

Mistreatment and Associated Factors Among Delivering Mothers in Dodota District Public Health Facility, Arsi, Oromiya, Ethiopia

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To cite this article:

Eshetu Girma Waktola. Mistreatment And Associated Factors Among Delivering Mothers in Dodota District Public Health Facility, Arsi, Oromiya, Ethiopia. *American Journal of Nursing and Health Sciences*. Vol. 2, No. 3, 2021, pp. 66-78. doi: 10.11648/j.ajnhs.20210203.12

Received: July 15, 2021; **Accepted:** July 28, 2021; **Published:** August 11, 2021

Abstract: Introduction: Globally, more than half a million women die annually because of pregnancy and childbirth related complication. In Africa, the maternal mortality is still 540 per 100, 000 live births, it accounts for 64% of maternal deaths. Ethiopia has one of the highest maternal mortality ratios that are 412 maternal deaths per 100,000 live births. Mistreatment during childbirth eventually contributes toward maternal and neonatal morbidity and mortality. Objective: To assess the magnitude of mistreatment and associated factors among delivering mothers in Dodotadistrict public health facility, Oromiya region, Arsi zone, Southeast, Ethiopia, from January 1 uptoFebruary28, 2021. Methods: Institutional based cross-sectional study design was employed using quantitative data collection methods. Study participant were selected through systematic random sampling. Semi structure and pretested questioner was used to collect data from study participant. The collected data was entered into EpiInfo version7.2.1 and analyzed using SPSS version 23. Descriptive statistics were used. Initially, binary logistic regression was carried out to see the association, Thereafter, the multivariable logistic regression method was used-value<0.05 and 95%CI was used to declare statistical significance. Hosmer–Lemeshow test was used to test goodness of fit of a model. Adjusted Odds Ratio (AOR) and 95% CI were used to report the strength of association between outcome and independent variables. Results: In this study, (70.3%) (95%CI: 1.579, 2.843) of the interviewed mothers reported having experience at least one form of mistreatment. The types of mistreatment during childbirth included Ineffective communication (66.6%), Verbal abuse (64.5%), Non-consented care (60.3%), Physical abuse (35.1%), Non-confidential care (21.8%), Discrimination (20.5%) and Abandonment (2.5%). Sex of health care provider (AOR=4.434; 95%CI: (2.83, 41.85), Medical supply shortage [AOR 5.219; 95%CI: (2.525, 10.8)], Number of health professions [AOR=6.08; 95%CI: (2.32, 15.88)] were factors significantly associated with mistreatment during delivery service. Conclusion and recommendations: From this study, we can conclude that women receiving labor and delivery care at the study health facilities are exposed to mistreatment to a higher extent suggesting to a need to urgent intervention. Resource shortage, Number and sex of health professions are factors associated with mistreatment. Fulfilling resource shortage, giving birth preparedness education is mandatory in order to tackle this problems.

Keywords: Disrespect, Abuse, Maternity, Child Birth, Women, Prevalence, Ethiopia

1. Introduction

1.1. Background

World Health Organization (WHO) defines mistreatment as interactions or facility conditions that local consensus seems to be humiliating or undignified and those interactions or conditions that are experienced as or intended to be humiliating or undignified [4, 7]. Disrespect and abuse or

mistreatment related to childbirth was recently introduced and conceptualized in 2010 and 2015, respectively.

Mistreatment during childbirth is a human rights violation in which disrespectful care provision is inflicted upon childbearing women, while their wishes and needs are neglected [1, 2]. It may encompass malpractices such as physical abuse, verbal abuse, non-consented care, non-confidential care, discrimination based on patient attributes, abandonment of care, and detention in facilities [3].

Mistreatment during childbirth is an issue across the globe, yet its occurrence is particularly prevalent in low-income settings. Factors such as frustration among healthcare personnel and unequal patient-provider relations can help to explain why women are being mistreated during childbirth; however, intrinsically good motives among healthcare might play a role as well [5].

In order to improve maternal and child well-being and reach the United Nations Sustainable Development Goal 3, which aims to reduce the global maternal mortality ratio to 70 per 100,000 live births and the neonatal mortality rate to 12 deaths per 1000 live births, a more patient-centered care approach is needed [2, 10–12]. Research has indicated mistreatment during childbirth to stem from societal level risk factors, organizational level risk factors, and individual level risk factors among healthcare, which may then give rise to poor health service characteristics and inadequate interpersonal interactions between healthcare professionals.

Currently, respectful maternity care is a top priority in the World Health Organization (WHO) recommendations on intrapartum care for a positive childbirth experience. The WHO recommends provision of respectful maternity care in accordance with a human rights based approach to decrease maternal morbidity and mortality, improve women's experience of labor and childbirth, and address health disparities [26, 42]. However, disrespect and abuse during childbirth is common throughout the world [19]. It can occur at the level of contact between the client and the care provider, as well as through systemic failures at the health facility and health system level [19]. Evidence from multiple countries in Sub-Saharan Africa showed that women would prefer to deliver in a facility, but choose home delivery not to because of the presence of inadequate, low quality, and disrespectful care in facilities [16]. In different countries the prevalence of mistreatment was 10% in Brazil (Pelotas town) [9], 10% in Tanzania [10, 38], 20% in Kenya [11, 36], and 36% in Ethiopia [12, 14, 21]. Study done in Ethiopia in three hospital and three health center found in East, West and KellamWallega showed that marital and educational statuses of women, types of health facility, monthly income, use of ANC, types of delivery, waiting time, knowledge and attitudes among health care workers, the working environment and the number of staffs were factors significantly associated with the mistreatment of women during childbirth.

