PREVALENCE OF DISREPECT&ABUSE AND ASSOCIATED FACTORS DURING CHILDBIRTH AT METU KARL REFERRAL HOSPITAL, ILLUABABORA ZONE, SOUTH WEST OROMIA, ETHIOPIA

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A RESEARCH THEESIS TO BE SUBMITTED TO JIMMA UNIVERSITY COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES, COORDINATING OFFICE OF INTEGRATED EMERGENCY OBSTETRICS, GYNECOLOGY AND GENERAL SURGERY (IEOS); IN PARTIAL FULFILLMENT OF MASTERS IN INTEGRATED EMERGENCY OBSTETRICS/GYNECOLOGY AND GENERAL SURGERY.

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ABSTRACT

Introduction: Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care. It is increasingly recognized that disrespect and abuse of women during childbirth is a violation of a woman's rights and a deterrent to the use of life-saving, facility-based labor and delivery services. Providing respectful maternity care services is one of the most important interventions to ensure survival of women. However, respectful maternity care has received less attention both in practice and research. No studies on disrespect and abuse in Mettu Karl Referral Hospital have been identified during my literature search. Hence, there is an urgent need to explore the frequency and the different types of disrespect and abuse among women during facility-based childbirth along with its associated factors. This study may contribute to frame some appropriate evidence based interventions which can be implemented to improve the skilled birth attendance and subsequently, maternal health in the long run.

Objective: To assess the prevalence of disrespect and abuse during childbirth and identify associated factors in Mettu Karl Referral Hospital, South West Oromia, Ethiopia.

Methods: A facility based cross-sectional study that applied both quantitative and qualitative methods was conducted in Mettu Karl Referral Hospital. Sample of eligible women who gave birth vaginally in the health facility during the data collection period was included in the study. Structured questionnaire was used to collect quantitative data and for qualitative data a semi-structured guide was used for in-depth interview of childbearing mothers and health care providers. SPSS version 22.0 was used for data entry and analysis. Logistic regression was applied to identify correlates of disrespect and abuse and thematic analysis was done to analyze the qualitative data.

Results: All childbearing mothers who included in the study faced at least one form of disrespect and abuse. The most commonly abused childbearing women right was mothers' right to confidentiality and privacy with all of them reported that both of the validation criteria were missed. The second commonly abused childbearing women right was mothers right to information, informed consent, and choice/preferences with 250(99.2%) of them reported that at least one of the eight validation criteria for the domain were missed. The multivariate logistic regression found that autonomy of the mother to decide on her health issues (P= 0.006) and educational level of mother (P=0.008) were significantly associated with disrespect and abuse.

Conclusion: This study showed that disrespect and abuse at health facility was prevalent; all child-bearing mothers experience at least one form of disrespect & abuse. This was serious concern for health sector and need due attention, working on fulfilling necessary infrastructure and equipment at facility, empowering and participate women on health issues; train health care providers on the childbearing women rights and aware the community were on their rights.

Key words: Disrespect and abuse, facility based childbirth, childbearing women's right

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LIST OF ACRONYMS

AHC: Abuse in health care

D&A: Disrespect and abuse

EDHS: Ethiopian demographic health survey

ETB: Ethiopian Birr

HSTP Health System Transformation Program

MCHIP: Maternal and Child Health Integrated Program

MDG: Millennium development goals

MKRH: Mettu karl referral hospital

MMR: Maternal mortality ratio

RMC: Respectful Maternity Care

SBA: Skilled birth attendant

SDG: Sustainable development goals

SPSS: Statistical Package for the Social Sciences

TRAction: Translating Research into Action

USAID: United States Agency for International Development

WHO: World health organization

WRA: White Ribbon Alliance

CHAPTER ONE: INTRODUCTION

1.1.Background

Childbirth is an event in a woman's life when her womanhood is celebrated. It is often a life changing event because during this time, the mother goes through a lot of biological, social and emotional transitions (1). A satisfactory childbirth can profoundly affect the future wellbeing of the mother, and her relationship with the baby and family (2).

Respectful maternal care refers to the right of every woman to the highest attainable standard of health, which includes the right to dignified, respectful health care at all health system around the world of childbearing woman throughout her pregnancy, birth, and the period following child birth. This was measured using maternal and child health integrated program (MCHIP) the rights of childbearing mothers during labor and delivery are categorized into seven categories. The right to be free from harm and ill treatment; the right to information, informed consent and refusal, and respect for her choices and preferences, including the right to her choice of companionship during maternity care; the right to privacy and confidentiality; the right to be treated with dignity and respect; the right to equality, freedom from discrimination, and equitable care; the right to healthcare and to the highest attainable level of health; the right to liberty, autonomy, self-determination, and freedom from coercion. These categories overlap and occur along a continuum from subtle disrespect and humiliation to overt violence (3, 4).

Disrespect and abuse (D&A) during childbirth infringes on the basic principles of human rights and violates the fundamental obligation to provide support and healing. Different attempts have been made to define and categorize D&A. Bowser and Hill, in a landscape analysis, categorized disrespectful and abusive care at childbirth into seven types: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities (4).

1.2. Statement of the problem

In 2015, maternal mortality ratio (MMR) was estimated at 216 globally. Almost all of these deaths occurred in low resource settings, and most could have been prevented. During the course of the Millennium Development Goals (MDG) era the global MMR declined by 44% – equating to an average annual reduction of 2.3% between 1990 and 2015. Accelerated progress is now needed as achieving the Sustainable Development Goals (SDG) Target 3.1 will require a global annual rate of reduction of at least 7.3%.The global coverage of skilled attendance at birth was estimated to have reached 73% in 2013(5).

Estimates from Ethiopian Demographic Health Survey (EDHS) indicates a substantial decline in the pregnancy-related mortality ratio in Ethiopia since 2000, from 871 deaths per 100,000 live births to 412 deaths per 100,000 live births in the 2016 EDHS survey. Institutional deliveries in Ethiopia have increased from 5% in 2000 to 26% in 2016. During the same period, home deliveries decreased from 95% in 2000 to 73% in 2016 (6).

In the past few years the relationship between lack of quality of care and adverse maternal outcomes is being highlighted globally. The World Health Organization (WHO) recently issued a statement for the prevention and elimination of disrespect and abuse during facility-based childbirth. Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care (7).

Most laboring women prefer to be in an environment where they feel secure, respected and can receive emotional and physical support from their families. They also want to practice cultural and traditional rituals which are common during birthing process. Whilst acknowledging that a lack of awareness of the risks of pregnancy and childbirth, transportation and money are common barriers, disrespect and abusive maternal care is another often unspoken but major deterrent that affects women from accessing maternity care at health facilities thereby contributing to maternal deaths(8).

It is increasingly recognized that disrespect and abuse (D&A) of women during labor and delivery is a violation of a woman's rights and a deterrent to the use of life-saving, facility-based labor and delivery services. In Ethiopia, rates of skilled birth attendance are still only 28% despite a recent dramatic national scale up in the numbers of trained providers and facilities. Concerns have been raised that women's perceptions of poor quality of care and fear of mistreatment might contribute to this low utilization (9).

This low utilization in Ethiopia also has been shown to be associated with women's education levels, residence, ethnicity, parity, autonomy and household wealth, among other factors (10-12). Other studies in Ethiopia also show that perceptions of poor quality of care such as lack of privacy and lack of psychosocial support, are significant factors in a woman deciding whether or not to give birth at a health facility (13, 14).

While many interventions aim to improve access to skilled birth care, the quality of relationships with caregivers has received less attention. Evidence suggests that in countries with high maternal mortality, the fear of D&A that women often encounter in facility-based maternity care is a more powerful deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance (15).

In accordance with Bowser and Hill's landscape analysis, it assumed that mistreatment during childbirth influences women's decision to seek out facility delivery in subsequent pregnancies, exposing women and neonates to the risks associated with labor and delivery birth without the assistance of a skilled birth attendant. Though this pathway is generally perceived as intuitive and many experts agree on its validity, it has not yet been definitively demonstrated that there is actually a direct correlation between experiences of mistreatment, low rates of institutional delivery, and adverse maternal and perinatal outcomes, postpartum visit or infant health visits, maternal postpartum depression and post-traumatic stress disorder, particularly in cases of extreme abuse (4, 41).

No studies on D&A of women by health providers during facility-based childbirth in Mettu Karl Referral Hospital (MKRH) have been identified during my literature search.

Hence, there is a need to explore the frequency and the different types of disrespect and abuse among women during facility-based childbirth along with its associated factors.

As for public health relevance, this study may contribute to frame some appropriate evidence based interventions which can be implemented to improve the skilled birth attendance and subsequently, maternal health in the long run.

