RESPECTFUL MATERNITY CARE AND ASSOCIATED FACTORS AMONG MOTHERS WHO ARE IN IMMIDIATE POST PARTUM PEPRIOD, IN PUBLIC HEALTH FACILITIES OF ADDIS ABABA, ETHIOPIA

BY:-

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A THESIS SUBMITTED TO JIMMA UNIVERSITY INSTIUTE OF HEALTH, DEPARTMENT OF POPULATION AND FAMILY HEALTH IN PARTIAL FULLFILLMENT OF MASTERS DEGREE IN PUBLIC HEALTH /REPRODUCTVE HEALTH.

MAY, 2018

JIMMA, ETHIOPIA

JIMMA UNIVERSITY

INSTITUTE OF HEALTH

DEPARTMENT OF POPULATION AND FAMILY HEALTH

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ABSTRACT

Background: - In countries with high maternal mortality, the fear of disrespect and abuse that women often encounter in facility-based maternity care is a more powerful deterrent in using a skilled care than commonly recognized barriers. Nevertheless, international efforts to reduce maternal mortality in low-income contexts have neglected these aspects and focused on increasing births attended in health institutions by skilled attendants. It could also be one of the reasons for the low number of delivery by skilled birth attendants in places where there are high health institutions and birth attendants.

Objective: - To assess respectful maternity care and associated factors among mothers who are in immediate post-partum period in public health facilities, Addis Ababa, Ethiopia.

Method and material: - A facility based cross sectional study design was conducted at Public health facilities in Addis Ababa, from March 15 to 22, 2018. The participant facilities for the study were selected by simple random sampling method. A total of 380 mothers attending post-partum care were enrolled in the study. A pretested standardized questioner was used for data collection. Data was entered and checked with Epidata version 4.1 and was exported to SPSS version21. Binary and multivariate logistic regression was used to identify the association and independent predictors of respectful maternity care. Finally p-value of less than 0.05 declared the association.

Result: - Three hundred eighty women were interviewed yield a response rate of 99.2%. Among interviewed women, 82.4% had received respectful care during their stay in maternity ward. Monthly income 2282.24 ETB and above AOR 1.92[95% C.I 1.048, 3.51], married mothers AOR 3.65 [95% C.I 1.59, 8.36], Mothers, who attended secondary education and higher AOR 3.86 [95% C.I 1.73, 8.62], Male health providers AOR 2.28 [95% C.I 1.281, 4.08] and giving birth by normal delivery AOR 2.368 [95%C.I 1.12, 4.99] were found to be the predictors of respectful maternity care.

Conclusion and recommendation: More than eighty two percent of the respondents in Addis Ababa public health facilities in immediate post-partum women have received respectful maternity care. Socio demographic (educational and marital status) and maternal birth experience (mode of delivery) were found to influence respectful maternity care. Priority should be given to train female health providers and process monitoring of the maternal health services were recommended.

Keyword: Respectful maternity, maternal health, Disrespect and abuse

ACKNOWLEDGEMENT

I would like to express my acknowledgement to Jimma University and department of population and family health for providing me this opportunity and support.

I would also like to extend my special gratitude to my advisors Dr. Gurmesa Tura (PhD. Associate professor), head of population and family health department and Mrs. Tsedach Alemu (MPH/RH, PhD fellow) for their invaluable comments, suggestions and offering me a useful hint throughout this thesis preparation.

My appreciation goes to my friends from different departments and instructors who gave me constructive ideas for the preparation of this thesis.

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ACRONYMS AND ABBREVIATIONS

D & A ----------Disrespect and Abuse

EDHS----------Ethiopian Demographic Health Survey

ETB----------Ethiopian Birr

FMOH----------Federal Ministry of Health

IRB----------Institutional Review Board

JU----------Jimma University

JUSH----------Jimma University Specialized Hospital

LB----------Low Birth

MNH---------- Maternal and Neonatal Health

RMC ----------Respectful Maternity Care

SBA----------Skilled Birth Attendants

SBMR©----------Standard Based Management and Recognition

SPA----------Service Provision Assessment

SPSS---------- Statistical program for social science

TRAction----------Translating a Research in to Action

CHAPTER ONE: INTRODUCTION

1.1 Background

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families which also represent a time of intense vulnerability. The concept of "safe motherhood" is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity and gender violence are also the core of maternity care (1)

Significant progress has been made globally in maternal and neonatal health (MNH) care, and both maternal and neonatal mortality rates have dropped in recent decades. Strengthened legal frameworks and effective clinical and programmatic practices have improved the quality of services provided. Despite these improvements, access to quality services is not guaranteed for many, especially in developing countries. Even when services are available, care may be compromised by social, ethnic and cultural barriers, an unwelcoming reception at the health care facility, lack of privacy and information for the client, disrespect and abuse (2)

Respectful maternity care (RMC) is a universal human right to every childbearing woman in every health system. It is not an option. It is not a luxury awarded only to women in certain geographies or demographic groups. It is a right (3)

A framework for describing interpersonal aspects of care during childbirth is the seven domains of disrespect and abuse (D&A) outlined in Bowser and Hill's (2010) landscape evidence review and were referenced by the WHO in their 2015 statement on the prevention and elimination of disrespect and abuse during facility-based childbirth, including physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care, and detention in facilities (4)

Women's experiences with maternity caregivers can empower and comfort them, or inflict lasting damage and emotional trauma. Evidence suggests that in countries with high maternal mortality, the fear of disrespect and abuse that women often encounter in facility-based maternity care is a more powerful deterrent to use of skilled care than commonly recognized barriers such as cost or distance. While many interventions aim to improve access to skilled birth care, the quality of relationships with caregivers during maternity care has received less attention (5)

In our set up there is no strong regulatory framework or guidelines to monitor this issue. Again in pre-service program even if the students learn some professional ethics, the curriculum has no place for this and needs revision to include respectful maternity care and associated factors.

1.2 Statement of the Problem

Recent studies showed that the prevalence of disrespect and abuse of mothers is worse in Sub-Saharan African countries. (6) Four studies; in Kenya, Tanzania, Ethiopia, and Nigeria analyzed women's experiences during childbirth to estimate prevalence of disrespect and abuse (20 %, 20–28 %, 78, and 98 %), respectively.(7,8)Many women did not have procedures or the labor process explained to them and did not hear about the findings of exams. The least observed checklist item was whether the client was asked if she had any questions, with a prevalence of 16 % in Ethiopia and high of only 42 % in Rwanda.(9)

A provider who asks for questions (and listens to and answers them) is providing an important opening for the client to establish herself as an informed and active participant in the care process but these practices are neglected and given no concern. In a study done on D&A in Ethiopia, women also reported a similar lack of client-provider information sharing: 63 % of women were not encouraged to ask questions, 43 % did not have procedures and the labor process explained, and 32 % received no update on the progress of their labor.(10)

According to 2016 Ethiopian Demographic and Health Survey, Slightly over one in 4 live births in the five years preceding the survey were delivered by a skilled provider (28 percent) or in a health facility (26 percent).Maternal mortality ratio in Ethiopia is 412/100,000 live births (EDHS, 2016) and neonatal mortality rate is 28/1,000 LB (EDHS, 2016) still it's very high. 0.05 midwives for every 100 expected deliveries. Again, 80 percent of births to urban mothers were assisted by a skilled provider and 79 percent were delivered in a health facility, as compared with rural mothers 21 percent and 20 percent, respectively. This implies that it needs prominent effort in reducing this figure to what is aimed to achieve in the sustainable development goal. (11)

Government has expanded a number of facilities, very successful Health Extension Program at community level , road access – still long way to go but has improved, ambulances was deployed to district level and maternal and neonatal health care facility services are now free. But still majority of births takes place at home with unskilled attendants and only 26% of births take place at health facility (11,12).

