider (n = 308) | | |
| Doctor | 139 | 43.6 |
| Nurse/midwife | 162 | 50.8 |
| Health extension worker’s | 7 | 2.2 |
| Number of ANC visit’s (n = 308) | | |
| <4 visits | 114 | 37.1 |
| Full visits (≥4) | 194 | 62.9 |
| Total no delivery | | |
| One | 94 | 29.5 |
| Two | 109 | 34.2 |
| Three or more | 116 | 36.3 |
| Stillbirth history | | |
| No | 267 | 83.7 |
| Yes | 52 | 16.3 |
| Sex of delivery attendant | | |
| Male | 181 | 56.7 |
| Female | 138 | 43.3 |
| The profession of delivery attendant | | |
| Midwives | 232 | 72.8 |
| Doctors | 87 | 27.3 |
| Getting of services by care provider they want | | |
| Yes | 246 | 77.1 |
| No | 73 | 22.9 |
| Mode of delivery | | |
| Normal delivery (SVD) | 165 | 51.7 |
| Caesareans section | 73 | 22.9 |
| Instrumental delivery | 81 | 25.4 |
| Hospital waiting time | | |
| Less than 1 day | 68 | 21.3 |
| One day | 126 | 50.2 |
| Two or more days | 125 | 41.5 |
| Facing complication | | |
| Mother | 85 | 26.6 |
| Baby | 17 | 5.3 |
| Both | 24 | 7.5 |

ANC: antenatal care; SVD: Spontaneous Vaginal Delivery.
Table 3. Level of respectful maternity care during labour and delivery at Addis Ababa Tirunesh Beijing Hospital (n = 319).

| Category and type of RMC                                      | Yes | %   | No  | %   |
|--------------------------------------------------------------|-----|-----|-----|-----|
| **Friendly care**                                            |     |     |     |     |
| Care in kind approach                                       | 316 | 99.1| 3   | 0.1 |
| Care in friendly manner                                      | 312 | 97.8| 7   | 2.2 |
| Care positively                                              | 273 | 85.6| 46  | 14.4|
| Care with empathy                                            | 306 | 95.9| 13  | 4.1 |
| Care with respect                                            | 311 | 97.5| 8   | 2.5 |
| Care for her with language that she can understand           | 267 | 83.7| 52  | 16.3|
| Care with call by name                                       | 187 | 58.6| 132 | 41.4|
| **Abuse free care**                                          |     |     |     |     |
| Provider respond to her need whether she asked or not        | 282 | 88.4| 37  | 11.6|
| Provider slapped her during delivery                         | 17  | 5.3 | 302 | 94.7|
| Provider shouted on her during delivery                      | 103 | 32.3| 216 | 67.7|
| **Timely care**                                              |     |     |     |     |
| She was waiting for a long period before receiving care      | 83  | 26.0| 236 | 74.0|
| Service provision were delayed                               | 39  | 12.2| 280 | 87.8|
| **Discrimination free care**                                 |     |     |     |     |
| Some of the health workers did not treat well because of some personal attribute | 11  | 3.4 | 308 | 96.6|
| Some of the health workers insulted me and my companion’s due to my personal attribute’s | 7   | 2.2 | 312 | 97.8|
| Provider did discriminate me by economics status and language | 2   | 0.6 | 317 | 99.4|
| The provider did discriminate against me by race and ethnicity| 2   | 0.6 | 317 | 99.4|

RMC: respectful maternity care.

Figure 1. Types of respectful maternity care during labour and delivery at Addis Ababa Tirunesh Beijing Hospital (n = 319).

In addition to this, our research revealed that a high level of friendly care which was 88.4%. This research was higher than research carried out at Bahir Dar which account (26.1%), and Eastern Ethiopia, Harar (59.8%).\textsuperscript{18,22} This deviation may be due to research period difference, sample size differences, and research settings as well as socioeconomic and sociodemographic deference’s.

Our research found that mothers who gave birth with caesarean section were 10.4 times more likely to experience respectful maternity care than women who were delivered by instrument (forceps’s and vacuum assisted delivery) this study finding is supported by study conducted in southern Ethiopia which reported that women’s who delivered by caesarean section were faced little mistreatment compared to others.\textsuperscript{28} On the other hand, women’s who delivered by spontaneous vaginal delivery were 2.9 times more likely to experience respectful maternal care compared to mothers who delivered by instrument assisted delivery. This finding was supported by other similar studies.\textsuperscript{22,29,30} This might be due to the nature of the procedure, that is, instrumental delivery has
some discomfort and needs more cooperativeness of the labouring mother. To ensure good birth outcome health workers used instrument to shorten the second stage of labour this will be perceived as painful experience for the mothers.

Women who have got service by the provider of their preference were 2.6 times more likely to get respectful maternal care than their counterparts. This might be due to women perception. When Women have got service by the provider of their preference, may feel safe, supported, respected and able to participate in shared decision-making.