1.3. Significance of the study

Globally an unacceptably high number of women and newborn continue to die during the process of childbirth and this is an important public health problem especially in developing countries where most the deaths and disabilities occur. The causes of maternal and neonatal deaths during childbirth are known and can be handled when deliveries are conducted by health care workers in hospitals. However, almost 50% of women do not deliver in health facilities.

The reasons for failing to use skilled services during delivery have been studied a lot and include increased distance, high cost of services, low staffing levels and even lack of supplies. There is inadequate research on the role of disrespect and abuse of women during facility based deliveries in decreased utilization of maternity services. This study aimed at filling this gap in knowledge.

The information that generated through this research may also assist policy makers to design appropriate programs addressing disrespect and abuse of women during delivery. Once addressed this would lead to increased maternity service utilization during delivery and hence decrease in maternal and neonatal mortality & morbidity.

CHAPTER TWO: LITERATURE REVIEW

2.1. Literature Overview

Most of the literatures reviewed shows D&A during delivery occur globally. However there is still limitation of studies especially on national prevalence and majority of the studies are qualitative (9, 14, 15, 27, 29, 42, 43, 45…..). Such descriptive studies have been done in Tanzania (17), South Africa (42), Malawi (43), Kenya (22, 23), Peru (19) and Nigeria (21, 39).

Studies on D&A during facility based deliveries are limited and especially the studies on global prevalence. This apparent lack of adequate research on the phenomenon prompted the WHO to release a press statement calling for accelerated research and advocacy (7).

The available studies are not based on a universally agreed operational definition and most are small studies that not nationally representative. Nevertheless, a commendable research on D&A has been done in Nordic countries although the work is based on a wider construct called Abuse in Health Care (AHC) of which D&A is a subset (16).

Most of the evidence gathered on disrespect and abuse during childbirth in facilities was either in the form of qualitative studies or documentation of anecdotal statements. As a result, the approximate burden of disrespect and abuse occurring in facilities are not well known (17).

Health professionals' attitudes towards patients is a critical element of care for successful labor outcome and non-medical factors such as cost, perceived quality of care and proximity to services. These components of care were influential on women's expectations which in turn influence acceptability and uptake of services (18).

2.2. Prevalence of D&A

Women in labor in United States reported non-consented care, operative delivery without indication, misrepresentation of medical situation, and even verbal abuse like scolding, shaming, coercing, and mocking (43).

Study done in Peru on 1528 postpartum women shows that the prevalence of having suffered at least one category of D&A was 97.4%. The most prevalent D&A category was non-dignified care (86.2%), followed by non-consented care (74.6%). Women in the jungle had a lower prevalence of abandonment of care and a higher prevalence of discrimination, women in the highlands had a lower prevalence of non-dignified care, compared to those in the coastal region (19).

A recent systematic review show that proportion of women who reported experiencing any mistreatment during childbirth was 19.5%; with common specific experiences included "non-dignified care (12.9%).This review also concluded that 'women wanted health professionals who combined clinical knowledge and skills with interpersonal and cultural competence' (20).

In another study done which was conducted on women coming to the immunization clinic in a teaching hospital in south-eastern Nigeria, 98% reported disrespect and abuse with physical abuse as high as 35.7 percent (21).

In a Ghanaian study, 98% of all the respondents reported experiencing at least one form of disrespect and abuse during delivery in the maternity units. The most common manifestation of D&A was non consented care 54.5% and physical abuse 35.7%, non-dignified care accounted for 29.6% of the cases, abandonment 29.1%, and detention in health facility 22%, and discrimination 20% (21).

In a facility and community survey carried in rural Tanzania, 19.1% of women in the exit sample and 28% in the follow-up sample reported having experienced at least one form

of disrespect and abuse (17). According to the same study the, specific D&A events reported by women were; being ignored by the health worker 14.24%, being shouted at 13.18%, threatening or abusive comments 11.54%, being slapped or pinched 5.1%.Approximately 5.31% of the women delivered without any assistance from a health worker (17).

Study in Kenya showed that 20% of women reported any form of D&A. Manifestations of D&A includes: non-confidential care (8.5%), non-dignified care (18%), neglect or abandonment (14.3%), nonconsensual care (4.3%) physical abuse (4.2%) and, detainment for non-payment of fees (8.1%). Women aged 20-29 years were less likely to experience non-confidential care compared to those under 19; Clients with no companion during delivery were less likely to experience inappropriate demands for payment; while women with higher parities were three times more likely to be detained for lack of payment and five times more likely to be bribed compared to those experiencing there first birth (22).

Another study done in Kenya 71.9% reported having experienced at least one form of D&A during childbirth, while only 28.1% did not experience any form of D&A. Majority of the women 67.1%had un-consented procedures with 38.2 % of the women being given unconsented episiotomies, 55.6% un-consented vaginal examinations while 31.4% had the episiotomies sutured without their consent. A total of 41.5% of the women reported having been physically abused with 28.5% having had their episiotomies and tares sutured or repaired without pain killers, 27.5%of the women reported having been beaten, slapped or pinched when giving birth. This was corroborated by one woman, who said *"…as she was assisting me to give birth she bit me with scissors and told me to behave"*. Another woman also experienced similar abuse and put it thus; *"Yeeees… the beating is always there! I was beaten by a male nurse and I felt very bad"*. The women who reported non-dignified care were 53.1% with 38.6 % and 35.7% of the women reported having been blamed, intimidated during childbirth and threatened with caesarean delivery for shouting and screaming in pain respectively. Other forms of non-dignified care included; being left naked after giving birth 1% (23).

Study done in Addis Ababa, Ethiopia showed that D&A was identified to be practiced in 96.5% of the deliveries surveyed. Failure to maintain women's right to information, lack of informed consent, and failure to maintain choice/preferences; all forming a single indicator, were the common problems reported by 95.4% of clients followed by leaving mothers without attention (39.3%). Though the level of practice of D&A was found to be very high, only 12.7% of mother claimed to have been disrespected and abused during childbirth, which shows that there is normalization of D&A in the study area. Besides, 77.2% of providers reported that disrespecting mothers based on any specific attribute was practiced in the three months preceding the survey (24).Furthermore, 79.6 % of providers believe that lack of respectful care is a factor which discourages pregnant women from coming to health facilities for delivery (25).

Another study in Ethiopia showed that 21% of women reported any experience of disrespect or abuse. The most commonly reported categories of D&A were non-consented care (17.7%), lack of privacy (15.2%), and non-confidential care (13.7%) (26).

In Ethiopia, qualitative study revealed that most health care providers insulted the women in labor. Some women also reported that health care providers were not friendly and mistreat mothers who went to health facilities to deliver. Women who delivered at health center disclosed that health workers uses rough words, insults and shows no respect to them and for those who accompanies them`. In addition, the women revealed that they are told to wait for long hours and referred without receiving any support from the health workers. The findings also revealed that all staffs of the facility abuses the pregnant women in addition to health care providers. In general, the report has revealed that there are problems of disrespect and abuse in health facilities that discourage mothers to deliver at health facilities (27).

2.3. Factors associated with D&A

I. Socio-demographic Characteristics

Although disrespect and abuse in facility based deliveries has not been exhaustively studied, there are socio-demographic characteristics that appear to be associated with D&A during delivery (22, 24, 28, 29, 42, 46, and 47). But in one study in Kenya and other in Nigeria said there is no relationship between maternal socio-demographic characteristics and D&A during delivery (21, 23).

AGE: Study in Kenya showed that health workers were particularly abusive towards young mothers for having an early active sexual life and did not provide medical care despite the seriousness of their condition (22, 29). In the Nordic study by Brüggemann abuse in health care was found to be associated with young women, women who experienced childhood abuse and women with little or no knowledge of their rights in a health care set-up (28).

Educational status: In the Nordic study by Brüggemann abuse in health care was found to be associated with women with little or no knowledge of their rights in a health care set-up (28).Other a multidisciplinary study shows illiterate mother's experience disrespectful and abuse during maternal care (29).

Income: In countries that still have a user fee system, poor women may be detained in the hospitals for failure to clear the required bills after delivery as indicated in the research in Ghana where 22% of the women in the sample were detained (21).In an Ethiopian study, women with a higher monthly incomes were less likely to experience D&A as compared to those with a lower monthly income (24). Other a multidisciplinary study showed that economic background of mother were significantly associated with their experience of disrespect and abuse during giving birth that is women with very low monthly income (29).