The contributing structural factors are insufficient communication and information sharing by providers as well as delays in care and abandonment of laboring women as deficiencies in respectful care. Failure to adopt a patient-centered approach and a lack of health system resources are also undeniable contributor to the problem. (13) There is limited evidence or record registration strategy on the prevalence of respectful care or D&A in facility-based maternity services delivered in low-resource settings. Neither routine health information systems nor facility assessments such as the Service Provision Assessment (SPA) capture this type of data (11)

Most of the evidence gathered on disrespect and abuse during childbirth in health facilities is 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. (14).

In Addis Ababa, the capital city of Ethiopia, where the proportion of births occurring in health institutions is relatively high (82.3%) when compared with the other towns , there are growing concerns about the respect and friendliness of safe delivery services.(10) Which are claimed to be a hidden deterrent, in utilizing skilled care services.

Therefore, the aim of this study is to assess respectful maternity care and associated factors among mothers attending post natal care in immediate post-partum period in public health facilities, in Addis Ababa, which is very important in increasing delivery service utilization and client satisfaction, and thereby reducing maternal and infant mortality in the country.

CHAPTER TWO: LITRATURE REVIEW

2.1 Maternity Care Services

The women-friendly approach focuses on the rights of women to have access to quality care for themselves as individuals and as mothers, and for their infants. A working definition of women friendly care was provided by the experts participated in the international conference as follows. Health services can be considered women-friendly when they are:

Available, accessible and affordable; when they are located as close as possible to where the women live and are reasonably priced for both the women and the health care system;

Provide safe and effective health and maternal care that complies with the highest possible technical standards, and makes use of the necessary supplies and equipment; even at the lowest level facility;

Motivate providers, encourage their participation in decision-making, and make them more responsive to user needs; and empower users and satisfy their needs by respecting their rights to information, choice, safety, privacy and dignity and by being respectful of cultural and social norms (15)

Systematizing Experiences in Implementing Women-Friendly Health Services in Mexico City, health services efforts to quality of health services rely on government initiative of licensure and audits. Less emphasis was given for motivation of health workers and satisfaction of clients. In the past three decades however, emphasis have been given to both medical approach to quality of care as well as providers and clients involvement to improve quality of care. The importance of interpersonal and communication skill of health workers begins to emerge as an important component of quality of care (8).

2.2 Practice of Respectful Maternity Care

An intervention done in Iran to improve the quality of maternity care at an Iranian Social Security Hospital, the practice of respectful maternity care is measured by women's satisfaction levels, and it improved significantly on 16 of 20 items. The result of the study revealed the provision of comfort mean and variance are 4.57, 0.29 respectively, Companionship after birth mean and variance respectively are 3.50, 2.61, Quick response to requests mean and variance 4.50, 0.30 respectively, Caring and sensitive staff- mean and variance 4.54, 0.32 respectively, Privacy during birth mean and variance 4.33,1.15 respectively, Quick admission mean and variance 4.68, 0.37 respectively.(16)

A study done in Uttar Pradesh, India, in most cases the provider did obtain formal consent from the patient prior to care (70.4%), answered all of the patient’s questions (88.7%), provided complete information about

treatment (72.3%), and were supportive during the patient's stay at the facility (86.3%).While among a sample of women delivering at public health facilities one in five (20.9%) reported mistreatment by their provider during child birth, including discrimination and abuse. The most commonly endorsed items on this measure were discriminatory behavior from the health provider, reported by 9.7%, and forcible pushing of the abdomen during delivery, reported by 8.0%.(17)

The prevalence and pattern of disrespectful and abusive care during facility-based childbirth in Enugu, southeastern Nigeria, in total, 437 (98.0%) of 446 respondents reported at least one form of disrespectful and abusive care during their last childbirth. Non-consented services and physical abuse were the most common types of disrespectful and abusive care during facility-based childbirth, affecting 243 (54.5%) and 159 (35.7%) respondents, respectively. Non-dignified care was reported by 132 (29.6%) women, abandonment/neglect during childbirth by 130 (29.1%), non-confidential care by 116 (26.0%), detention in the health facility by 98 (22.0%), and discrimination by 89 (20.0%).(18)

In Kenya a pre-and-post study measured D & A levels in a three-tiered intervention at 13 facilities under the Heshima project revealed a 7 % absolute reduction in the prevalence of any feelings of humiliation or disrespect, from 20 to13 %, was identified. Unadjusted results for the six typologies showed that physical abuse, verbal abuse, violations of confidentiality, and detainment. Although not statistically significant, feelings of abandonment did increase, from 13 % at baseline to 17 % at end line.(19)

According to a study done in Tanzania on the prevalence of disrespect and abuse during facility-based childbirth revealed that during postpartum interviews, 15 % of women reported experiencing at least one instance of D&A. This number was dramatically higher during community follow-up interviews, in which 70 % of women reported any experience of D&A. During postpartum interviews, the most common forms of D&A reported were abandonment (8 %), non-dignified care (6 %), and physical abuse (5 %), while reporting for all categories of D&A, excluding detention and non-consented care, was above 50 % during community follow-up interviews. (20). In rural Tanzania in 2009 the frequency of any abusive or disrespectful treatment during childbirth was found to be around 19.5 percent in the exit sample and 28.2 percent in the follow-up sample.(21)

Whereas a study done in Zanzibar and Madagascar the practice of respectful maternity care, 88.3 % of the health providers in both countries greets client in a respectful manner, 22.1 % and 66.5 % encourages client to have support person respectively, 65.0 % and 49.1 % explains procedures before proceeding, 66.0 % and 67.8 % informs client of findings, 71.6 % and 54.4 % provider encourages or assists client to ambulate and assume different labor positions, 90.5 % and 79.5 % provider supports client in friendly way during labor and 21.4 % and 28.8 % asks client if she has any questions respectively.(9)

As elsewhere, in Ethiopia, D&A is a deterrent to women seeking childbirth in health facilities. A 2014 synthesis of evidence from 65 studies on the barriers of facility-based delivery in low-and middle-income countries showed many individual, community, and health system related factors, including mistreatment of women, geographic accessibility, health care costs, perceptions of quality, cultural and personal preferences, and education, contributed to low SBA rates.