According to Ethiopia Mini Demographic and Health Survey (EMDHS) 2019, the prevalence of institutional delivery was low (48%) [12]. Absence of appropriate labor pain management, respectful care, fear of showing the body to health professionals, perceived cost of using a health facility during birth are all known to contribute to low facility delivery rates [13]. Studies done in Ethiopia revealed that most women accept mistreatment during facility based childbirth as they believe it is for their own benefit (14–17). This shows normalization of mistreatments a known individual-level contributor to be mistreated during child birth [17].

1.2. Statement of Problem

Mistreatment in facility-based childbirth constitutes a huge quality of care problem and is often closely associated with poor clinical quality of care and poor patient satisfaction with care [6]. In addition, mistreatment during childbirth can potentially deter women from seeking medical care in the future, leading to severe negative health implications. Recently, increased attention is being paid to the reasons why women, who know fully the benefits of facility-based deliveries and who have the means to access a facility, continue to choose home births [16]. In Ethiopia, the proportion of childbirths attended by a Skilled Birth Attendant (SBA) in 2016 was 28%, compared to 50 to 53% in other Sub-Saharan African countries, especially in East Africa [17]. One of the reasons for low rate of childbirth assisted by skilled birth attendants is the absence of respectful maternity care and the actual and perceived high mistreatment committed by health providers.

Globally, many women faced disrespectful and abusive treatment from their health care providers during facility based childbirth. Such treatment interrupts the rights of women to RMC; impend their rights to health, life, bodily integrity, and freedom from discrimination. Disrespect and abuse of women during facility-based childbirth is one of the major problems that affects women during labor and delivery, and the most important barriers to maternal health service utilization. However, it is not given attention like other barriers to access and choice of maternal care during labor and delivery. Even though a central component of global efforts to reduce maternal mortality is to ensure that all women have access to skilled care before, during, and after childbirth, access to quality services is not guaranteed for many women, especially in LMICs [22]. Even when services are available by skilled birth attendant, care may be compromised by abusive and disrespectful care during childbirth [23].

The fear of disrespectful and abusive treatment that women often think during facility-based childbirth is a more powerful preventive to use of skilled care than any recognized community barriers such as cost and distance in countries with high maternal mortality [24]. In developing countries, the lack of compassionate and respectful care (CRC) during facility based childbirth continues to raise problems, as shown by maternal morbidity and mortality that could be attributed to low maternity quality of care [25]. D and A during facility based childbirth is responsible for the low healthcare facility based births among the population, hence resulting in slow progress in the attainment of improved health care delivery system. A study conducted in Kenya to identify associated factors with occurrence of obstetric complications, 93.5% cases of women reported disrespect and abuse [27]. This indicates that D and A during labor and delivery is a major contributing factor for obstetric complications.

A study done in Ethiopian public health facilities, 36% of women observed who faced at least 1 form of D and A [28].

A study conducted in Addis Ababa showed that the prevalence of D and A is 78.6% [15]. Since governments have not dedicated to or advanced in sharing accountability mechanisms which guarantee women's rights to RMC, the practice of D and A by health care providers during childbirth continues to occur [29]. As the result, the world community focused its attention to the violence and lack of RMC that many women suffer during facility based childbirth [30]. A qualitative study conducted in Ethiopia indicate the reason that women prefer to give birth at home after experience of facility child birth includes abusive and disrespectful treatment, unskilled care, poor client provider interaction, lack of privacy, and traditional practices are some of the main deterring factors [18].

Disrespectful and abusive care by health care providers during childbirth has the potential to form negative, disempowering and traumatic experiences for women that will inform their future relationships with care providers and the healthcare facilities [1]. There is no study that assesses mistreatment during facility-based childbirth based on the new WHO framework in Oromiya. Therefore, this study aims to assess the magnitude of mistreatment during delivery service in Dodota district public health facility by using the new WHO framework.

1.4. Conceptual Frame Work of the Study

1.3. Significance of the Study

Provision of compassionate and respectful maternity care during facility-based childbirth is one of the augmenting factors to promote facility childbirth. Assessing respectful maternity care during childbirth is core component for improvement of quality of maternity service and to reduce maternal morbidity and mortality. Currently, the issue of non-clinical intra partum practices such as respectful care, provision of emotional support through labor companionship and effective communication in money settings are not regarded as priorities. Therefore, there is no study done considering these WHO priorities during labor and delivery.

Therefore, assessing the magnitude of mistreatment during facility based childbirth using new WHO framework in Dodota district public health facility will help health professionals, health managers and policy makers in designing appropriate intervention to increase compassionate and respectfully maternity care and to improve the health status of mothers. In addition, the result will be used as body of information for further large-scale studies on the same problem.