Ethnicity/ race: In Tanzania, women of the Pogoro tribe were abused as they could not produce 'vifaa' (essentials required during delivery), 'asante' (thank you tip) or if their husband was a drunkard (46). Likewise, women of the Kichwa tribe in Ecuador were habituated to deliver only by giving pressure vertically and were selectively abused when they could not deliver in the typical supine position preferred by the health providers (47).In South Africa study, young black

women are abused and disrespected more as compared to young white females during delivery (42).

Parity: Study in Kenya said women with a higher parity were found to be more likely to be detained for non-payment and be solicited for bribes (22).

Marital status: The same study in Kenya also said women who had no companion during labor and delivery and single women were more likely to be disrespected and abused and married women were less likely to be detained for lack of payment (22).

Maternal factors

.Individual

-Normalization of disrespect and abuse during childbirth

A core theme that emerged during many interviews concerns the normalization of disrespect and abuse in facility-based childbirth for many women who have never known any other system of care or been exposed to concepts of patient rights. The autonomy, dignity, preferences, and fundamental human rights of women giving birth are so frequently violated that such care is seen by the community as normal (24, 30).

-Lack of community engagement and oversight

Community and civil society oversight and participation in management of facility health services have been demonstrated in some studies to improve demand for quality of care and to increase accountability of facility providers and managers. For example, in a humanization of childbirth study in Ecuador, community health members worked closely with facility providers sometimes as part of quality improvement teams, to improve responsiveness of childbirth services to client needs and preferences with some success (31).

-Financial barriers

One of the important barriers to both respectful and non-abusive care in childbirth as well as skilled birth care utilization is the financial status of the woman and her family (32-34).

-Lack of autonomy and empowerment

While there is little empirical evidence explicitly linking a lack of women‘s autonomy and empowerment to disrespectful and abusive birth care, there is evidence that female autonomy and empowerment are associated with improved choices for childbirth (35-38).

Health Care Provider factors

Determinants of the attitudes and behavior of the provider may include factors such as their working conditions, including workload, stress, lack of privacy, and fear of infection, their level of training and communication skills, norms in the workplace including the influence of role models, their personal characteristics, including gender, culture, ethnicity, and class, and personality attributes such as self-confidence, caring, courtesy, and charisma (44).

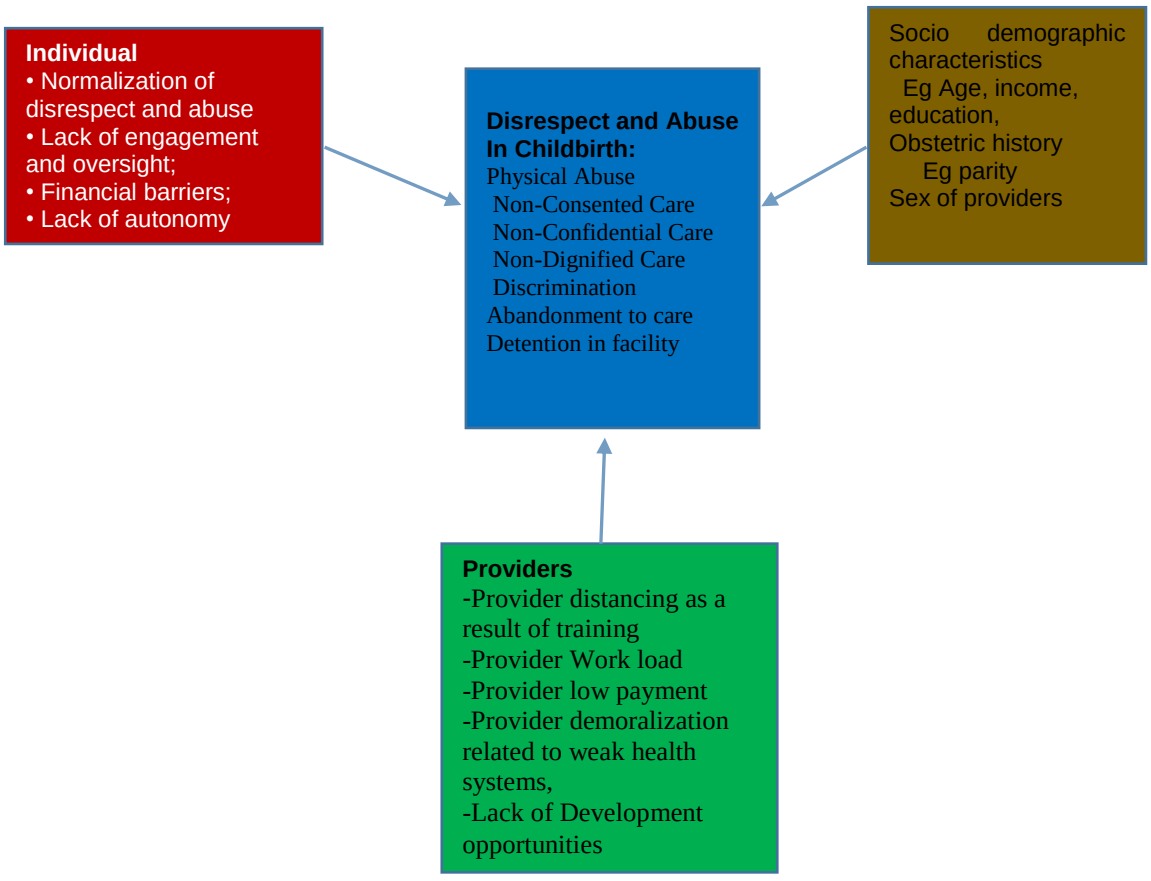
A qualitative study done in labor ward of a Palestinian public referral hospital showed factors that makes midwives D&A during care were high workloads, low pay, poor supervision, lack of supportive guidance, and being humiliated at work. The study found the responsibilities and duties of midwives greatly exceeded those of both doctors and nurses. Despite their high level of education, they also reported the lowest salary. Some of the midwives described themselves as *‘machines’*: *“They give us workloads that are extremely exceeding our abilities as individuals and humans. It’s insane!”* (45).

In South Africa’s study Midwives said that problems such as understaffing, poor pay, heavy workloads, and lack of equipment and medical supplies contribute to negative attitudes, abuses and poor quality of care (42). One midwife said: *“I know we are not always right, but the department forgets our problems. You work so hard and there is no appreciation. At the end of the month you earn peanuts.”* Some managers were aware that poor behavior often results from excessive stress: *“The nurse asked the client about her HIV status and an argument ensued. The sister slapped the client. It was a busy time and we had gross shortage of staff on that day. We had many complicated cases and were preparing women for theater. So everybody was stressed.”*(42)

2.4. Conceptual frame work

Based on USAID country analysis report described seven major categories of disrespect and abuse that childbearing women encounter during maternity care (4). In order to measure the level of disrespect &abuse of childbearing mothers and associated factors this frame work is important. As facility based Cross sectional study this research mainly was focused on individual level, at provider and socio-demographic characteristics& obstetric history.

Figure 1: Conceptual framework of disrespect and abuse



CHAPTER THREE: OBJECTIVES

3.1. General Objective

To assess the prevalence of D&A during childbirth and identify associated factors among women who gave birth at MKRH, South west Oromia, Ethiopia.

3.2. Specific Objectives

i. To determine the prevalence of D&A of women during childbirth in MKRH.

ii. To determine the relationship between socio-demographic characteristics of women and D&A during childbirth in MKRH.

iii. To explore health care providers factors facilitating D&A during childbirth in MKRH.

CHAPTER FOUR: METHODS & MATERIALS

4.1 Study area and period

The study was conducted at MKRH, Illuababora Zone, Southwest Oromia, Ethiopia from January 2017 G.C to April 2018 G.C, which is about 595 km from Addis Ababa. It was established by Swedish Missionaries & RasTeferi in1932. It is one of the referral and teaching hospitals in the country giving services to people living in Ilu Aba Bora zone and its surroundings estimated to be 1.47 million people. In the hospital there are 161 health professionals of different fields including specialists, Integrated Emergency surgery (Obstetrics, Gynecology and General Surgery) (IESO), general practitioners, health officers, nurses, laboratory technicians & 143 supporting staffs. The number of pregnant mothers in catchment per year is 55,860. There are a total of 160 beds in the surgical, medical, gynecology-Obstetrics & pediatrics ward of the hospital. Of which 48 beds (38 gynecology ward & 10 in obstetrics ward) and 3 delivery Koch's are found in the gynecology and obstetrics ward. It is also serving as a clinical post graduate attachment site for MSc in Integrated Emergency Obstetrics, Gynecology and General Surgery, BSc in Public Health, BSc Nurse and BSc Midwifery. Department of Obstetrics and Gynecology has two wards (Gynecology and obstetrics), one MCH clinic, one Gynecologic referral clinic, one family planning clinic. It has one Obstetrician & Gynecologist, Two IESO and thirteen midwifes. Data collection was done from January 2018 G.C to April 2018 G.C.