A pilot project undertaken in four primary health care units of Amhara and Southern Nations, Nationalities, and Peoples' (SNNP) regions of Ethiopia, the overall prevalence of 21% of postpartum women reported any experience of disrespect or abuse. The most commonly reported categories of disrespect and abuse were non-consented care (17.7%), lack of privacy (15.2%), and non-confidential care (13.7%). There were however, no reports of detention in facilities and discrimination. (22)

A 2014 study conducted in Addis Ababa at two health centers and one university teaching hospital found that 78% of women reported having experienced some form of D&A. (23)

Another study by Mekonin (2013) selected three catchment health centers in Addis Ababa in August 2013 and reported that disrespect and abuse was identified to be practiced in 96.5% of the deliveries surveyed. From the seven categories of disrespect and abuse, "failure to maintain women's right to information, informed consent, and choice/preferences"; all forming a single indicator was the common problem reported by 95.4% of clients followed by leaving mothers without attention (39.3%), normalization of D&A by mothers to be 12.7%. (24)

2.3 Factors Associated With Respectful Maternity Care

2.3.1 Socio demographic factors

Several individual and community factors were found to be related to observed RMC practices. Bowser and Hill and others group into; Individual and community-level factors, normalizing D&A during childbirth; lack of community engagement and oversight; financial barriers; lack of autonomy and empowerment are contributors of this experience.(25)

The maternal age, economic status of the woman, solely or in association with her education and empowerment status, acts as an influencing factor in her health care seeking behavior. According to the 2010 Bangladesh Maternal Mortality and Health Care Survey, 31.2% of the women from the poorest wealth quintile receive ante-natal care from a medically trained provider, 5 compared with 81.9% of women from the richest wealth quintile. (26)

In Sierra Leone, a study by CARE found that 68% of mothers said the decision on where to deliver the child was usually made by the husband at the onset of labor. Which is significantly associated with the treatment they receive during delivery care in health institutions because of their decision making power when compared with 32% whose decision making power is no influenced by their husbands. (4)

In Tanzania a cross sectional study done and reported on two surveys found, 5 % and 14 % of women in the postpartum and community follow-up surveys reporting being asked for informal fees, respectively. Again, reports at community follow-up were significantly less positive than the postpartum interview, with 24.3 % of respondents in the community follow-up interview reporting "poor" provider respect compared to 3.3 % during the postpartum interview ($P < 0.001$).(20)

Basic infrastructure is also lacking; nationally representative surveys in Ethiopia, Kenya, Rwanda, and Tanzania reported no electricity available in 14, 26, 18, and 50 % of facilities, respectively.(9)

A study done in north west showa also showed that there was normalization of D&A which was evidenced with only 12.7% of mothers reported to be disrespected and abused during childbirth. (24)

Cultural barriers to health care, relating to the lack of autonomy and decision-making power, often constrain women's access to health care. In some areas, for example, women are not allowed to leave home unaccompanied, while in others, women are not permitted to be attended by male health care providers. Sometimes, the fear of not having her cultural values respected inhibits a woman from accessing the services she needs. To eliminate these barriers, health services should be organized in a way that respects women, their culture, religion, and beliefs.(8)

2.3.2 Socio-economic factors

Studies from rural northern Ghana and Peru reported that poor and uneducated women were mainly subjected to abusive behavior by the providers. Similarly, in Bangladesh and Kenya, rich women received care earlier as compared to the poor, despite the seriousness of the medical condition. The poor were denied care even for the services which are provided free of cost by the government.(14)

Whereas according to a study done in Addis Ababa the finding showed that disrespect and abuse by socio-demographic and obstetric variables, respondents' monthly income was significantly associated with a different level of disrespect and abuse (89.5% among those with a monthly income of <713 birr and 70.3% among those with monthly income of ≥ 713 birr (10).

2.3.3 Provider factor

First, the type of health worker was significantly associated with provision of RMC care; midwives were better RMC service providers compared to nurses, health officers and doctors perhaps because their training focuses primarily on maternity care. The other factor is according to a literature review done on barriers to quality midwifery care discussed, the triple burdens faced by female midwives like: (1) reproductive (childbearing), (2) productive (economic), and (3) community management (e.g. unpaid work in support of the community) the effect of social, economic and professional barriers resulted in moral distress and burn out, which may have led to abusive behavior.(9)

Providers' lack of training on alternate birth positions, particularly during their pre-service practicum, may also explain why some do not allow women to deliver in their preferred position. Health workers in a study in Bangladesh and Uganda reported that they had not been trained to deliver women in positions other than lying at their backs and thus did not feel confident to do so .(18,27)

In Uganda, Sorroti District Hospital only 60% of midwifes had training in essential emergency obstetric care: 25% had no in-service midwifery training; only 33.3% could document and interpret a partogram; and training in infection prevention and immediate care of the new born was deficient. Whereas one Ghanaian hospital experiences a 500% increase in birth rate in six years with no additional midwifery staff recruited. This results in four midwives supporting up to 1,200 births per month, and up to 50 births with in a 24-hour period. (28)

In Nairobi a quasi-experimental study done on one large maternity hospital and across the six districts conducted in 2010, from a voucher evaluation baseline population survey results, indicated that 22% of women said they did not seek medical care because of unfriendly providers.(29)

Due to lack of a previous measure for D&A in the literature, the study in thirteen facilities in Nairobi, utilized an estimated 22.2% of women who reported not using facilities due to provider related reasons. The assumptions were that provider related reasons were associated with humiliating behavior or perceived to be disrespectful by the clients. (27)

And the other contributing factor is in Ethiopia, the proportion of childbirths attended by a Skilled Birth Attendant (SBA) in 2014 was 15%, compared to 50–53% in other Sub-Saharan African countries, especially in East Africa.(18,20) Higher likelihood of performing high level of RMC was found among male providers vs. female midwives in facilities, implementing a quality improvement approach among laboring women accompanied by a companion(10,20)

All staff members are entitled to receive training so that they can continuously update their skills. Health personnel must be trained in putting the women-friendly approach into practice. Training must be competency based, culturally sensitive, geared to community and provider needs, and enjoy continuous access to information. It must emphasize both technical and interpersonal skills. It should use a team approach to solving problems and be interactive, allowing for sharing experiences.(8)

2.3.4 Service delivery and maternal birth experience

Health services, especially in large facilities, are often arranged in such a way that women have to see different providers for related services. In urban areas, the lack of communication between providers and the complexity of the system tend to increase delays in care-seeking and timely treatment.(8)

The current study found that availability of essential supplies for deliveries at visited facilities was lacking (range 20–57 %) by countries which are Ethiopia, Kenya, Rwanda, and Tanzania.(9)

In many countries, one of the reasons for low rate of childbirth assisted by SBA is absence of RMC and the actual and perceived high D&A committed by health providers (30,31). A systematic review of barriers to institutional delivery by Bohren et al, found that being asked to adopt unfamiliar birthing positions and having no control over choice of birthing position are important reasons why some women prefer home deliveries. Quality improvement using SBM-R© and having a companion during labor and delivery were associated with RMC. Lack of standards and leadership/supervision for respect and non-abuse in childbirth; lack of accountability mechanisms at care site are also the contributing factors. (31)

2.3.5 Policy and government factor

Reducing maternal mortality requires co-ordinated, long-term efforts at the level of national legislation and policy formation, especially in the health sector. According to a qualitative study done in Nigeria, long-term political commitment is essential for reviewing national laws and policies in the area of family planning and adolescent health ensuring availability of skilled attendants at birth, regulation of health practices, and the organization of health services.(8) Policy makers need to consider the role of quality improvement approaches and accommodating companions in promoting RMC. (32,33) Numerous factors can contribute to this experience that Bowser and Hill and others group into: lack of legal and ethical foundations to address D&A, lack of leadership, lack of standards and accountability, and provider prejudice due to training and lack of resources.(25)

Despite acknowledgement of these behaviors by policy makers, program staff, civil society groups and community members, the problem appears to be widespread but prevalence is not well documented. Given the variety of forms it can take and the multiple contributing factors, coupled with a lack of research describing the practice and evaluating interventions.(29)