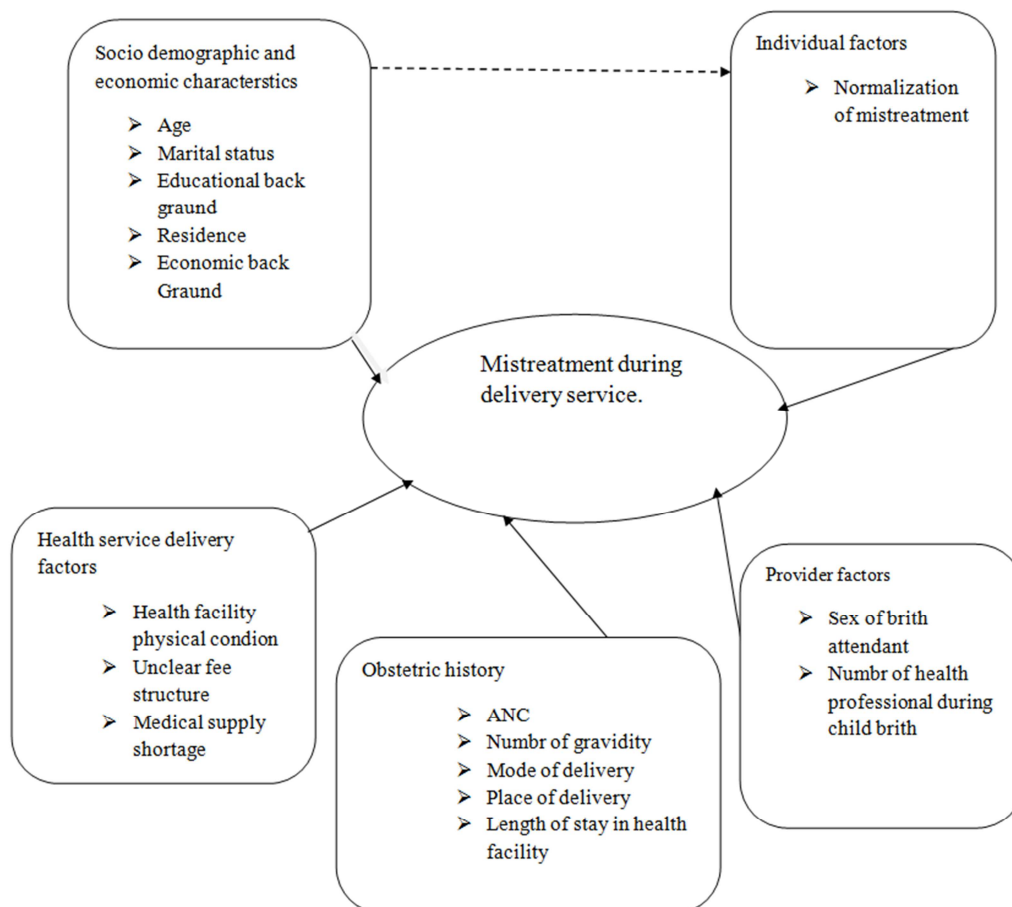


Figure 1. Conceptual framework is adopted from USIAD country TRA project analysis and reviewing different literature on Exploring the proposed relationship between the dependent variable and independent variables for mistreatment during childbirth [16].

2. Objective of the Study

2.1. General Objective

To assess the magnitudes of mistreatment and associated factors among delivering mothers in Dodota district public health facility, Oromiya Region, South East Ethiopia, from January 1 up to February 28, 2021.

2.2. Specific Objectives

- 1) To assess the magnitudes of mistreatment during facility based Delivery in Dodota district public health facility, Oromiya, South East Ethiopia.
- 2) To identify factors associated with mistreatment during facility-based childbirth in Dodota district public health facility, Oromiya, Southeast Ethiopia.

3. Methods and Materials

3.1. Study Area

This study was conducted in the Dodota district, which is one of the 16 woredas in Arsi zone of Oromiya region, Ethiopia. The district is located 125 KMs South East of Addis Ababa, the capital city of Ethiopia. The districts structured in to 15 kebeles (the lowest administrative unit (12 Rural and 3 Urban). The health infrastructure in the woreda comprises of two health centers, 12-health post. According to Dodota district health office report, the total population during 2018/2019 was 93,273. The numbers of women who are in childbearing age group (15-49) were 20706 of which about 1650 received labor and delivery care at public health institution during the year 2019. The estimated six-month average delivery service in Dodota district public health facility is 825.

3.2. Study Design

Institutional based cross-sectional study design was employed using quantitative data collection methods.

3.3. Populations

3.3.1. Source Population

All mothers who have got delivery service in Dodota district public health facility.

3.3.2. Study Population

All randomly sampled women who were got delivery service in Dodota district public health facility during the study period.

3.3.3. Inclusion and Exclusion Criteria

Inclusion criteria

Women who delivered in nominated health centers during the entire study period.

Exclusion criteria

Mothers who are health professionals and/or working in the study facility and give birth were excluded from the study because it is believed that they might be treated with respect

by their fellows. Moreover, in and out referred mothers were also excluded.

3.4. Sample size Determination and Sampling Procedure

3.4.1. Sample Size Determination

The single population proportion formula was used with the assumptions of 67.1% of delivered mothers would face at least one form of mistreatment during childbirth [2]. 5% margin of error (d), 95% confidence level and with the possible 10% non-response rate.

$$\frac{(Z_{\alpha/2})^2 \times p(1-p)}{(d)^2} = \frac{(1.96)^2 \times \frac{0.671(0.329)}{(0.05)^2} = 339$$

Since the source of population (N) 825 less than 10,000, the finite population correction formula were used to reduce the sample size:

$$n = \frac{n_0}{1 + \frac{n_0}{N}} = \frac{339}{1 + \frac{339}{825}} = 240$$

Using the above formula, the estimated sample size of the study sample were 240 from the recent health facility delivered women. For the possible non-response of 10% of calculated sample size will be adjusted as follows, $240 \times 10\% = 264$.

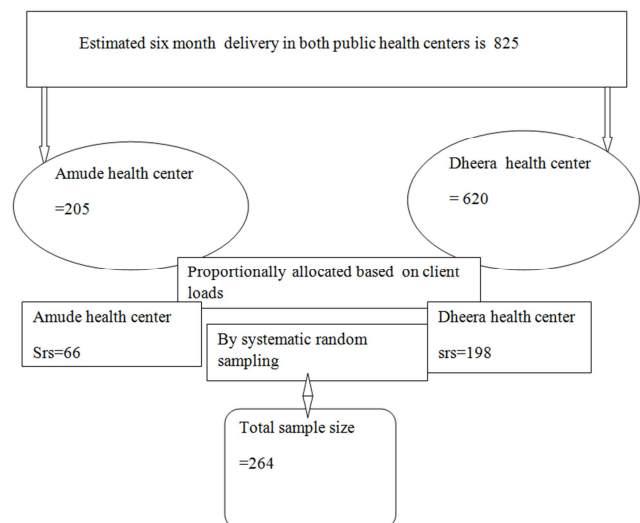


Figure 2. Schematic presentation of the sampling procedure used in the study Dodota district, Arsi Zone, South East Ethiopia, 2021.

NB.