4.2 Study design

A Hospital-based cross-sectional study design was applied. The study had two components: 1) Quantitative assessment of disrespect and abuse during childbirth (Quantitative study), and 2) In-depth interview of mothers and health care providers (Qualitative study).

4.3 Study Population

4.3.1 Source population:

The source population was all women who gave birth in MKRH.

4.3.1 Study population:

Women who gave birth vaginally at MKRH during the study period.

4.4 Eligibility Criteria

4.4.1 Inclusion Criteria

Women who gave birth vaginally in MKRH.

4.4.2 Exclusion Criteria

Women who gave birth vaginally and unable to hear and speak in MKRH

4.5 Sample Size and Sampling Procedure

Quantitative Study: A single proportion formula was used to estimate the sample size required for the study. The sample size calculation assumed the proportion (p) of women experiencing one or more category of disrespect and abuse from past study done in Kenya that reported 20% of them had experienced D&A (22), 5 % margin of error (d), with 95% confidence level($P<0.05$), and 10% non-response (refusal to be enrolled and drop outs). Accordingly, the total sample size was estimated at 256.Consecutive sampling procedure was used that is maternity care users at postnatal care who delivered vaginally in the hospital and who was willing to participate in the study was included in the study until the calculated sample size was attained during the data collection period.

Qualitative Study: In order to ensure richness of data to be gathered, participants was purposively sampled for in-depth interview based on their exposure to disrespect and abuse immediately after quantitative data collected. In addition, health care providers who was involved in the provision of maternity care was included in the in-depth interview to explore factors that makes them D&A during childbirth. So I used the minimum sample size that used for in-depth interview. Based on that I took12 samples from maternity care users and 6 samples from health care providers. The qualitative data from mothers and health care providers was used to assess the same aspects of the services that was assessed through the quantitative data to improve validity of the conclusions and to explore factor why midwives D&A mothers during childbirth.

4.6 Data Collection Procedure

Quantitative Study: Data was collected using a pretested questionnaire. The questionnaire was developed based on the items developed by Maternal and Child Health Integrated Program (MCHIP) to assess disrespect and abuse. The MCHIP respectful maternity care standard described seven major categories of disrespect and abuse that childbearing women encounter during maternity care. These are physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities(3).

Data collectors was trained and collect data by interviewing childbearing women at the exit. During data collection the investigator was regularly discussed with the data collectors on issues of concern that they encountered.

The categories have respective verification criteria such as for physical ill treatment there are seven verification criteria (physical abuse, verbally (insulting) abuse during labor or delivery, denied from food or fluid, separate mother from baby without medical indication, receiving unnecessary uncomfortable/pain-relief treatment, support staffs insult me and my companion and demonstrating caring in a culturally inappropriate way) and for the remaining six categories they have their respective verification criteria (4).

Other variables (socio-demographic variables, obstetric characteristics, past history of institutional birth, sex of service providers ,number of service providers attending the labor and birth, profession of the service provider and total length of stay of mother in the health facility) was added to the data collection tool as additional information.

Qualitative Study; In-depth interview was conducted with mothers and health care providers using semi-structured guide to conduct the interviews. The interviews was Mobile sound-recorded and note was also taken. Mothers was asked about their experience during care, whether there were anything that makes them unhappy, whether physically or verbally abused etc. Providers was asked to explore factors why they disrespect and abuse mothers during childbirth.

4.7 Operational Definitions

Respectful maternity care: is the human right of childbearing mother's throughout her pregnancy, birth, and the period following childbirth; which is measured using seven specific rights standard and with 25 verification criterias.

Disrespect and abuse: is rude conduct and usually considered to indicate a lack of respect or violation of maternity care rights of mothers; at least one of the criteria is missed, it classified as disrespected and abused.

Physical Harm or Ill Treatment: physical force or abrasive behavior with mother, including slapping or hitting or demonstrating care in a culturally inappropriate way; measured using 7 criterias:

1. Physically abused during labor/delivery (force/slapped /hit/beat)
2. Verbally (insult) abuse during labor or delivery
3. Separate mother from baby without medical indication
4. Denied from food or fluid in labor unless medically necessitated
5. Receiving unnecessary uncomfortable/pain-relief treatment
6. Support staffs insult me and my companion
7. Demonstrating caring in a culturally inappropriate way

Non-confidential care: lack of confidentiality and lack of privacy during maternal care; measured using two criterias:

1. Providers didn't use drapes or covering to protect mother's privacy
2. Delivery couches/beds not separated by screen

Non-consented care: absence of informed consent, or patient communication, forced procedure, measured using 8 criterias.

1. Providers not introduce themselves
2. Providers not encourage mother to ask questions
3. Providers not respond mother's question with promptness, politeness and truthfulness

4. Provider explain what is being done and what to expect throughout labor and birth
5. Providers didn't give updates on status and progress of your labor
6. Providers deny mother to freedom of movement during labor
7. Providers deny mother to choice of position for birth
8. Mother lack consent or permission prior to any procedure

Non-dignified care (including verbal abuse): Lack of dignity, respect and intentionally humiliating, scolding, or shouting at patient's value and for women; measured using 1 criterion.

1. Provider didn't speak politely

Discrimination based on specific attributes: Lack of equality, freedom from discrimination and equitable care; measured using three criterias:

1. Providers discriminates by race, ethnicity, and economic status
2. Mother detained at the facility because of lack of payment of fees
3. Providers speaks in a language and at a language-level that mother can't understand

Abandonment or denial of care: Lack of right to timely healthcare and to the highest attainable level of health, measured using two criteria..

1. Mother lack encouragement of call if needed
2. Provider didn't come quickly when the mother called him/her

Detention in facilities: detaining of mothers in health facility: deprivation of liberty, autonomy, self-determination, and coercion; measured using two criterias.

1. Mother left alone or unattended during labor and delivery
2. Mother detained in health facility against her will

Normalization: In some cases, women who have no experience with other health facilities and who have never been introduced to the concepts of patient or human rights have normalized the occurrence of disrespect and abuse during facility-based childbirth.

4.8 Study Variables

4.8.1 Dependent variables

Disrespect & abuse

4.8.2 Independent variables

Race

Residence

Sex of health care provider

Religion

Age

Decision maker for the women to seek care

Poverty

Occupation

Marital status

Educational level

Income

Parity

Qualification of health care provider

Provider Work load

Provider low payment

Lack of engagement and oversight;

Provider demoralization related to weak health systems,

Lack of development opportunities

Normalization of disrespect and abuse

Financial barriers;

Lack of autonomy

4.9 Data quality control

Before the start of the data collection the data collectors and supervisors who work outside the studying facility was received training on the objective and data collection method for two days. Topics addressed in the training includes data collection method, objective of the study, how to ask respondents each of the questions, basic category of respectful maternity care and their verification criteria etc. In addition, data collectors was trained on how to undertake in-depth interview one by one and discussed their meanings and operational definitions. Furthermore, maintaining confidentiality and privacy of the study participants was addressed during the training.

Data collectors was also supervised during data collection. Supervision includes observing how data collectors administer the questions to the respondents and daily meeting with data collectors to review the filled questionnaires and discuss on issues of concerns that data collectors encountered during data collection.

4.10 Data Processing & Analysis

Quantitative Study: After collection of quantitative data, the questionnaires was cleaned, sorted then coded. Data entry was then done using SPSS Version 22 data editor followed by analysis. For category of disrespect and abuse with more than one criterion, women was considered they experienced disrespect and abuse category, if they faced at least one of the verification criteria under that category. On the other hand, mothers was considered they experienced disrespect and abuse if they experienced at least one of the seven categories of disrespect and abuse. Descriptive statistics was done and presented using tables. The availability and strength of associations of independent variables and dependent variable was assessed using Binary Logistic regression, multiple Logistic regression analysis and statistical significance was declared for $P<0.05$. Selection of independent variables for the multiple Logistic regression model was based on significant association on bivariate Logistic regression ($P<0.05$). In addition, variables documented to have association in other literature was considered even if they have $P>0.05$ on bivariate Logistic regression.

Qualitative Study: Microsoft Word was used to analyze the qualitative data. In-depth interview was done on 18 respondents (12 childbearing women, and 6 health care providers). All interviews was recorded and transcribed into Amharic and then to English. After repeatedly read the data was entered into Microsoft Word. Coding, categorizing and tabulation was done and themes developed. Thematic analysis was employed to analyze the data. Use of the thematic analysis framework gave an opportunity to understand the issue more widely and visualize data using quotations. It aimed to provide evidence, support and validate interpretations. Finally the data analysis process was linked by arranging and organizing concepts and thoughts. Data

collection and analysis was done simultaneously in order to update the questions and know if saturation is reached.