Conceptual Framework

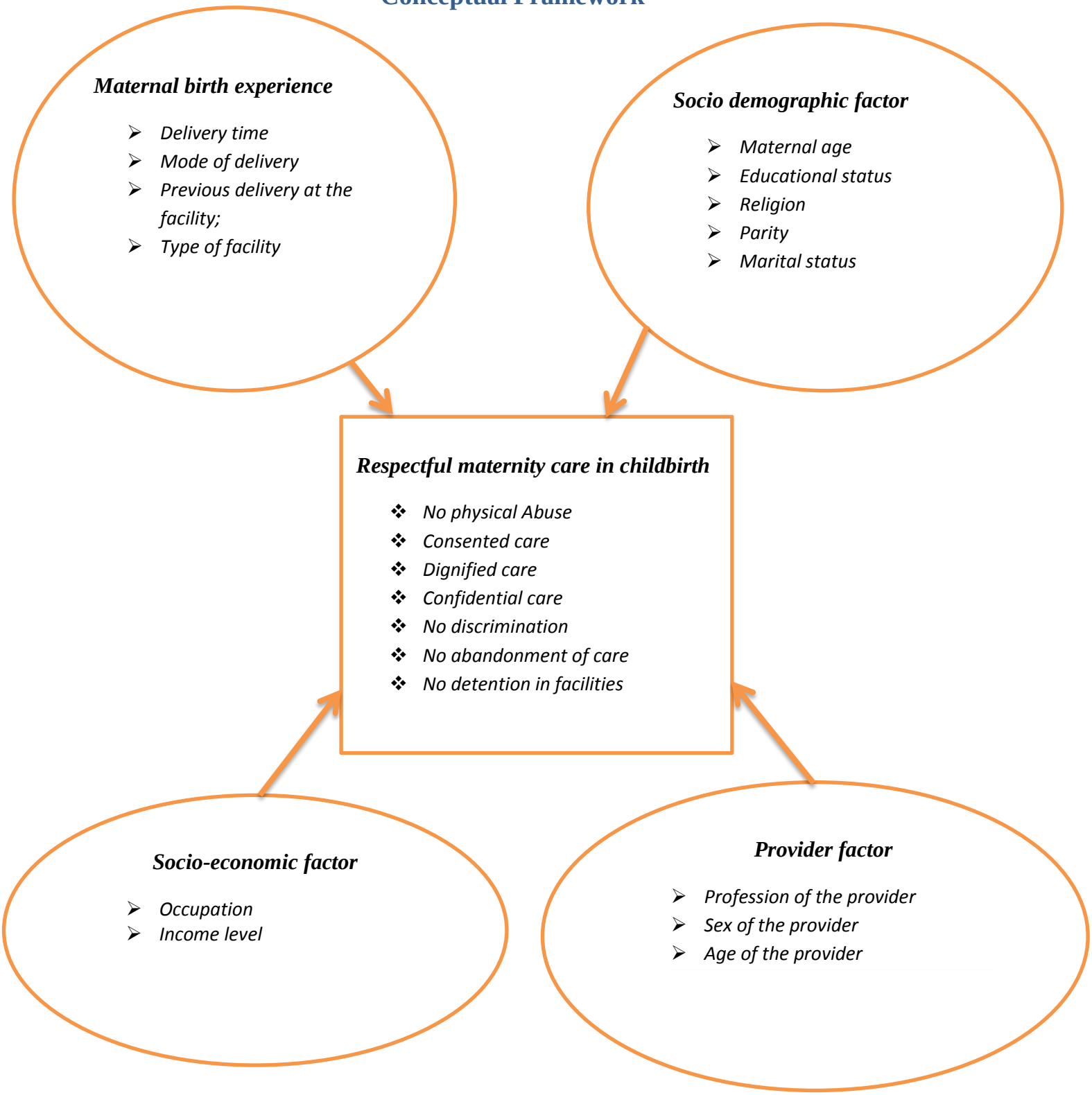

Figure 1 Conceptual framework developed after literature review (8, 9, 13, 14, 15, 16, and 17)

2.4 Significance of the Study

Many of the indignities that women experience in health facilities keep them from seeking the care they need. More than cost, more than distance from the health facility, fear of being mistreated keeps women at home.

End all forms of discrimination against all women and girls everywhere are one of the sustainable development goals that is goal 5. Ethiopia, as one of the countries which have adapted these goals, is supposed to meet until 2030. (7)

Therefore; the finding from this study mainly benefits the women; it helps to empower women on their reproductive health and increase client satisfaction and helps to produce competent reproductive health care provider on compressive reproductive health services. Since there are limited studies done on this topic in the study area, assessing the status and factors associated with respectful maternity care is very important to improve utilization of maternity services and their by increase client satisfaction, develop regulatory framework or guidelines, revising student curriculum, increase women's autonomy and their by reducing maternal and neonatal mortality in the country then finally meet the sustainable development goal 5.

CHAPTER THREE: OBJECTIVES

3.1 General Objective

- The aim of the study is to assess respectful maternity care and associated factors among mothers who are in immediate postpartum period in public health facilities, Addis Ababa, Ethiopia 2018.

3.2 Specific Objectives

- To assess the magnitude of respectful maternity care on mothers in immediate postpartum period in public health facilities, Addis Ababa city, 2018.
- To identify factors associated with respectful maternity care among mothers in immediate postpartum period in public health facilities, Addis Ababa city, 2018.

CHAPTER FOUR: METHODS AND MATERIALS

4.1 Study Area and Period

The study was conducted in Addis Ababa, capital city of Ethiopia. The city is found between 9 degrees latitude and 38 degrees longitude at an altitude of 2220-2800 meters above sea level. The town has 28 woredas with a total of 328 kebeles. The population projection of 2015/16 of the town is 2.9 million people, with total reproductive age groups of 34.4%. The city consists, a total of 13 government hospitals and 23 health centers. The study was conducted from, March 15- 22, 2018 on mothers who gave birth in Addis Ababa public health hospitals and in immediate post-partum period at the time of discharge.

4.2 Study Design

Facility based cross-sectional study design will be conducted, which involves both quantitative and qualitative method.

4.3 Population

4.3.1. Source population

All mothers who delivered in Addis Ababa public health facilities and in immediate post-partum period.

4.3.2. Study population:

All mothers who are available and in immediate post-partum period in post natal care unit in public health facilities of Addis Ababa, during the study period and included in the study.

4.4 Inclusion and Exclusion Criteria

Inclusion criteria

All mothers who are in post natal care unit and in immediate post-partum period, at the selected health facilities leaving the maternity ward after giving birth

Exclusion criteria

Mothers who are critically ill or those who have known mental illness.

4.5 Sample Size Determination

Determined using Epi Info ™ version 7.1.1.4 with the assumptions of confidence level = 95%, margin of error = 5% for single population proportion and power for the double population proportion= 80%.

Table 1 Sample size determination for outcome variables and associated factors of the study

Population	Proportion	Sample size	10%non-response	Final sample size	Reference	Studies
Single population	**P1= 66%**	**n_1= 345**	**34.5**	**380**	**(23)**	**In public health facilities of Ethiopia from 2002 to 2003 EC**
Double population proportion	**P_{2a}= 89.5%, P_{2b}= 70.3%**	**n2= 155**	**15.5**	**171**	**(10)**	**In Addis Ababa health facilities Income level < and ≥ 713 birr per month.**
	P3a= 56.4% P3b= 79.4 %	**n3= 147**	**14.7**	**162**	**(34)**	**Educational status of the mother in a study done in Amhara region.**

Therefore the largest sample size, n= 380 was taken

Where: -

- P1- refers to the proportion of women experiencing respectful maternity care in a study done in Ethiopian public health facility.
- P2a- refers to mothers who have experienced respectful maternity care having an income level <713 birr.
- P2b- refers to mothers who have experienced respectful maternity care having an income level ≥713 birr
- P3a- refers to those mothers who are not educated and experienced respectful care during delivery
- P3b- refers to those mothers who are educated and experienced respectful care during delivery.