SRS. Systematic random sampling

3.4.2. Sampling Procedure

Systematic random sampling method was implemented to select participants in each of the selected Health facilities by the assumption of: N (the estimated deliveries in six months period in the selected health centers which is 825, and n (required minimum sample size=264 which gives sampling fraction (k) of 3): $k = N/n \Rightarrow 825/264 \approx 3$. To start data collection, the first women from each health center who

come to give birth were selected by lottery method. Every third woman from each health center was included in the study starting from the woman who was selected.

3.4.3. Study Variables

Dependent variable

Mistreatment during delivery service

Independent Variables

Age

Marital status

Residence

Educational background

Socio economic background, Parity

Place of delivery, length of stay in health center

Lack of resource

Physical condition of health facility

Staff shortage

Financial barrier

Normalization of mistreatment

3.5. Operational Definition

Mistreatment: Mistreatment during childbirth can represent a violation of women's reproductive rights [5]. Measured using eight criteria women who answers yes to at least one of the criteria then she was considered as being mistreated during delivery service [1].

Physical abuse: Use of force and physical restraint during child birth, such as beating, slapping, pinching, physically restraining to the bed; measured using five criteria [1]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of child birth.

Verbal abuse: Women faced harsh or rude language, threats and blaming during childbirth; measured using seven criteria [1]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of childbirth.

Stigma and discrimination: Women discrimination based on socio demographic characteristics and medical conditions; measured using four criteria [1]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of childbirth

Abandonment of care: leaving laboring woman alone, women giving birth by themselves at health facilities, failure of care givers to monitor women in labor and intervene in life threatening conditions and ignorance of women during labor and delivery while asking for pain relief or medication; measured using three criteria [1]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of childbirth.

Non-consented care: Providers not giving women or her relatives proper information about medical procedures, not asking for women's permission to conduct medical procedures such as, episiotomies and cervical examinations; measured using two criteria [1]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of child birth. **Non-confidential care:** Giving birth in a public view without privacy barriers such as curtains; and having healthcare providers share sensitive

clients' information, such as HIV status, age, marital status, and medical history, in a way that other people who are not involved in their care can hear; measured using two criteria [41]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of childbirth.

Detention in facilities: Detaining of mothers in health facility against her will using power: deprivation of liberty and self-determination; measured using one criterion [41]. A woman who answers yes to this criteria then she was considered as being abused at the time of labor and delivery.

Ineffective communication: Not interacting with the woman's companion of choice to provide clear explanations on how the woman can be well supported during labor and childbirth; measured using ten criteria [41]. A woman who answers yes to at least one criteria then she was considered as being abused at the time of childbirth.

3.6. Data Collection Tools and Procedure

Mistreatment during childbirth was measured using 8 performance standards (categories of disrespect and abuse) and 34 verification criteria according to the new WHO framework of mistreatment of women during childbirth [1]. Semi Structured and pre-tested questionnaire was used to collect data from the study participants. The tool consists of three sections the first section were use to assess socio-demographic characteristics of mother, the second section were used to assess obstetric characteristics of participants and the third section were used to assess categories of mistreatment women experience during facility child birth. The questionnaire were designed in English, translated in to official language Amharic and Afaanoromo by language expert, and then translated back to English by a third person (language expert) to check for consistency. Data were collected by semi structure interviewer administrated questionnaire. Three-diploma holder female was selected to collect the data and one BSc holders nurse as supervisors from other area outside of study site. Before data collection data Collectors and supervisors were trained on the objective, benefit of the study, individual is right, Informed consent and techniques of the interview for one day.

3.6.1. Data Quality Control

Before starting the actual data collection to assure the data quality high emphasis was given to designing data collection instrument, first the questionnaire was pre-tested on 5% of sample in awash health center, after pre-testing further adjustments to the data collection tool were made to improve clarity, understandability, and simplicity of the messages.

All of the questionnaires are checked for completeness and accuracy before, during and after the period of data collection. Throughout the course of the data collection, interviewers were supervised, regular meetings we held between the data collectors and the principal investigator together in which problematic issues arising from interviews during the data collection and mistakes found during editing was discussed. The collected data was again reviewed and checked for completeness before data entry. Data entry

format template were prepared and programmed by principal investigator.

3.6.2. Data Analysis

For quantitative collected data was checked manually for completion and any incomplete or misfiled questions then the data were cleaned and stored for consistency and entered in to Epiinfoversion 7.2.3 software then it was exported to statistical package for social sciences (SPSS) version 23 software for analysis. The verification criteria were dichotomized responses, “Yes” or “No” to identify reported events of mistreatment. For categories of mistreatment with more than one verification criterion, a woman was labeled as “mistreated in the respective category” if she reported “Yes” to at least one of the verification criteria during childbirth. On the other hand, if a mother is identified as having face mistreatment in at least one of the eight categories, she is considered mistreated.

Descriptive statistics was done and presented using, frequency, mean, standard deviation, tables and figures. Initially, bivariate logistic regression was carried out to see the association of each of the independent variables with the outcome variables. Thereafter, the multivariate logistic regression method was used. The variables that are not significant in the bivariate logistic regression were not considered in the multiple regression analysis. P- Value of <0.05 and 95% confidence level is used as a difference of statistical significance.

The multicollinearity effect between independent variables was checked using tolerance and variance inflation factor. AOR represents the measure of association obtained following adjustment for other factors/confounders. The fitness of the model was confirmed by HosmerLemeshow statistic test. Finally, results were compiled and presented using tables, graphs and texts.

3.7. Ethical Considerations

To conduct this research project, ethical approval was

secured from Institutional Review Board (IRB) of School of Public Health at Adama Hospital Medical College. Written permission from Dodota District Health office was obtained following permission from Adama hospital and medical college. Each randomly selected participant was briefed about the aim of the study and selection process and benefit of the study along with his or her right to refuse. Furthermore, the study participants were reassured for an attainment of confidentiality for the information obtained from them and written consent was taken before passing to interview.