4.11 Ethical Considerations

Ethical approval was obtained from Institutional Review Board of College of Health Sciences of Jimma University, IlluAbabora zonal health office was also asked for permission and wrote a support letter to childbirth in MKRH. Permission to conduct the study was also obtained from childbirth in MKRH. Informed verbal consent was taken from each study participant prior to the interviews. Data was collected anonymously to ensure confidentiality. Informants was assured that only the investigators will access to the data and no third party would have access to their individual information and recognize them in the report. If a serious of disrespect and abuse is found during interview mother will be counseled and if possible will be linked for psychological support.

4.12 Plan for Dissemination of Result

The result of this thesis will be submitted to Jimma University College of Public Health & Medical Sciences, IlluAbabora Zonal Health office and respective health facilities and Ministry of Health of Ethiopia. It will be also submitted for national and international journals for publication.

CHAPTER FIVE: RESULTS

5.1 Socio-demographic and Obstetric history profile of respondents

5.1.1 Socio-demographic profile of respondents

From a total of 256 mothers who were invited for interview 252 consented to participate in the study and 4 mothers declined from the study giving a response rate of 98.4%.

In terms of demographic characteristics the mean age of the mothers was 24.9 years, 34.9 % (n=88) were aged between 21 and 25 years and 28.2%(n=71)were aged between 26 and 30 years, 96.0% (n=242) were married, 40.5% (n=102) had primary level of education. The main occupation of the respondents was housewife 46.0% (n=116) while 40.9% (n=105) , had an estimated monthly income between 1500-2999 ETB With average income of 3609.52 ETB. 81.7% (n=206) were Oromo in ethnicity, 38.1 %(n=96), 35.3 %(n =89) were protestant and orthodox in religion respectively. 53.6 %(n= 135) were urban inhabitants.

TABLE 1: SOCIO DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS, MKRH, SOUTHWEST OROMIYA, ETHIOPIA 2018

Variables	Frequency	Percent
Age in complete years		
15-20	60	23.8
21-25	88	34.9
26-30	71	28.2
31-35	22	8.7
36-40	11	4.4
Total	252	100
Marital status		
Married	242	96.0
Single	3	1.2
Divorced	5	2
Widowed	2	0.8

Total	252	100
Educational level		
Illiterate	38	15.1
Primary education	102	40.5
Secondary education	96	38.1
Tertiary education	16	6.3
Total	252	100
Residence		
Urban	135	53.6
Rural	117	46.4
Total	252	100
Occupation		
Housewife	116	46
Farmer	80	31.8
Employed	32	12.7
Student	14	5.6
Others	10	4
Total	252	100
Ethnicity		
Oromo	206	81.7
Amhara	24	9.5
Others	22	8.8
Total	252	100
Religion		
Orthodox	89	35.3
Protestant	96	38.1
Muslim	66	26.2
Others	1	0.4
Total	252	100

Monthly income		
<1,500	15	6
1500-2999	103	40.9
3000-4499	75	29.8
4500-5999	22	8.7
>=6000	37	14.7
Total	252	100
Decision maker		
Mother	44	17.5
Husband	16	6.3
Jointly	175	69.4
Others	17	6.7
Total	252	100

5.1.2 Obstetric history profile of study participant mothers

From the total interviewed mothers 127 (50.4 %) had previous birth history. Of those who gave birth before 96(76.8%) of them had reported previous institutional delivery. The primary reason for mothers who had at least one home delivery was facility being too far and lack transportation 22(75.9%) followed by facility not opened 5(17.2%)

Most of the mothers 249 (98.8%) had ANC follow up for the current pregnancy. Majority of the mothers were seen by midwife/nurse for ANC follow up 232(93.2%). Of those who received ANC service majority were seen at governmental health facilities mainly at health centers 156 (62.7%) followed by hospital 76(30.5%). 227(90.1%) of mothers waiting time at health facilities for getting service was <24Hrs. 138(54.8%) delivery were attended by female health care providers.

TABLE 2: OBSTETRIC HISTORY PROFILE OF STUDY PARTICIPANT MOTHERS IN MKRH, SOUTHWEST OROMIYA, ETHIOPIA, 2018

Variables	Frequency	Percent
ANC for this Pregnancy		
Yes	**249**	**98.8**
No	**3**	**1.2**
Total	**252**	**100**
Where did you receive ANC		
Government hospital	**76**	**30.5**
" clinic	**156**	**62.7**
Private hospital	**2**	**0.8**
Private clinic	**15**	**6**
Total	**249**	**100**
Who did you see on ANC		
Doctor	**15**	**6**
Midwives/Nurses	**232**	**93.2**
Other	**2**	**0.8**
Total	**249**	**100**
How many did you receive ANC		
One up to three	**44**	**17.7**
Four	**126**	**50.6**
More than four	**79**	**31.7**
Total	**249**	**100**
Have you give birth before		
Yes	**125**	**49.6**
No	**127**	**50.4**
Total	**252**	**100**
How many times did you give birth		
One	**64**	**51.2**
Two	**28**	**22.4**

Three	**19**	**15.2**
Four	**9**	**7.2**
More than four	**5**	**4**
Total	**125**	**100**
Have you deliver stillbirth before		
Yes	**26**	**20.8**
No	**99**	**79.2**
Total	**125**	**100**
How many did you deliver stillbirth		
One	**23**	**88.5**
Two	**2**	**7.7**
More than two	**1**	**3.8**
Total	**26**	**100**
Is there any home delivery before		
Yes	**29**	**23.2**
No	**96**	**76.8**
Total	**125**	**100**
Why did not deliver at health facility		
Health facility not opened	**5**	**17.2**
Too far/No transportation	**22**	**75.9**
Husband/Family not allowed	**2**	**6.9**
Total	**26**	**100**
Who assisted your current delivery		
Midwives/Nurses	**249**	**98.8**
Others	**3**	**1.2**
Total	**252**	**100**
Is there complications during current delivery		
Yes	**11**	**4.4**
No	**239**	**94.8**

I don't know	**2**	**0.8**
Total	**252**	**100**
What complication happens to you		
Hemorrhage	**7**	**63.6**
Hypertensive disease	**3**	**27.3**
Others	**1**	**9.1**
Total	**11**	**100**
How long did you wait to get service		
<12 hours	**89**	**35.3**
12-24 hours	**138**	**54.8**
>24 hours	**25**	**9.9**
Total	**252**	**100**
How many health care providers attend your birth		
One	**8**	**3.2**
Two	**222**	**88.1**
More than two	**22**	**8.7**
Total	**252**	**100**
Sex of main birth attendant		
Male	**114**	**45.2**
Female	**138**	**54.8**
Total	**252**	**100**

5.2 Types of disrespect and abuse

Based on landscape analysis done by Maternal and Child Health Integrated Program (MCHIP) the rights of childbearing mothers during labor and delivery are categorized into seven with 25 validation criteria. The table below presents the prevalence of disrespect and abuse disaggregated by the seven categories and 25 validation criteria.

The result of the study showed that all mothers who received labor and delivery care in the health facility had experienced at least one type of disrespect and abuse.

The most commonly abused childbearing women right was mothers' right to confidentiality and privacy with all of them reported that both of the validation criteria were missed.

The second commonly abused childbearing women right was mothers right to information, informed consent, and choice/preferences with 250(99.2%) of them reported that at least one of the eight validation criteria for the domain were missed. The commonly violated criterion under this domain was providers' failure to introduce themselves to the mother 249(98.8%) followed by denying mother to choice of position for birth 244(96.8%).

Experience of physical harm or ill treatment was reported by 248(98.4%) mothers. Of seven criteria used to measure this domain the most commonly violated was allowing mothers and companions to observe cultural practices 248(98.4%) followed by support staff insulting and abusing mothers and their companions in 10(4%) of the mothers.

Another types of disrespect and abuse experienced by child bearing mothers was mothers left without care/attention 30(11.9%), non-dignified care 7(2.8%), detention at facility 3(1.2%), and discriminatory care 2(0.8%).

98% (247/252) mothers reported that they were satisfied by the care they received and they planned to deliver at the facility again if they become pregnant and they advise others to come.