4.6 Sampling Technique and Procedure

From a total of 36 public health facilities, by taking 30%, 11 Public health facilities were selected by simple random sampling method that is, 7 health centers and 4 hospitals were involved in the study. The last six months delivery number per month was taken from the registration book the average delivery number was calculated and the sample size was proportionally allocated to the health facilities. And finally all mothers who are eligible and available during the study period and who satisfy the inclusion criteria were recruited in the study.

Schematic presentation of the sampling process

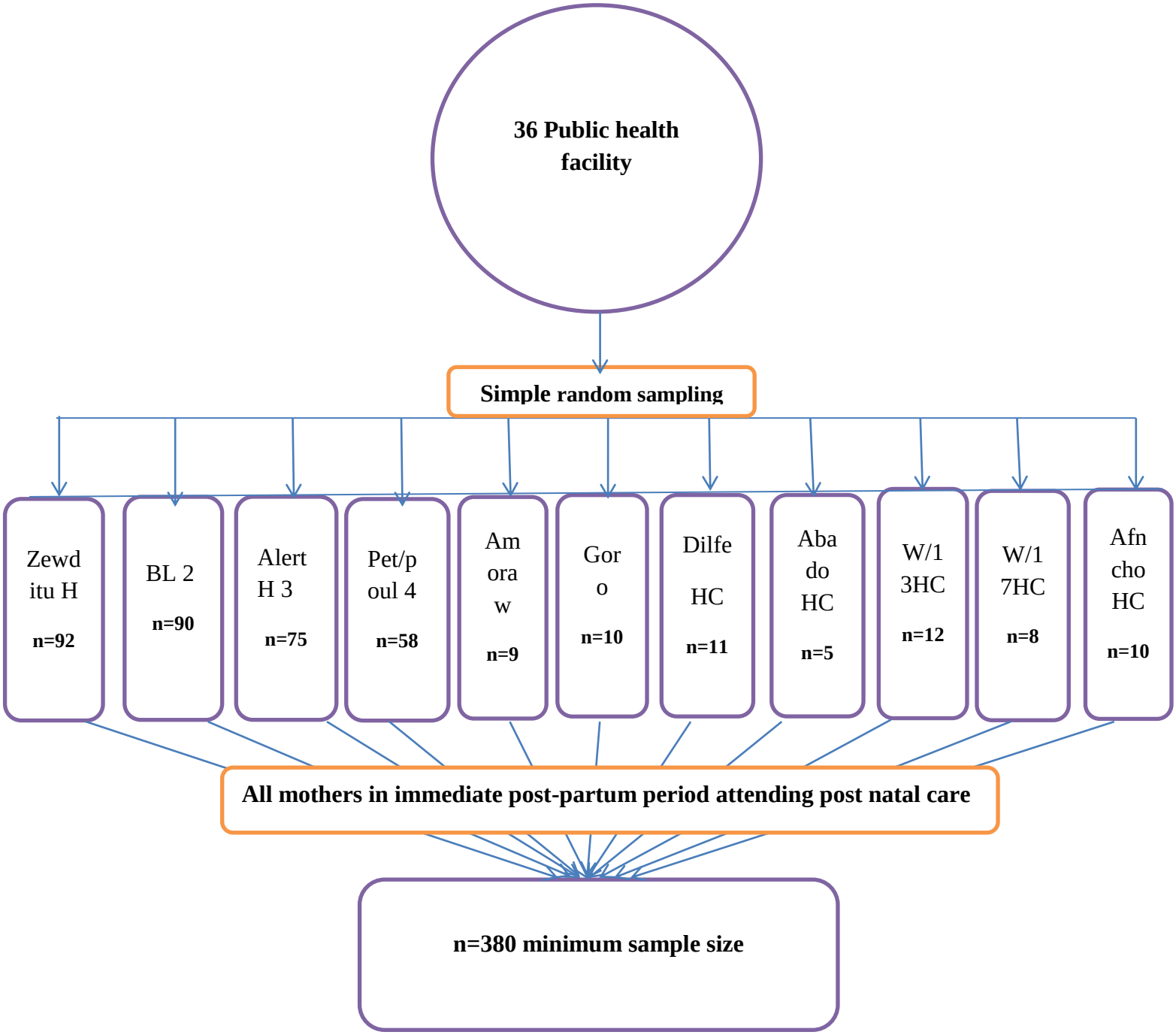

Figure 2 Schematic presentation of sampling process in Addis Ababa public health hospitals, 2018

4.7 Study Variables

Dependent variable:

- Respectful maternity care

Independent variables:

- **Service delivery factors and birth experience:** Delivery time; Mode of delivery; Birth attendant; previous delivery at the facility; Type of facility
- **Provider factor:** Profession of the provider; Sex of the provider; Experience of the provider
- **Individual and socio demographic factors:** Maternal age; Educational status; Religion; Parity; Marital status
- **Socio-economic factors:** Occupation; Income level

4.8 Measurement

Respectful maternity care was measured using a total of 16 questions using the seven classifications. To assess if the mother has experienced **physical Abuse**, 5 questions were used 1. Pushed 2. Pinched or otherwise beat her, 3. Used force as a restrain during labor/ delivery/ examination and 4. Procedures were done without anesthesia or other forms of pain relief. For each items the response was scored as: 1 "No" if a woman didn't experience any of the abuse, 2 "yes" if she has experienced the any of the abuse. For **consented care** one question was asked, 1. Surgical or other procedures done without asking her consent and the response was scored as 1. "No" if there were procedures done without her consent and 2. "Yes" if her consent was not taken for any procedures. For **dignified care**, 3 questions were asked, 1. If the health providers shouted at or scolded her, 2. If they made negative comments about her, 3. If they threatened to withhold treatment because she could not pay or did not have supplies and for any of the questions the response was scored as 1."No" if she was not dignified and 2. "Yes" if she was dignified. **Confidential care** was assessed by 2 questions 1. If the health providers discussed her private health information in a way that others could hear and 2. If her body (private parts) was seen by other people (apart from health providers) during delivery. For each items the response was scored as: 1 "No" if a woman didn't experience any of the abuse, 2 "yes" if she has experienced the any of the abuse. **Discrimination** was measured with 2 questions 1.If she was treated poorly because of poverty, 2. Because of her religion, her age or her marital status. And it was scored 1."No" if she didn't face any of the actions and 2. "Yes" if she has experienced the actions.

Abandonment of care was measured by 2 questions, 1. If the health providers ignored or abandoned her when she called for help and 2. If she delivered without any assistance. . For each items the response was scored as: 1 "No", if a woman didn't experience any abandonment, 2 "yes", if she has experienced abandonment. **Detention** in facilities was measured with 1 question, 1. If she was not allowed to leave the health-facility due to failure to pay .The response was scored 1. "No", if the mother didn't experience any of the actions and 2. "Yes", if she has experienced the abuse or action.