Mothers with a history of still birth were 5.8 times more likely to experience respectful maternal care than those who don’t have a history of still birth. This finding seems negative but it might be due to special treatment of mothers with a history of still birth because they are a high-risk group and needs special attention and treatment.

Male birth attendant was found to be remarkably associated with respectful maternal care it was 3.6 times more likely to get kind care than their counterparts (women who gave birth by female birth attendants) these finding was supported by similar studies.¹⁸,²⁹ This might be due to high number of male birth attendants in our study.

**Strength and limitation**

Face-to-face interviews are used in this study because they are thought to be the most reliable method of gathering data, making it strong. The study also aims to fill a knowledge gap in the area of respectful maternity care, which is somewhat complex and understood overall and in this study area. Despite the strengths mentioned above, there are some limitations to this study; the problem (RMC) on its own is challenging because the data were gathered from mothers. This makes it challenging to investigate the true causes. In addition, some of the mothers were reluctant to share any unfavourable incidents they had while at the facility, and the research was limited to one hospital.

### Table 4. Factors associated with respectful maternity care in Addis Ababa Tirunesh Beijing Hospital.

| Variables                        | Category      | RMC | COR (95% CI) | AOR (95% CI) | p-value |
|----------------------------------|---------------|-----|--------------|--------------|---------|
| Types of delivery                | SVD           | 137 | 2.1 (1.1, 3.9) | 2.9 (1.4, 6) | 0.003   |
|                                  | C/S           | 71  | 14.9 (3.4, 65.9) | 10.4 (1.8, 61) | 0.010   |
| Instrumental                     |               | 24  | Ref.         | Ref.         |         |
| Main provider                    | Midwife       | 183 | Ref.         | Ref.         |         |
|                                  | Doctor        | 82  | 4.4 (1.7, 11.4) | 1.1 (0.3, 3.9) | 0.926   |
| Getting service by the provider  | Yes           | 214 | 2.9 (1.5, 5.4) | 2.6 (1.3, 5.2) | 0.008   |
|                                  | No            | 51  | Ref.         | Ref.         |         |
| Stillbirth                       | Yes           | 50  | 6 (1.4, 25.6) | 5.8 (1.3, 25.8) | 0.022   |
|                                  | No            | 215 | Ref.         | Ref.         |         |
| Sex of delivery attendant        | Male          | 166 | 4.4 (2.3, 8.3) | 3.6 (1.8, 7.5) | 0.0001  |
|                                  | Female        | 99  | Ref.         | Ref.         |         |

RMC: respectful maternity care; COR: crude odds ratio; CI: confidence interval; AOR: adjusted odds ratio; Ref.: reference.

**Recommendation**

Health care providers should give more attention to punctuality and be polite while giving care and attending delivery. We recommend for future researchers to explore the reasons for disrespect and abuse by qualitative research.

**Conclusion**

A significant number of mothers have got respectful maternity care in our study area, but respectful maternity care is not merely the absence of mistreatment. Women value being provided with care that is respectful, inclusive and of good quality. Also, mothers are still exposed to a different type of disrespect and abuse during delivery service.

**Acknowledgements**

We would like to express our appreciation to the patience of women who participated in this study during the time of the interview and the data collectors for their greatest effort for the success of this project.

**Declaration of conflicting interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Ethical approval**

Ethical approval for this study was obtained from Institutional Review Board (IRB) of Debre Berhan University with protocol number Po 27. Then, permission letter to conduct the study was obtained from the hospital administration office.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.
Informed consent

The respondents were informed about the purpose of the study and data was collected after obtaining oral informed consent from the study participants. This method of obtaining informed consent was approved by the Institutional Review Board of Debre Berhan University.

ORCID iDs

Alemu Basazin Mingude https://orcid.org/0000-0003-0369-8734
Samuel Derbie Habtegiorgis https://orcid.org/0000-0002-3284-3761