3.8. Dissemination of Result

The results of this finding will be disseminated or communicated to Adama hospital and medical college school of public health, Arsi zone health office, Dodota district health office and other concerned bodies through reports and publication on an appropriate journal. Efforts will be made to present the results on scientific conferences and publications will be considered.

4. Results

4.1. Socio Demographic Characteristics

Two hundred sixty four delivering mothers were planned to be included in the study and it was possible to interview 239 making a response rate of 90.5. Mean age of the respondents was 27.6 (SD±4.2) years and 136 (56.9%) of respondent age fall in 25-34 years age group. About 137 (57.3%) of the study participant were urban residents and 203 (84.9%) of them were married. Concerning their educational background and occupation, 104 (43.5%) of the study participant were attended secondary school, and 70 (29.3%) were government employee. The median monthly income was calculated to be 2100 ETB and 148 (61.9%) of the respondents earning below the median income level.

Table 1. Socio-demographic and Economic background of the respondent of Dodota district Oromiya, South East Ethiopia, from January 1-February 28, 2021.

Variable	Frequency	%
Age of mother in year		
15-24	75	31.7
25-34	136	56.9
35 and above	28	11.7
Marital status		
Married	203	84.9
Unmarried	36	15.1
Mother level of education		
No formal education	21	8.7
Read and write	32	13.4
Primary school	33	13.8
Secondary school	104	43.5
College and above	59	24
Mother occupation		
House wife	84	35.1
Merchant	25	10.5
Private employee	60	25.1
Government employee	70	29.3

Variable	Frequency	%
Residence		
Urban	137	57.3
Rural	102	42.7
Mother religion		
Orthodox	59	24.7
Muslim	136	56.9
Protestant	28	11.7
Catholic	16	6.7
Family month income in (ETB]		
Greater than 2100 and above	91	38.1
Less than 2100	148	61.9

NB: ETB Ethiopian birr.

4.2. Obstetrics Characteristics

From the total respondents 195 (81.6%), had a history of ANC follow up for their recent most delivery. More than half (53.1%) of the respondents had at least four visits for ANC service. From the total respondents, 189 (79.1%) of mothers gave birth through spontaneous vaginal delivery. 146 (61.1%) of mothers normalized mistreatment during labor and delivery and from the total respondents, 107 (44.8%) were given birth preparedness education during ANC follow-up.

The median duration of stay of respondents in their respective health facility during labor was estimated to be six hours, although 41.9% of mothers stayed for 24 hours or

more. Mothers were asked to recall the number of health providers who attended their childbirth. Accordingly, less than two service providers at different points attended 51.5% of mothers during childbirth. The sex of the health provider who mainly attended (as rated by respondents) laboring mothers was reported to be female in 57.7% of scenarios. 34.3% and 60.7% of respondents reported that people other than the main service providers had access to see them, got ANC, and delivery service in overcrowded and unclean room during childbirth respectively. In current pregnancy three fourth 165 (69%) of them gave birth at urban health center (Table 3).

Table 2. Obstetric characteristics of mother delivering in Dodota district public health facility, Oromiya, South East Ethiopia, from January 1-February 28, 2021.

Variable	Frequency	%
ANC follow up		
Yes	195	81.6
No	44	18.4
Number of ANC received during pregnancy		
Less than four	112	46.9
Greater than four and above	127	53.1
Mode of delivery		
SVD	189	79.1
Other than SVD	50	20.9
Gravidity		
Prim parity	73	30.5
Multi parity	166	69.5
Any payment asked for recent delivery		
Yes	21	8.8
No	218	91.2
Number of health profession attend delivery		
Less than 2	123	51.5
Greater than 2 and above	116	48.5
Can someone access to see you during delivery other than concerned health profession		
Yes	83	34.3
No	156	65.3
Normalization of mistreatment		
Yes	146	61.1
No	93	38.3
ANC and delivery ward dirty, overcrowded		
Yes	145	60.7
No	94	39.3
Got birth preparedness education		
Yes	107	44.8
No	132	55.2
Types of health facility where you got delivery service		
Urban health center	175	69
Rural health center	64	31
Stay in health facility after delivery service		

Variable	Frequency	%
Yes	133	55.5
No	106	44.4
Medical supply shortage during delivery		
Yes	159	66.5
No	80	33.5
Sex of main provider conduct delivery		
Female	138	57.7
Male	101	42.3
How many hours you stay in health facility after delivery		
Less than 24 hours	54	22.6
Greater than 24 hrs and above	185	77.4

NB SVD. Spontaneous vaginal delivery, Other than SVD include delivery by episiotomy and forceps delivery

4.3. Magnitude and Type of Mistreatment during Facility Based Child Birth

Based on verification criteria for categories of mistreatment we counted mothers who faced at least one condition among the possibilities. Accordingly out of 239 respondents interviewed, 168 (70.3%) (95%CI: 1.579, 2.843) reported having experienced at least one form of mistreatment during facility based Childbirth. The most commonly experienced form of mistreatment was ineffective communication between maternity care providers and women during labor and delivery 159 (66.5%). The second commonly reported types of mistreatment were verbal abuse 153 (64.0%). 144 (60.3%) of respondents were not given consented care and the commonly violated criterion under this domain was the provider did not explain what is being

done and what is expecting through labor 90 (37.7%). 84 (35.1%) of the mothers were not protected from physical abuse. Commonly violated criterion under this domain was health care providers physical hit slapped push and pinch during delivery and labor 71 (29.1%). Among 239 respondents 52 (21.8) were faced non-confidential care. From total respondent 35 (14.6%) reported under this domain were health providers did not use cover or drapes during delivery service to protect mother privacy. Among the total respondents 49 (20.5%) of women experienced discriminated during labor and delivery. Under this domain commonly reported criteria was health providers discriminate by race, religion, ethnicity during labor and delivery (38.9%). In addition to these six (2.5%) of mothers were experienced abandonment or neglect of care. (Table 3 plus figure 3).