4.9 Data Collection and Quality Control

Data collection techniques for quantitative data

Data was collected for one week in the selected health facilities, exit interviews were conducted to all of postpartum women in the maternity unit who have recently delivered at the selected facilities as they leave the maternity ward after giving birth. All women satisfying these inclusion criteria were recruited until the required sample sizes was reached by using structured face to face and in-depth interview questioner first prepared in English and translated in to Amharic for appropriateness and easiness in approaching the study participants and back to English by different persons to check the consistency of meaning. Non- staff member of 11 diplomas and 1 BSc Midwifery background personnel and have experience of qualitative data collection technique were recruited as data collectors and supervisor respectively.

Data collection techniques for qualitative data

For qualitative data collection; the data collectors and investigator selected the participants and organized appropriate time and comfortable place for the interview. During conducting the in-depth interview explanation and elaboration of the need to do the in-depth interview were made and the interviewees were asked for their willingness to participate in the study and the in-depth interview was conducted after the confirmation of the individuals consent.

Data collector training manual was prepared. One day training was given for supervisor and data collectors on the basic techniques of data collection, approaches and on the issue of confidentiality and privacy by the principal investigator and collaborators.

Then questionnaire was pre-tested on 5% (19 mothers) in Alemgena health center and necessary modifications were made specifically on the understandability of specific item. All steps in data collection were closely monitored by the principal investigator.

The filled questionnaires were also checked carefully on the spot and daily basis for their completeness, accuracy, and clarity. Any error, ambiguity, incompleteness, or other problem encountered were early identified communicated, discussed, and solved before starting next day activities.

4.10 Data Processing & Analysis

After data collection, each questionnaire was checked for completeness, consistency and clarity and was coded and entered in to Epidata manager 4.1 and was exported to SPSS version 21. Data was cleaned and explored for outliers, missed values and any inconsistencies and it was analyzed using SPSS version 21. Descriptive statistics like frequency tables, graphs and descriptive summaries was used to describe the study variables. An odds ratio (95% confidence intervals) and Binary Logistic regression analysis was used to assess the association of different variables with respectful maternal care and p value < 0.25 were candidates for multivariate logistic regression and P value <0.05 were considered statistically significant in all tests of significance. Whereas: for the qualitative data 11 health professionals were interviewed then, and it was written in narrative forms and supplemented with the notes taken during the discussion. And finally the findings from these different data collection methods were complemented.

4.11 Ethical Consideration

Ethical clearance to conduct the study was obtained from IRB (institutional review board) of Jimma University institute of health sciences and letter of cooperation was obtained and sent to selected public health facilities and to the non-selected health institution for pretest. Confidentiality of the information was ensured by not asking the name of the client or other identifiers.

4.12 Operational Definitions

Respectful maternity care: - Means mothers who didn't experience any of the disrespect and abuse approaches during her stay in the health facility. (10,18,20)

Disrespect and abusive maternity care:- Means mothers who face one of the following abuse, physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), and discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities.

- **Physical Abuse** – Means mothers who replied yes to any of these actions, health provider(s) hitting, slapped, pushed, pinched or otherwise beat her, used force as a restrain during labor/ delivery/ examination and procedures were done without anesthesia or other forms of pain relief.

- **Non- consented care** - Means mothers who replied yes to surgical or other procedures done without asking her consent.
- **Non- dignified care**- Means mothers who replied yes to any of these actions, health providers shouting at or scolded her, they made negative comments about her, threatened to withhold treatment because she could not pay or did not have supplies.
- **Non- confidential care**- Means mothers who replied yes to any of these actions, health providers discussed her private health information in a way that others could hear, Your body was seen by other people (apart from health providers) during delivery.
- **Discrimination**- Means mothers who replied yes to any of these actions, treated poorly because of poverty, ethnicity, religion or tribe, her age or her marital status.
- **Abandonment of care**- Means mothers who replied yes to any of these actions, the health providers ignoring or abandoned her when she called for help and delivered without any assistance.
- **Detention in facilities**- Means mothers who replied yes to any of these actions, not allowed to leave the health-facility due to failure to pay and health providers suggest or ask for a bribe or informal payment for better care.

Immediate postpartum period: is a period that extends from date of delivery till their day of discharge from the health facility.

4.13 Dissemination Plan

The finding of this study will be disseminated through publication. A copy of it will be offered to Jimma University institute of health sciences, population and family health department; FMOH, Federal Health Bureau and other concerned bodies so that they can use the results for planning, implementation and monitoring of maternal health programs.

CHAPTER FIVE: RESULT

5.1 Socio-demographic Characteristics of the mothers

Three hundred eighty women were interviewed yield a response rate of 99.2%. The mean (+ SD) age of the women was 26.12 (+ 4.253) years. Two hundred twenty three (58.7%) of the religion of the respondents were Orthodox followed by Muslim (25.8%) and (14.5%) were Protestant. One hundred eighty nine (49.7%) of the respondents attended primary education, 40.3% of them attended secondary education and above, whereas (13.2 %) have no formal education. Three hundred forty five (90.1%) of the participants were married and Two hundred thirty nine have only one child (62.9%) see table 2.

Table 2 Socio demographic characteristics for respectful maternity care among mothers in immediate post-partum period in Addis Ababa public health facilities march 2018.

Socio-demographic characteristics	Category	Frequency	Percent
Maternal age (in years)	15-19	18	4.7
	20-24	117	30.8
	25-29	171	45
	30-34	56	15
	35-39	18	4.5
Educational level	Primary	189	46.7
	Secondary and above	143	40.1
	No formal education	48	13.2
Religion	Orthodox	223	58.7
	Muslim	98	25.8
	Protestant	55	14.5
	Catholic	4	1
Parity	Only 1 child	239	62.9
	Above 2 children	141	37.1
Marital status	Married	345	90.1
	Not in marital union	35	9.9

5.3 Socio-economic factors

The study revealed that the majority of mothers one hundred sixty two occupation were government employees (42.3%) followed by daily wedge earner and self-employed (36%) and mothers whose income level is above 2282.24 birr per month which is the mean value of the overall monthly income of the mothers are two hundred twelve (55.8%) see table 3

Table 3 Socio economic factors for respectful maternity care among mothers in immediate post-partum period in Addis Ababa public health facilities march 2018.

Socio-economic factor	Category	Frequency	Percent
Occupation	House wife	68	18
	Daily wage earner and self employed	137	36
	Student	13	3.7
	Government employee	162	42.3
Income level	2282.24 birr and above	212	55.8
	Less than 2282.24 birr	168	44.2

5.2 Service delivery and maternal experience

Majority of delivery too place during the night time. Only one hundred sixty five (43.4%) have given birth at day time. More than half (58.4%) of the mothers gave birth by spontaneous vaginal delivery. Two hundred ninety two of the mothers (76.8%) have used the current facility for themselves before and two hundred forty (63.2%) gave birth in hospital and one hundred forty (36.8%) went to health center see table 4

Table 4 Service delivery and maternal experience for respectful maternity care among mothers in immediate post-partum period in Addis Ababa public health facilities march 2018.

Service delivery and maternal experience	Categories	Frequency	Percent
Delivery time	Night	215	56.6
	Day	165	43.4
Mode of delivery	SVD	222	58.4
	C/S	88	23.2
	Instrumental delivery	70	18.4
Previous delivery	Yes	292	76.8
	No	88	23.2
Type of facility	Health center	140	36.8
	Hospital	240	63.2

Concerning service delivery and availability of guide lines for controlling and regulating the care given to the mothers, almost all of the interviewee has not heard about women friendly care and guidelines, but all of the respondents have agreed the importance of the availability of the guideline inorder to improve the quality of the service provided.