TABLE3: PREVALENCE OF DISRESPECT AND ABUSE DURING CHILDBIRTH BY CATEGORIES IN MKRH, SOUTHWEST OROMIYA, ETHIOPIA, 2018

	Experienced D&A			
Type and category of disrespect and abuse	Yes		No	
	Frequency	Percent	Frequency	Percent
Physical harm or ill treatment	**248**	**98.4**	**4**	**1.6**
Physically abused during labor/delivery (force/slapped /hit/beat	4	1.6	248	98.4

Verbally/insult/abuse during labor or delivery	10	4	242	96
Separated mother from baby without medical indication	0	0	252	100
Denied me from food or fluid in labor without medical indication	0	0	252	100
Receiving unnecessary uncomfortable /pain-relief treatment	0	0	252	100
Support staff insulted and abused me and my companion	4	1.6	248	98.4
Demonstrating caring in culturally inappropriate way	248	98.4	4	1.6
Abuse Woman's right to information, informed consent, and choice/preferences	**250**	**99.2**	**2**	**0.8**
Health providers didn't introduce themselves	249	98.8	3	1.2
The providers didn't encourage mother to ask questions	82	32.5	170	67.5
The provider didn't respond mother's question with promptness, politeness and truthfulness	8	3.2	244	96.8
The provider didn't explain what is being done and what to expect throughout labor and birth	5	2	247	98
Provider didn't give updates on status and progress of your labor	4	1.6	248	98.4
Providers deny mother to freedom of movement during labor	34	13.5	218	86.5
Providers denying mother to choice of position for birth	244	96.8	8	3.2
Mother lack information, consent or permission prior to any procedure	83	32.9	169	67.1
The woman's confidentiality and privacy is not protected	**252**	**100**	**0**	**0**
The providers didn't use drapes or covering to protect mother's privacy	252	100	0	0
The couches/beds were not separated by screen	252	100	0	0

The woman didn't treated with dignity and respect	**7**	**2.8**	**245**	**97.2**
The providers didn't speak politely	7	2.8	245	97.2
The woman didn't receive equitable care, free of discrimination	**2**	**0.8**	**250**	**99.2**
Health care providers discriminates by race, ethnicity, and economic status	2	0.8	250	99.2
Mother's detained at the facility because of lack of payment of facility fees	0	0	252	100
The health providers speaks in/at a language-level that mother can't understand	2	0.8	250	99.2
The woman is left without care/attention	**30**	**11.9**	**222**	**88.1**
Mother's lack encouragement to call if needed	28	11.1	224	88.9
The provider didn't come quickly when the mother called him/her	6	2.4	246	97.6
The woman is never detained or confined against her willingness	**3**	**1.2**	**249**	**98.8**
The mother left alone or unattended during labor and delivery	3	1.2	249	98.8
The mother detained in health facility against her will	2	0.8	250	99.2
Considering what you experienced during your recent delivery in the hospital, will you give birth in the hospital again?	**247**	**98**	**5**	**2**
Would you advice a relative, a close friend or a neighbor who is expectant to give birth in a health facility?	**247**	**98**	**5**	**2**

On the other hand, by combining the 25 criterias and calculating the mean of the sum of the score of all the criteria we found that 31.4 % of the mothers got above the mean score and categorized mothers who faced high level of disrespect and abuse during childbirth.

By treating the sum of the scores of the 25 verification criteria as categorical variable (with coded '1' for experiencing disrespect and abuse and '0' for those didn't experience) Logistic

regression model run to identify mother &health care providers related factors that correlate with disrespect and abuse in childbirth care. The multivariate logistic regression found that autonomy of the mother to decide on her health issues (AOR= 1.78(0.93, 4.20), P=0.006) and educational level of mother (P=0.008) were significantly associated with D and A.

For specific category of D&A; autonomy of the mother to decide on her health issues were significantly associated with non-consented care. Educational level of mother were also significantly associated with non-consented care.

TABLE 4: LOGISTIC REGRESSION RESULT BY CATEGORY OF DISRESPECT AND ABUSE, MKRH, SOUTHWEST OROMIYA, ETHIOPIA, 2018

	Non dignified care			Discriminatory care			Detention at facility			Abandonment of care		
Independent Variables	**OR**	**P value**	**95%CI**	**OR**	**P value**	**95%CI**	**OR**	**P value**	**95%CI**	**OR**	**P value**	**95% CI**
Age	1.07	0.83	0.57, 2.02	0.6	0.21	0.37, 1.29	1.08	0.81	0.59, 1.98	1.07	0.83	0.57, 2.02
Marital status	1.10	0.72	0.65, 1.89	0.70	0.19	0.41, 1.19	1.38	0.23	0.82, 2.32	1.10	0.72	0.65, 1.98
Educational level	1.09	0.12	0.87, 3.21	0.97	0.80	0.21, 1.40	0.94	0.59	0.77, 1.18	1.20	0.91	0.38, 1.31
Occupation	1.03	0.92	0.60, 1.78	0.72	0.79	0.54, 1.49	1.28	0.10	0.96, 1.78	1.08	0.10	0.48, 2.00
Residence	1.12	0.42	0.86, 1.46	1.19	0.95	0.62, 2.47	1.23	0.71	0.99, 1.52	0.95	0.65	0.76, 1.91
House hold income	1.18	0.29	0.87, 1.60	1.17	0.67	0.57, 2.42	0.79	0.54	0.38, 1.64	0.71	0.39	0.33, 1.54
Decision maker	1.78	0.006 *	0.93, 4.20	1.25	0.28	0.84, 2.85	1.27	0.24	0.85, 1.92	1.14	0.56	0.76, 1.82
Sex of provider	0.59	0.21	0.24, 1.48	0.78	0.51	0.35, 1.68	1.15	0.73	0.52, 2.53	1.21	0.31	0.65, 3.98

Independent Variables	Physical abuse			Non consented care			Non confidential care		
	OR	P value	95% CI	OR	P value	95%CI	OR	P value	95%CI
Marital status	1.2	0.65	0.70, 1.94	1.14	0.67	0.65, 1.98	1.07	0.96	0.56, 1.84
Education level	1.03	0.93	0.51, 2.09	4.1	0.008 *	1.98, 6.70	1.06	0.60	0.84, 1.35
Occupation	1.08	0.80	0.57, 2.50	1.2	0.998	0.68, 2,21	0.85	0.56	0.36, 1.56
Residence	1.1	0.41	0.86, 1.83	1.23	0.87	0.79, 2.92	0.94	0.82	0.56, 1.84
Ethnicity	1.85	0.10	1.33, 2.56	5.62	0.02	1.35,18.61	1.02	0.97	0.51, 2.12
Decision to women health	1.03	0.94	0.42, 2.49	0.87	0.21	0.61, 1.80	0.86	0.68	0.51, 1.15
Sex of provider	1.02	1.0	0.78, 1.89	0.52	0.17	0.23, 1.30	0.70	0.21	0.34, 1.51

***** Represents significant association.

5.3 Qualitative study result

Once the data was transcribed it was coded in order to organize the data into meaningful groups by using Open code. This enabled to identify key issues in the birth experience and to group main themes together.

Based on the finding from the in-depth interview delay at getting services was experienced by most of the respondents. Delay before getting service occur at different level (on health center referral process): the main findings from this study shows, delay during the process of writing referral from health centers to hospital and in between the life mother and their new born were at risk for serious problem even death. Even the women come after process at referral, they might not get bed at hospital as fast as possible; these all caused delay to get service.

A mother said:

"*I faced delay in getting referral service from health center to Hospital. Despite the bleeding I had, they didn't timely write the referral to hospital*".

Analysis of the in-depth interviews found that health care providers' poor communication with mothers and companions were another challenge. During more than one health care providers treating mothers, they were communicate each other by medical words and mostly they speak English; at that time mothers had confusion and fear the case may serious and they take any action without permission.

A mother said:

"*During treatment, health care providers often speak in English and I couldn't understand what they were saying*."

There was lack of bed and the client flow is high. Lack of infrastructure those were necessary for respectful maternity care were raised by all health care providers and mothers.

A mother said:

"*There was lack of bed and the client flow is high, because of that after delivery the providers want to discharge me without giving enough counseling*"

Mothers who participated in the in-depth interviews also reported that their privacy has been violated during childbirth and postnatal period. A mother reported entry of several individuals into the labor room without their consent.

A mother said:

"*In the morning many health care providers and students come into the room. I feel my privacy was invaded and feel stressed*."

Another type of D&A reported by mothers was health care providers didn't come quickly if call needed.

A mother said:

"*I saw a women giving birth without attendant and that time the 'nurses' are in the office talking. When you call them, they tell you they are coming but they don't come timely"*.

Health care providers concluded one of the causes of disrespect and abuse care as: the primary and all providers raised lack of infrastructure (lack of bed) is the main cause of disrespect & abuse

Health care provider said:

"*The main problem that cause complains by patient was lack of infrastructures, special waiting and delivery rooms. as much as possible we try to renew un served rooms and use them but even with that there was problem and even higher levels/region came and seen the problem and promising to do building but still now there is no any progress*".