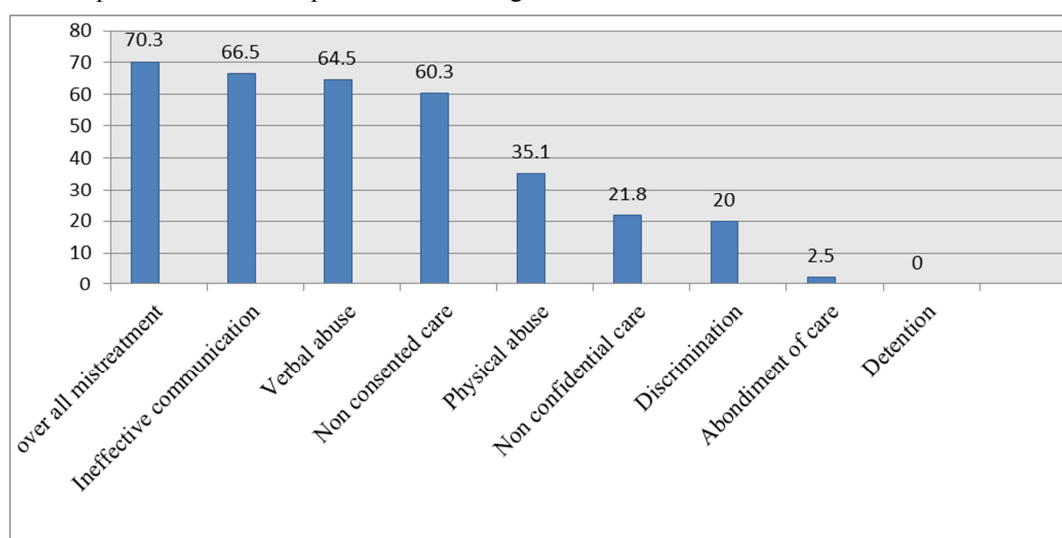


Figure 3. Magnitude of mistreatment by category during facility based childbirth in Dodota district public health facility January 1 –February 28, 2021.

Table 3. Types of mistreatment experienced among women delivering in Dodota district public health facility, Oromiya, Southeast Ethiopia, 2021.

Sno	Categories	Types of mistreatment	Yes (%)	No (%)
1	Physical abuse	Over all mistreatments	168 (70.3)	71 (29.7)
		Hit, slapped push or pinch	84 (35.1)	155 (64.9)
		Restrained to the bed	71 (29.1)	168 (70.3)
		Separate mother from baby without medical indication	23 (29.1)	216 (90.4)
		Receive unnecessary pain relief treatment	17 (7.1)	222 (92.9)
		Denied from food or fluid	8 (3.3)	231 (96.7)
2	Non confidential care	Didn't use drapes to protect mother privacy	6 (2.5)	233 (97.5)
			52 (21.8)	187 (79.1)
			35 (14.6)	204 (85.4)

Sno	Categories	Types of mistreatment	Yes (%)	No (%)
3	Non consented care	Discussed private health information in way that other could hear	18 (7.5)	221 (92.5)
		Didn't obtain consent prior to pelvic examination	144 (60.3)	95 (39.7)
		Didn't explain what is being done and expect through labour	73 (30.50)	166 (69.5)
4	Verbal abuse	Health provider shouted or scolded	90 (37.7)	149 (62.3)
		Support staff insult you and your companion	153 (64.0)	86 (36.0)
		Verbally insult during labour and delivery	113 (47.3)	126 (52.7)
		Health provider through undignified words during pelvic examination	96 (40.2)	143 (59.8)
		Threat you by telling poor outcome	27 (11.3)	212 (88.7)
		Health care provider through undignified words during pelvic examination	27 (11.3)	212 (88.7)
		Health provider made negative comment about you	21 (8.8)	218 (91.2)
		Health provider blame you for your poor outcome	13 (5.4)	226 (94.6)
5	Abandonment or neglect of care	Health provider blame you for your poor outcome	12 (5.0)	227 (95.0)
		Ignored when you called for help	6 (2.5)	233 (97.5)
		Ignored when you called for help	7 (2.9)	232 (97.1)
		Left unattended during second stage of labour	2 (.8)	237 (99.2)
6	Discrimination	Provider refuse to give pain relieve when you ask	4 (1.7)	235 (98.3)
		Discriminate by race ethnicity, religion	49 (20.5)	190 (79.5)
		Discriminate because of teenage	33 (13.8)	206 (86.2)
		Discriminate because of HIV positive	10 (4.2)	229 (95.8)
		Discriminate based on socio economic background	10 (4.2)	229 (95.8)
7	Detention	Discriminate based on socio economic background	22 (9.2)	217 (90.8)
		Discharge postponed until health centre bill are paid	0	239 (100)
8	In effective communication	Discharge postponed until health centre bill are paid	0	239 (100)
		Health provider not introduce them selves	159 (66.5)	80 (33.5)
		Not call by your name during communication	140 (58.6)	99 (41.4)
		Provider not encourage to ask question	134 (56.1)	105 (43.9)
		Provider not respond question with politeness and truth fullness	81 (33.9)	158 (66.1)
		Provider dismiss your concern	42 (17.5)	197 (82.4)
		Provider not respect your need	29 (12.1)	210 (87.9)
		Provider not respect your need	40 (16.7)	199 (83.3)
		Face language and interpretation issue with your provider	40 (16.7)	199 (83.3)
		Provider not support your emotion with compassion and respect	190 (79.5)	49 (20.5)
		Provider not support your emotion with compassion and respect	27 (11.3)	212 (88.7)
		Provider not interacting with companion of choice in clear explanation	20 (8.4)	218 (91.2)
		Provider not gives periodic update on status and progress of labor	21 (8.8)	218 (91.2)