A 28 years old male staff nurse from health center

"Guidelines are I think important to help us give the appropriate drugs or services properly what I wanted to say is there are different guidelines in our facility like ANC guideline and others"

A 50 years old Staff midwife from health center

"There are many guide lines like different guidelines on how to administer the drugs and other guidelines like ANC guidelines but I don't know any guidelines on how to give women friendly care. They are very much relevant because it will control on how to approach the clients properly and to add on our service if there are any kinds of updated services"

A 35 years old female staff midwife from hospital

" I don't know….but I think it will be good to guide us on how to handle and approach the clients but rather than putting a guideline I think it would be better to train staffs and prepare controlling mechanisms like collecting the patients comments in written form and evaluate monthly….when I say this it should not just be evaluation there should be some kind of rewards or some kind of incentive for the staffs who are liked most by the clients…..so this way the staffs may take it seriously in giving the proper care and try to avoid negligence for the sake of the reward."

5.4 Provider factor

Majority of the mothers who gave birth in hospitals are attended by medical doctors that is two hundred thirty three (60.8%) while one hundred fifty were attended by midwives and nurses (39.2%), Male health providers attend higher number of deliveries (58.7%) when compared with females (41.3%) and health providers who are in the age group of youth (55.5%) attend more delivery than adults (36.3%) and elderly (8.2%) see table 5.

Table 5 Provider factors for respectful maternity care among mothers in immediate post-partum period in Addis Ababa public health facilities march 2018.

Provider factors	Categories	Frequency	Percent
Provider profession	Doctor	233	60.8
	Midwife and nurses	150	39.2
Sex of the provider	Male	223	58.7
	Female	157	41.3
Age group of provider	Youth	211	55.5
	Adult	138	36.3
	Elderly	31	8.2

Staff midwifes and nurses from different hospitals and health centers gave their perception on how the age group of the service givers might affect the respectful maternity care given. They said that inorder to provide respectful care there must be some consideration given to the profession and the health professionals, especially to those who served longer because as the number of service years increases the threshold for stress tolerance decreases and there will be major behavioral change which will affect the care giving.

A 35 years old female staff midwife from hospital

"*To tell you the truth…it's very much boring and tiresome with no adequate salary and no thankfulness from the office as well as from the clients"*

"First of all there are no enough training provided to us. Even if there is, the bosses are the once who will get the chance to go….and what is very sad is we are the once who are working and carrying the burden and who confronts the blame which results from not giving the service. And another thing we don't even get the information weather there is training on the services or the drugs we are using."

A 50 years old Staff midwife from health center

"Ummmm…..i really like my profession very much….i have no words to express my satisfaction."

"Our work needs a very special attention and we have to be careful in every step we take or every decision we make…..emm specially since I am working in health center, most of the decisions are made by midwives because there are no doctors….so practical skill and knowledge is very much mandatory in our position. When I say this when the mothers reach to term we are the once who should decide whether she should

continue follow up in this health center or to refer her for further management and also all the responsibility concerning her safety and safe delivery relay on us because anything can happen at any time starting from the onset of labour till the time of her discharge after delivery."

A 28 years old male staff nurse from health center

"It is not as I have expected but i don't think I will be working with this profession. In the beginning I didn't want to learn this profession but I didn't have choice. It is to say that I am not interested to work with this it is just for the time being"

"Almost everything in this profession is very difficult….umm may be it is because I don't like the profession but as you can see there is a double burden we give care for the mother as well as we care for the wellbeing of the fetus inside her. And most of all it is full of contamination you don't know when you are going to get touched or splashed with different body fluids. And the other major thing that I don't want to pass without saying is there is corruption in every promotions or every trainings that come for the facility only the higher or the closest to the administer gets the benefit. So…..this makes this profession even harder and uninviting to continue."

The most important thing that the health professionals think they need from their supervisors currently, inorder to provide respectful and supportive care is technical support, appreciation and getting the opportunity to upgrade and update their current knowledge as well as position.

A 50 years old Staff midwife from health center

"From our supervisors…..we will need professional support and help us whenever we face different problems during our service and to listen to us and find a solution to our problems that is all."

A 28 years old male staff nurse from health center

"Support in every way that we might need either skill sharing or motivation to do our work and establish favorable working environment so that we would like our facility."

A 35 years old female staff midwife from hospital

"Mostly appreciation and support. Because if I get thanks from the clients and my supervisors give credit and show me gratefulness with my work it will be very much motivating for me so that I will be very eager to do better and professional support to give proper service"

The magnitude of respectful maternity care in Addis Ababa public health facilities is 82.4% whereas the magnitude of disrespect and abuse is 17.6% see the pie chart below. Figure 3

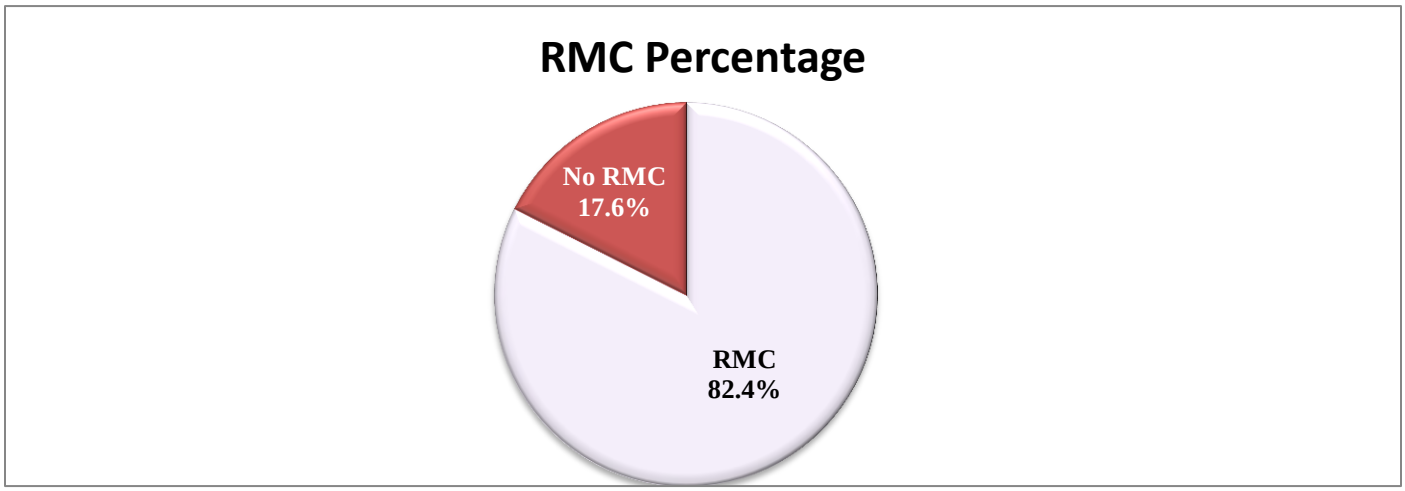

Figure 3 Magnitude of RMC of respectful maternity care among mothers in immediate post-partum period in Addis Ababa public health facilities march 2018.