Lack of educational opportunities was also the main cause of unhappy services by health care providers. Health care providers were different in educational status. The educational development opportunities were there by zone, but the opportunity include only first degree holders and Diploma holders were excluded from this opportunity. Because of this health care providers told they had complain and frustration on their work.

Health care provider said:

"*I excluded from long term training b/c I'm Diploma holder, this demoralizes me and affected our work. When I feel this I couldn't perform activities freely; because of woreda health office experts report false coverage of activities and they get work improvement like training but for us no body seen our work quality and measured only by number.*"

Another reason as a cause of disrespect and abusive care reported by most of the midwives was work load for health care providers.

Health care provider said:

"*At duty time (night) patient flow is high, because health centers refer mothers with normal and abnormal labor, but midwives are three sometimes two per duty this makes us busy(loaded work) and leads us for intentional and unintentional disrespecting of the mother so it is better to increase the number of midwives to avoid that".*

Midwives also report that low salary dissatisfies them and this leads to poor quality of care for mothers.

"*I know we are not always right, but the government forgets our problems. You work so hard and there is no appreciation. At the end of the month you earn small which is from hand to mouth*."

Many also felt that often midwives' mistreatment of patients was a function of their efforts to provide medically necessary care:

Health care provider said:

"*We do that [abuse] for the sake of the mothers. When the labor is in the second stage mothers doesn't care for the baby, we may slap the thigh of the mother only with the aim to save the baby. In this situation, the mother may dislike us, not knowing our[good] intention".*

CHAPTER SIX: DISCUSSION

This study attempted to determine the level of disrespect and abuse among childbearing mothers at health facility. In addition, the study aimed at identifying factors that correlate with disrespect and abuse during childbirth care using qualitative and quantitative methods.

The result showed that all women included in the study have reported that they experienced at least one form of disrespect and abuse. The overall level of disrespect and abuse reported by the study participants in my study was high compared to what was reported by other studies.

The level of disrespect and abuse reported by previous studies in Ethiopia and other countries with similar context ranges between 19.1% in study done in Tanzania (17) and 97.4%&98% study in Peru (19) and Nigeria(21) respectively. The difference in the level of disrespect and abuse faced by mothers during childbirth across studies could be due to the difference in socio-demographic characteristics of maternity care user, vary with the status and commitment of health care providers and used program related to respectful maternal care.

The most common form of D&A which is experienced by all mothers was mothers' right to confidentiality and privacy with all of them reported that both of the validation criteria were missed. No studies was found similar to this result. This high prevalence may be due to differences in infrastructure and human power (low).

The second most common form of disrespect and abuse experienced by 250 (99.2%) of the mothers I studied was violation of the woman's right to information, informed consent, and choice/preferences (non-consented care). This is near to two researches done in in Addis Ababa that the right of mothers to information, informed consent, and choice/preference were not respected in nearly 95.4% (25) and 94.8% of respondents (p = 0.002) (18). But higher than study done in Ghana in which woman's right to information, informed consent, and choice/preferences (non-consented care) was abused in 54.5% followed by physical abuse in 35.7% and non-dignified care in 29.6% (21)

The study findings suggest that disrespect and abuse may have been normalized by both providers and clients. Many instances of D&A, such as non-consented care, were considered routine by providers. Despite a high prevalence of reported D&A at client interviews, clients also reported high levels of satisfaction with the care they received and most women who want

to have more children reported intending to deliver again at the same facility 98%(247/252). This is almost double to studies done in India and Dominican Republic of which those D&A 50% of them were satisfied and they planned to deliver at the facility again if conceived (24, 30).This may be because, the wellbeing of the child and herself is the biggest priority for a woman who is from a poor socio -economic background and had anyhow made it to the facility against all odds. This normalization of disrespect and abuse leads to the continuity of the practice and its underreporting.

Based on this study disrespect and abuse was significantly associated with educational level i.e illiterate mothers (p=0.008). Similar to my study there were two studies done in India that disrespect and abuse were significantly associated with educational level (28, 29).

In this study lack of women's autonomy and empowerment for decision making was significantly associated with women's disrespect and abuse during childbirth (p=0.006). There were studies that found associations between lack of women's autonomy and disrespect and abuse done in South Africa (42), Tanzania (46) and Ecuador (47).But this was in contrast to studies done in Kenya and Nigeria that there was no relationship between maternal socio-demographic characteristics and D&A during delivery (21, 23).

My qualitative study showed factors that makes midwives D&A during childbirth were lack of infrastructures, lack of educational opportunities and training, work load and low salary. This finding was similar to studies done in Palestinian public referral hospital (45) and South Africa (42) Midwives said that problems such as understaffing, poor pay, heavy workloads, and lack of equipment and medical supplies contribute to negative attitudes, abuses and poor quality of care in both studies.

Overall, provider reporting of emotions and feelings associated with job stress and burnout was low.

This study applied qualitative and quantitative methods with different perspectives, to validate the finding and which was used for captured experience of childbearing mothers more than identified indicator in the past. In addition, recall bias was minimized while the mother interviewed immediately before exit from health facilities. The limitation of this study was facility based, which restricts generalizability to the entire population; the study focused on

specific only on contributors of disrespect and abuse, lack of standardized questionnaire might affect the result.

Many stakeholders and maternal health experts agree that disrespect and abuse in facility-based childbirth represent important causes of suffering for women, an important barrier to skilled care utilization, important quality of care problems, and often a violation of women‘s human rights. Improving quality health service at all health system is the main pillar and has been recognized as key issues on Health system transformation plan (HSTP); Working through the process of quality assurance and quality improvement should be serious concern.

This study initiate all stakeholders those aim to improve qualities service at the health system and minimize maternal and newborn mortality through creating compassionate and respectful health facilities environment. To this effort this study result indicates the main violated item and their determinants; in addition, used indicators at the study might be helpful for health care providers to follow their service quality.

Future research could use other than exit interview data collection method and more focused on community based approach important to generalize the result for the general population. I also recommend that health administrators at all level and service providers promote and institutionalize locally contextualized respectful maternity care standards to promote respectful maternity care at all facilities.

CHAPTER SEVEN: CONCLUSION &RECOMMENDATIONS

Now health service coverage is on good progress. However, quality of health service still needs improvement and it is the core focus of health systems as indicated in HSTP in Ethiopia. In order to improve quality of service in health facilities evidence based decision-making is needed.

This study showed disrespect and abuse at health facility was prevalent; all child-bearing mothers experience at least one form of disrespect & abuse. This experience was significant for mothers who made decision on their health jointly and who were illiterate.

Hence, this was serious concern for health sector and need due attention, working on fulfilling necessary infrastructure and equipment at health facility, empowering and participating women on health issues; train health care providers on the childbearing women's rights and aware the community on their rights, improving human resource and salary is recommended..

Future research should focus on governance and leadership, health care providers and national laws and policy indicators on disrespect and abuse will be important. In addition, study on community setting may useful. For this study exit interview was employed for quantitative data collection, but b/c of fearing of service compromising by telling the truth the participant shows somehow told very superficial data, so changing data collection approach setting will be helpful to get more reliable data.

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ANNEXES

ANNEXI: CONSENT FORM

I. *Information sheet*

Good morning /afternoon, my name is_____ and I am a midwife/nurse/ working for ---------- hospital/health center/clinic. I am also a part of a team carrying out study on disrespect and abuse in maternal care among childbearing women at this facility. The purpose of this study is to assess the prevalence of disrespect and abuse during childbirth and to identify possible factors contributing disrespectful maternal care and abuse among childbearing women at this hospital. There will not be any an immediate benefit in terms of money; rather you may be morally satisfied for you contribute to the community welfare that *Disrespect and abuse, facility based childbirth, respectful maternity care, quality of care* may be attained from the result of the study. We believe that the study findings will help in order to improve respectful maternal care for mothers and their newborns.

If you participate in the study, it will not take us more than 15-20 minutes. Your name will not be written on this form, thus the information you provide will not be known to others. There is no risk involved in participating in the study. Your participation is purely voluntary, and you can withdraw any time after you get involved in the study without compromising the services you ought to get from the hospital/health center. I hope that you will participate in this study since your views are important.

Do you have any questions about the survey? May I begin the interview now?

If you have any question contact the principal investigator at any time convenient for you using the following addresses:

Name of principal Investigator: Abraha Hailu (BSc in Public Health)

Address: Jimma University

Phone No. 0938779997

Email: abrahaleey@gmail.com

II. Consent form

I selected as a participant, heard the information in the consent sheet and understood what is required from me and what will happen to me if I take part in the study. I understand that all the information regarding me, like name and all answers given by me must not be transferred to the third party. I can also understand that I can withdraw from the study at any time without giving a reason and without me or my families' routine service utilization being affected for my refusal.