4.4. Factors Associated with Mistreatment Among Delivering Mother

The association of maternal socio-demographic characteristics, obstetrics factors, health service related, individual and provider related factors with experience of mistreatment during facility-based delivery was examined. However, in the final model number of health care provider, medical supply shortage, Sex of main provider and health facility lack of standard were significantly associated with mistreatment (p-value<0.05). The odd of mistreatment

among mother who got delivery service by less than two health care providers were six time higher than their counter parts (AOR=6.080; 95%CI: (2.32, 15.88). The odd of mistreatment among mothers who had got delivery service in facility there was medical supply shortage were five times higher than those had no scarcity (AOR=5.219, 95% CI: (2.53, 10.77). Also the odd of mistreatment among mother whose delivery was attended by male care provider was more than 4.4 time higher than a mother whose delivery was attended by a Female provider (AOR=4.432; 95%CI: (2.83, 11.85).

Table 4. Factors associated with mistreatment during labor and delivery among mothers who have given birth in Dodota district, Oromiya, Ethiopia, 2021.

Variable	Response category	Mistreatment during delivery service		COR: (95%CI)	AOR: (95% CI)
		yes	No		
Residence	Urban	95	42	0.899 (0.512, 1.578)	0.919 (0.45, 1.89)
	Rural	73	29	1.00	1.00
Number of ANC follow-up	Greater than four and above	85	44	1.667 (0.947, 2.941)	0.862 (0.11, 1.80)
	less than four	83	27	1.00	1.00
Parity	Primi Para	50	23	0.884 (0.487, 1.607)	0.791 (0.29, 2.10)
	Multi Para	118	48	1.00	1.00
Number of health providers attend delivery	less than two	105	18	4.907 (2.642, 9.116)*	6.080 (2.32, 15.88)***
	Greater than two and above	63	53	1.00	1.00
Medical supply shortage	Yes	134	25	7.252 (3.919, 13.420)*	5.219 (2.53, 10.77)**
	No	34	46	1.00	1.00
Sex of main provider	Male	69	9	6.35 (3.70, 40.60)**	4.434 (2.83, 11.85)**
	Female	88	73	1.00	1.00
Got birth preparedness	Yes	56	51	0.196 (0.107, 0.360)**	0.354 (0.16-0.75)***

Variable	Response category	Mistreatment during delivery service		COR: (95%CI)	AOR: (95% CI)
		yes	No		
education	No	112	20	1.00	1.00
ANC and deliver ward	Yes	121	24	5.042 (2.778, 9.150)	4.382 (2.14, 8.97)
were overcrowded and unclean room.	No	47	47	1.00	1.00

NB. COR-Crude odd ratio, AOR-Adjusted odd ratio, *- $P < 0.05$, **- $P < 0.01$, *** $p < 0.001$

5. Discussion

Despite the efforts made by the Ethiopian Ministry of Health in advocating for compassionate and respectful care in all settings, this finding indicated that there is a greater need to improve the maternity care that women receive. In this study, we found that the overall magnitude of mistreatment during labor and delivery was (70.3%) which was high among women who delivered at the study health facilities. Ineffective communication, nonconsented care, non-confidential care, verbal abuse, abandonment/neglected care, physical abuse, in health facility and discrimination were the manifestations of mistreatment in this study. The present magnitude of mistreatments higher than findings from a study conducted in Bahir Dar (67.1%) and Bishoftu General hospital (56.3%), Ethiopia [15, 1]. This might be due to that we used eight categories of mistreatment unlike the previous studies. In this study, we added ineffective communication that is crucial to respectful maternity care during labor and delivery. The previous studies used the same definitions for the categories of mistreatments the present study, but used fewer items: whereas 34 items were used in the present study, the studies in Bahir Dar and Bishoftu General hospital used 25, 23 items respectively [15, 1]. In contrast, the current magnitudes lower than the study conducted in Nigeria (98%) and Arba Minch town (98.9%), Ethiopia on mistreatment of women during childbirth in public health facilities [35, 4]. This discrepancy might be due to the difference of study settings.

The previous studies include a hospital and health centers in Ethiopia and Nigerian study at teaching hospital. Similarly, this finding was lower than the same study done in Peru (97.4%) [20, 32, 40]. This inconsistency might be due to the difference in data collection method and study settings. The previous study was collected from direct observation of laboring and delivering mother and from hospital. According to this study, ineffective communication is the most commonly experienced component of mistreatment and its magnitude was (66.5%). This showed that most women faced poor communication that reflects women's social, cultural and linguistic needs, where relevant to labor and childbirth, despite communication being referred to as a core component of high quality, respectful maternity care. This could be due to maternity care providers give less attention to effective communication than other categories of mistreatment.

The most commonly experienced form of ineffective communication was most mother face language and

interpretation issue with their provider and provider did not introduce himself/herself to mother and her companion in respectful manner. This might be due to that health care providers took respectful greeting is not as such important. Asking women for agreement is an important measure of showing respect for the laboring mother. In this study, (60.3%) of laboring mother received non-consented care. This might be due to women did not know they had rights to be asked their consent before any procedures. This figure is similar with findings from study done on Prevalence of disrespect and abuse of women during childbirth and associated factors in Bahir Dar town, Ethiopia that showed that 57.6% of respondents experienced of non - consented care [28]. This also in line with the findings from a study conducted in Nigeria where the prevalence of non-consented care was 54.5% [35]. These similar figures in the two studies may be due to the same verification criteria used to measure non-consented care. This finding was lower than the studies conducted in Peru and Pakistan [33-35]. This discrepancy might be due to data collection method, study period and study place difference. However, this finding was higher than the same study conducted in Tanzania [39]. This inconsistency might be due to difference in health police and implementation program.