References

1. Shakibazadeh E, Namadian M, Bohren MA, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. BJOG 2018; 125(8): 932–942.
2. Erlandsson K, Sayami JT and Sapkota S. Safety before comfort: a focused enquiry of Nepal skilled birth attendants’ concepts of respectful maternity care. J Evidence Based Midwifery 2014; 12(2): 59–64.
3. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. World Health Organization, Geneva, 2014.
4. Kassa ZY and Husen S. Disrespectful and abusive behavior during childbirth and maternity care in Ethiopia: a systematic review and meta-analysis. BMC Res Notes 2019; 12(1): 83.
5. Kassa ZY, Tsegaye B and Abeje A. Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa: a systematic review and meta-analysis. BMC Int Health Hum Rights 2020; 20(1): 23.
6. Bradley S, McCourt C, Rayment J, et al. Disrespectful intra-partum care during facility-based delivery in sub-Saharan Africa: a qualitative systematic review and thematic synthesis of women’s perceptions and experiences. Soc Sci Med 2016; 169: 157–170.
7. World Health Organization. Trends in maternal mortality: 1990-2015: estimates from WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. World Health Organization, Geneva, 2015.
8. World Health Organization. Trends in maternal mortality 1990 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. World Health Organization, Geneva, 2019.
9. Berhan Y and Berhan A. Perinatal mortality trends in Ethiopia. Ethiop J Health Sci 2014; 24(Suppl): 29–40.
10. Jena BH, Biks GA, Gelaye KA, et al. Magnitude and trend of perinatal mortality and its relationship with inter-pregnancy interval in Ethiopia: a systematic review and meta-analysis. BMC Pregnancy Childbirth 2020; 20(1): 432.
11. Bhutta ZA, Das JK, Bahl R, et al. Can available interventions end preventable deaths in mothers, newborn babies, and still-births, and at what cost? Lancet 2014; 384(9940): 347–370.
12. Ethiopian Public Health Institute (EPHI), Federal Ministry of Health (FMoH), ICF. Ethiopia Mini Demographic and Health Survey 2019. EPHI/FMoH/ICF, Addis Ababa, Ethiopia, 2021.
13. Bohren MA, Hunter EC, Munthe-Kaas HM, et al. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reproductive Health 2014; 11(1): 71.
14. Gehremichael MW, Worku A, Medhanyie AA, et al. Mothers’ experience of disrespect and abuse during maternity care in northern Ethiopia. Glob Health Action 2018; 11(Suppl. 3): 1465215.
15. Asea A and Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reprod Health 2015; 12(1): 33.
16. Tekle Bobo F, Kebebe Kasaye H, Etana B, et al. Disrespect and abuse during childbirth in Western Ethiopia: should women continue to tolerate? PLos One 2019; 14(6): e0217126.
17. Yosef A, Kebede A and Worku N. Respectful maternity care and associated factors among women who attended delivery services in referral hospitals in Northwest Amhara, Ethiopia: a cross-sectional study. J Multidiscip Healthc 2020; 13: 1965–1973.
18. Bante A, Teji K, Seyoum B, et al. Respectful maternity care and associated factors among women who delivered at Harar hospitals, eastern Ethiopia: a cross-sectional study. BMC Pregnancy Childbirth 2020; 20(1): 86.
19. Sheferaw ED, Mengesha TZ and Wase SB. Development of a tool to measure women’s perception of respectful maternity care in public health facilities. BMC Pregnancy Childbirth 2016; 16(1): 67.
20. Amsalu B, Aragaw A, Sintayehu Y, et al. Respectful maternity care among laboring women in public hospitals of Benishangul Gumuz Region, Ethiopia: a mixed cross-sectional study with direct observations. SAGE Open Med 2022; 10: 1–11.
21. Wubetu Y, Sharew N and Yimer O. Respectful delivery care and associated factors in public health facilities in Debre Berhan Town, Ethiopia, 2021, https://assets.research-square.com/files/rs-62205/v2/5f89f83-6c2c-4123-aa9a-cf377b12071.pdf?c=1631872848
22. Wassihun B and Zeleke S. Compassionate and respectful maternity care during facility based childbirth and women’s intent to use maternity service in Bahir Dar, Ethiopia. BMC Pregnancy Childbirth 2018; 18(1): 294.
23. Hajizadeh K, Vaezi M, Meedya S, et al. Prevalence and predictors of perceived disrespectful maternity care in postpartum Iranian women: a cross-sectional study. BMC Pregnancy Childbirth 2020; 20(1): 463.
24. Abuja T, Warren CE, Miller N, et al. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PLoS One 2015; 10(4): e0123606.
25. Yosef A, Kebede A and Worku N. Respectful maternity care and associated factors among women who attended delivery services in referral hospitals in Northwest Amhara, Ethiopia: a cross-sectional study. J Multidiscip Healthc 2020; 13: 1965–1973.
26. Mohammed S and Edae C. Compassionate health care service and associated factors among mothers attending public hospitals of east hararge zone. EC Gynaecol 2021; 10: 1–17.
27. Bulto GA, Demissie DB and Tulu AS. Respectful maternity care during labor and childbirth and associated factors among women who gave birth at health institutions in the West Shewa zone, Oromia region, Central Ethiopia. BMC Pregnancy Childbirth 2020; 20(1): 443.
28. Asefa A, Morgan A, Gebremedhin S, et al. Mitigating the mistreatment of childbearing women: evaluation of respectful maternity care intervention in Ethiopian hospitals. *BMJ Open* 2020; 10(9): e038871.

29. Tagesse B, Tamiso A, Rodamo K, et al. Prevalence and associated factors of disrespectful and abusive care during childbirth among women who gave birth in health facilities in Hawassa city, Southern Ethiopia. A cross-sectional study, 2020, https://assets.researchsquare.com/files/rs-107805/v1/b67409b5-0bb6-4111-b91c-b15634fed4c0.pdf?c=1631861650

30. Banks KP, Karim AM, Ratcliffe HL, et al. Jeopardizing quality at the frontline of healthcare: prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia. *Health Policy Plan* 2018; 33(3): 317–327.