Now please tell me if you agree to participate in the interview.

The Participant:

1. Agreed

2. Did not agree End the interview and thank the respondent.

Interviewer Agreement

I certify that I have taken written consent from the respondent that she has agreed to participate in study and I have confirmed the agreement is correct.

Interviewer Name: _____ Signature_____

Date |_____ month |_____| 2018.

Supervisor Name: _____ Signature_____

Date |_____month |_____| 2018.

Type of facility: Mettu Karl Referral Hospital

Mother's code……

|_____|_____|_____| Date |_____|_____| 2018.

Interviewer's code |_____|_____|

Start Time _____:____ End time_____:_____

ANNEX II: STUDY QUESTIONNAIRE

Section I: Maternal Socio-Demographic Data

1. What is your age in years? ---------
2. What is your marital status? 1. Married 2. Single 3. Divorced 4. Separated 5. Widowed 6. Other(Specify)-----
3. What is your level of education? 1. Illiterate 2. 1ry education 3. 2ry education 4.3ry education
4. Where is your residential area? 1. Urban 2. Rural
5. What is your occupation? 1. Housewife 2. A Farmer 3. Student 4. Employed 5. Other (Specify)--
6. What is your ethnicity? 1. Oromo 2. Amhara 3. Tigray 4. Other(Specify)---
7. What is your religion? 1. Orthodox 2. Protestant 3. Muslim 4. Catholic 5. Other (Specify)----
8. How much is your household income per month? ---------ETB
9. Who is decision maker to seek care here? 1. Yourself 2. Husband/Partner 3. Jointly 4. Others(specify)--------

Section II: Obstetrics History

1. Did you see anyone for antenatal care for this pregnancy? 1. Yes2. No
2. If "1" is yes who did you see? 1. Health officer 2. Doctor 3. Midwife/Nurse 4. HEW 5. Other(Specify)----
3. Where did you receive antenatal care for this pregnancy? 1. Home 2.Government hospital 3. Government HC 4. Private hospital 5. Private clinic 6. Other (specify)----
4. How many times did you receive antenatal care during this pregnancy? 1. One 2. 2-3 3. 4 4. >4
5. Have you given birth before this? 1. Yes 2. No
6. If Q '5' is yes, how many children did you gave birth? 1. One 2. Two 3. Three 4. Four 5. Five 6. Six 7. Others(specify) ------
7. Have you ever deliver a stillbirth before? 1. Yes 2. No
8. If '7' is yes how many you delivered a stillbirth? 1. One 2. Two 3.Three 4. Four 5. Five 6. Other(Specify) --------

9. How many of your delivery was assisted by skilled Health providers? 1. One 2. Two 3. Three 4. Four 5. Five 6. Six 7. Others(specify) -------
10. Is there any delivery at Home? 1. Yes 2. No
11. If Q10 yes why didn't you deliver in a health facility? 1. Cost too much 2. Facility not open 3. Too far/no transportation 4. Don't trust5. Poor quality of facility service 6. No female providers at facility.7. Husband/family don't allow 8. Other (Specify) -----
12. Who assisted you your current delivery? 1. Health officer 2. Nurse/Midwife 3. Doctor 4. Other health personnel (Specify) -----
13. Did you have any problems/Yes?

1. Yes 2. No 3. I don't know

14. If Q"12" is yes, what Cx happened to you? 1. Hemorrhage2. Hypertensive disorders 3. Obstructed labor 4. Infection (postpartum) 5. Others (specify) ------

15. For how long did you wait to get this service? 1. <12 hrs2. 12-24 hrs 3. > 24 hrs

16. How many health professionals attended your current Delivery? 1. One 2. Two 3. Three to four 4. Five and above

17. What was the sex of main health provider who attends your delivery?

1. Male 2. Female

Section III: Experiences of Disrespect and Abuse during Childbirth

A. Experience of physical harm or ill treatment

1. Physically abused during labor/delivery (force/slapped /hit/beat)1. Yes 0. No

2. Verbally (insult) abuse during labor or delivery1. Yes 0. No

3. Separate mother from baby without medical indication1. Yes 0. No

4. Denied from food or fluid in labor unless medically necessitated1. Yes 0. No

5. Receiving unnecessary uncomfortable/pain-relief treatment1. Yes 0. No

6. Support staffs insult me and my companion1. Yes 0. No

7. Demonstrating caring in a culturally inappropriate way1. Yes 0. No

B. Woman's right to information, informed consent, and choice/preferences

8. The providers introduces themselves 1. Yes 0. No

9. The providers encourage mother to ask questions1. Yes 0. No

10. The provider respond mother's question with promptness, politeness and truthfulness1. Yes 0. No

11. The provider explain what is being done and what to expect throughout labor and birth 1. Yes 0. No

12. Provider gives updates on status and progress of your labor1. Yes 0. No

13. Providers deny mother to freedom of movement during labor1. Yes 0. No

14. Providers denying mother to choice of position for birth1. Yes 0. No

15. Mother's lack of information obtains consent or permission prior to any

Procedure1. Yes 0. No

C. The woman's confidentiality and privacy is protected

16. The providers uses drapes or covering to protect mother's privacy1. Yes 0. No

17. The couches/beds were separated by screen1. Yes 0. No

D. The woman is treated with dignity and respect

18. The provider speaks politely1. Yes 0. No

E. The woman receives equitable care, free of discrimination

19. Health care providers discriminates by race, ethnicity, and economic status

1. Yes 0. No

20. Mother's detained at the facility because of lack of payment of facility

fees1. Yes 0. No

21. The health providers speaks in a language and at a language-level that mother can't understand 1. Yes 0. No

F. The woman is never left without care/attention

22. Mother's lack encouragement to call if needed1. Yes 0. No

23. The provider come quickly when the mother called him/her1. Yes 0. No

G. The woman is never detained or confined against her willingness

24. The mother left alone or unattended during labor and delivery1. Yes 0. No

25. The mother detained in health facility against her will1. Yes 0. No

H. Considering what you experienced during your most recent delivery in the hospital, will you give birth in the hospital again? 1. Yes 0. No

I. Would you advice a relative, a close friend or a neighbor who is expectant to give birth in a health facility? 1. Yes 0. No

ANNEX III: IN-DEPTH INTERVIEW GUIDE

INDEPTH INTERVIEW GUIDE FOR CHILDBEARING MOTHERS.

1. During your recent childbirth in the hospital how is your experience?

2. During labor was a relative or spouse allowed to stay with you? Did you request someone to be allowed to stay with you?

3. Is there anything done during labor that made you unhappy? (Probe on vaginal examinations, abandonment, privacy)

4. Please describe your experience during second stage/Childbirth (Probe on position, instructions, encouragement, and episiotomy)

5. During your entire stay in maternity were you physically or verbally abused? (Please explain, probe on; inappropriate touching, slapping, pinching and shoving)

6. Would you recommend other women to come here? _____Why or why not?

Ask the client whether there is anything she would like to add.

INDEPTH INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS.

1. In your own opinion what would you say about the following caring behaviors in this facility?

2. Could you please describe the underlying factors for disrespectful and abusive maternity care in your facility?

3. In your own opinion, what would you say about service providers' working conditions? Probe for what and how regarding support and supervision from higher &facility managers, professional associations, caring for the careers, team work, etc. Probe for any challenges and success experienced in the maternity unit or facility in relation to childbirth?

4. Could you please describe the feedback/anonymous reporting mechanism for unprofessional behaviors in your facility?

5. Is the issue of respectful care been addressed? IF SO, HOW? Probe (Local laws and regulations, Clinical guidelines and protocols, Training, Quality improvement approaches, Community activities including campaigns)

If you have any other idea to add related to this……

DECLARATION

I. The undersigned, declare that this thesis is my original work, has not been presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

Name: Abraha Hailu (BSc in Public Health)

Signature: _____

Name of the institution: _Jimma University College of Health Sciences

Date of submission: 25/11/2018

This thesis has been declared for final submission with my internal examiner and advisors

Approval as university:

Name of internal examiner_____

Signature_____

Date_____

Confirmed by advisors:

1. Name of first advisor: Dr. Yesuf Ahmed (MD, Gynecologist, Assistant professor and consultant in Department of OB/GYN)

Date_____ Signature_____

2. Name of second advisor: Mr. Tsegaye Tewolde (MSc, MPH/Epidemiology, Assistant Professor).

Date _____ Signature_____