The statement of the universal rights of childbearing women states that healthcare providers must protect the patient's privacy and confidentiality during any procedure and when handling a woman's information. In contrast, this study revealed that 21.8% of women had been provided care in a non-confidential manner. This could be due to the lack of appropriate physical barriers like curtains at health facilities and/or poor understanding of the importance of confidentiality during childbirth among healthcare providers. This finding is high from the study that was conducted in urban Tanzania and Kenya [37-39, 23]. This difference might be due to data collection methods. The previous studies found data from direct observation of mothers during labor and delivery. They suffered to Hawthorne effect, in which providers will show acceptable behavior during service provision because they know that they are being observed. According to these findings, the other category of mistreatment experienced by women was verbal abuse (64.0%). This might be due to health care providers took nondignified care as routine care for mothers and neonates benefit. This finding is higher than study conducted in Tanzania and Kenya [39, 23]. This discrepancy might be due to fact that there is socio cultural and socio economical difference that affect professionals'

behavior and their reactions in the context of clinical care. Similarly, the other category of mistreatment reported in this study was abandonment/neglected care during labor, which accounts for (2.5%). This could be due to lack of empathy by health care providers for continuous caring laboring mothers. The other category of mistreatment reported in this study was physical abuse, which accounts the magnitude of 35.1%. This finding is similar with studies conducted in Pakistan and India on women's experiences of mistreatment during facility based childbirth [8, 32]. However, this figure is higher than the studies conducted in Nigeria, Bishoftu General Hospital and Bahir Dar, Ethiopia [43, 1, 25]. This difference might be due to data collection method and study setting.

Number of health care provider, staff and medical supply shortage, sex of main provider, give birth preparedness education during ANC follow-up and health facility lack of standard were significantly associated with mistreatment. In this study, sex of delivery attendant was significantly associated with disrespect and abuse. The odds of mistreatment among mothers who attended their delivery by male providers were 4.4 times higher than those their delivery attended by female. This finding was consistent with study conducted on respectful maternity care in Ethiopian public health facilities from direct observations, revealed that female providers were observed engaging in RMC practices more frequently than male providers [22].

The odd of mistreatment among mothers who had delivery service in facility there was medical supply shortage were five times higher than those had no scarcity. This finding was the same with direct observational study that was conducted in South Africa showed that lack of resource, staff shortage and lack of training was identified factor for mistreatment during childbirth [9]. The odd of mistreatment among mother who got delivery service by less than two health care professionals were six times higher than their counter parts. This finding was consistent with similar study that was conducted at Ghana showed that provider shortage during deliveries was more associated with mistreatment (8). Women who were given education during ANC checkup on birth preparedness faced 65.5% less likely mistreatment care compared to women who were not given on birth preparedness education.

5.1. Strengths of Study

The study tried to measure eight categories of mistreatment based on the new WHO framework using 34 verification criteria. Therefore, it reduces underestimate of mistreatment practices during childbirth.

5.2. Study Limitations

The study assessment relied on self-report, and thus does not provide an objective measure of the frequency of poor and abusive care in facilities. The study also not supported by qualitative study to get information about mistreatment from community leader prospective and maternity caregiver prospective.

6. Conclusions and Recommendations of the Study

6.1. Conclusion

The result revealed that the magnitude of mistreatment is high in Dodota district public health facility during delivery that is 70.3%. The specific types of mistreatment varied from woman to woman, but the most prevalent types of abuse were ineffective communication 66.5% and verbal abuse 64.5% followed by non-consented care 60.3%.

From this study, we can conclude that women receiving labor and delivery care at the study health facilities are exposed to mistreatment to a higher extent suggesting to a need to urgent intervention. This could result in low use of health care facilities, which needs urgent measures by health care managers.

Medical supply shortage, health facility lack of standard, number and sex of health professions are factors associated with mistreatment. The fact women had normalized mistreatment is an indication of the seriousness of the problem which suggests women's desperation to accept abuses as part of the package of services. This study in general indicates the need for a more integrated intervention including empowering all women of childbearing age about their rights at health facilities and the type of care they deserved at health facilities, full filling resource and staff shortage and providing training for all health care providers both on job and during their basic trainings.

6.2. Recommendations for Services

Dodotadistrict health office, Non- governmental organizations dealing with maternal and Child health is had better to immediately embark on programs to lower the unacceptably high magnitude of mistreatment during childbirth.

Dodota district health office is better to address those identified factors to mistreatment. Training for maternity caregivers on childbirth and respectful maternity care, fulfilling staff and medical supply shortage, giving birth preparedness education during ANC follow up and empowering of all pregnant women about their rights during labor and delivery.

For research: Further community-based research incorporated with qualitative method will be needed for policymaking, for educational purpose and to explore the possible reasons of mistreatment during facility-based childbirth

Abbreviation and Acronyms

ANC: Anti Natal Care

CRC: Compassionate and Respectful Maternity care

D and A: Disrespect and abuse

EMDHS: Ethiopia Mini Demographic and Health Survey

FMOH: Federal Minster of Health

L and D: Labor and Delivery

LMIC: Low and middle-income country

MCHIP: Maternal and Child Health Integrated Program

MMR: Maternal mortality ratio

PHCU: Primary Health Care Unite

RMC: Respectful maternity care

TRA: Translating Research to Action

USAID: United State Agency for International Development

WHO: World Health Organization

Acknowledgements

My deepest gratitude goes to Adama Hospital Medical College for giving this chance to prepare the thesis. My valued Instructors, of Adama Hospital Medical College who contributed to my knowledge and skill through their best teaching methodologies and gave me the fundamentals of carrying out of this research.

I would like to thank my advisors Dr. Sileshi Garoma (PhD, Associate professor) and MR. Sultan Kalu (BSc, MPH) for the very detail, exhaustive and constructive comments and advices they gave me for the preparation of this thesis and their willing in helping and giving valuable comments in the subsequent time and also I like to thank Bluestar international health care network who cover full budget need for this study.

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