Mothers who faced no physical abuse are (84.5%), those who said that their privacy is kept are (83.7%) and none of them (100%) were detained in the facility and consent was taken from all the mothers for any procedure done during their stay. According to the descriptive result among the seven classifications of respectful maternity care, there is poor dignified care (18.2%) when compared with the others followed by the problem of confidentiality (16.3%).The overall percentages of the seven classifications of Browser and Hill for disrespect and abuse are as follows. See figure 4

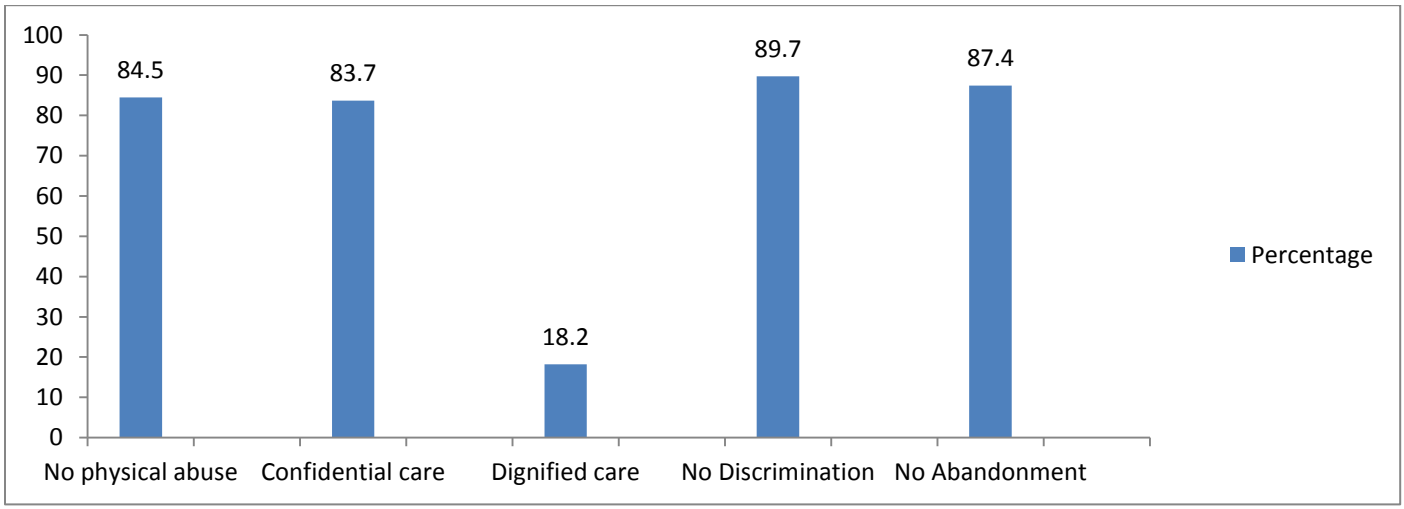

Figure 4 Classifications of RMC among mothers in immediate post-partum period in Addis Ababa public health facilities march 2018.

A 28 years old male staff nurse from health center said about dignified care

"*It is very difficult to maintain our attitude to all the clients because our work needs so much patience and it is tiresome, we need them to cooperate with us but mostly those mothers who are accompanied by many relatives don't hear us so we had to shout even if we don't want too, inorder to do our work peacefully*"

A 35 years old female staff midwife from hospital said that the problem of keeping their confidentiality is because of

"…as to me the client's complaint is true but it's related mainly with lack of adequate bed rooms, equipments and materials to the facility, like bed screens and curtains to keep the clients privacy"

5.4 Predictors of respectful maternity care in public health facilities

In bivariate logistic regression analysis, each explanatory variable with outcome variable (respectful maternity care) was assessed for its association and the observed associations were reassessed by multivariate analysis to identify adjusted association with the probability of receiving respectful care. And these variables which give P-value >0.25 were considered as not significant, so that they cannot be candidate to multiple logistic Regression for farther analysis.

Variables such as, income level, marital status, previous use of the facility, sex of the provider. Educational status of the mothers, age group of the provider, mode of delivery and profession of the provider were associated with respectful maternity care in bivariate logistic regression analysis. See table 6 below

Table 6 Candidate variables for multivariable logistic regression of respectful maternity care among mothers in immediate postpartum period in public health facilities of Addis Ababa March 2018

Variables	Respectful maternity care				
	Yes (%) (n=313)	**No (%) (n=67)**	**P-value**	**COR[95% C.I]**	**ROW TOTAL**
INCOME LEVEL					
2282.24 ETB and above	44(20.8)	168(79.2)	0.075	1.65[0.95, 2.86]	212
Less than 2282.24 ETB	23(13.7)	145(86.3)		1	168
MARITAL STATUS					
Married	53(15.4)	292(84.6)	0.001	3.67[1.75, 7.67]**	345
Not in marital union	14(40)	21(60)		1	35
PREVIOUS USE OF THE FACILITY					
Yes	246(84.2)	46(15.8)	0.082	1.676[0.93,3.00]	292
No	67(76.1)	21(23.9)		1	88
SEX OF THE PROVIDER					
Male	28(12.6)	195(87.4)	0.002	2.30[1.34, 3.93]	223
Female	39(24.8)	118(75.2)		1	157
Education status					
No formal education	31(62)	19(38)	0.001	3.40[1.68,6.87]	50
Secondary and above	132(86.3)	21(13.7)	0.69	0.89[0.48,1.63]	153
Primary	150(84.7)	27(15.3)		1	177
Sex of provider					
Male	28(12.6)	195(87.4)	0.002	2.30[1.34,3.93]	223
Female	39(24.8)	118(75.2)		1	157
Mode of delivery					
Cesarean section	17(19.3)	71(80.7)	0.45	1.279[0.67,2.42]	88
Vacuum & forceps	15(21.4)	55(78.6)	0.27	1.45[0.74,2.86]	70
Normal delivery	35(15.8)	187(84.2)	0.5	1	222
AGE GROUP OF THE PROVIDER					
Youth	177(83.9)	34(16.1)	0.034	0.40[0.17,0.93]	211
Adult	115(83.3)	23(16.7)	0.05	0.42[0.17,1.01]	138
Elderly	21(67.7)	10(32.3)	0.09	1	31

But in multivariate logistic regression after adjusting for potential confounders, having higher monthly income, being married, attending formal education, being male and giving birth by normal delivery were found to be predictors of respectful maternity care.

In the analysis having monthly income 2282.24 ETB and above were about twice (AOR 1.92[95% C.I 1.048, 3.51]) more likely to receive respectful maternity care. Being married were more than three times AOR 3.65 [95% C.I 1.59, 8.36]) more likely to receive respectful maternity care than their counterparts. See table 7

Mothers, who attended secondary education and higher, tend to receive almost four times AOR 3.86 [95% C.I 1.73, 8.62] better respectful maternity care, Male health providers who attended deliveries give more than two times AOR 2.28 [95% C.I 1.281, 4.08] and giving birth by normal delivery or spontaneous vaginal delivery is more than two times 2.368 [95%C.I 1.12, 4.99] likely to receive respectful maternity care than their counterparts. See table 7

Table 7 Independent predictors of respectful maternity care among mothers in immediate postpartum period in public health facilities of Addis Ababa March 2018

Variables		Respectful maternity care			
		Yes (%) (n=313)	**No (%) (n=67)**	**COR[95% C.I]**	**AOR[95% C.I]**
Monthly Income					
	2282.24 ETB and above	44(20.8)	168(79.2)	1.65[.95, 2.86]	1.92[1.048, 3.51]*
	Less than 2282.24 ETB	23(13.7)	145(86.3)	1	1
Marital status					
	Married	53(15.4)	292(84.6)	3.67[1.75, 7.67]*	3.65 [1.59, 8.36]*
	Not in marital union	14(40)	21(60)	1	1
Education status					
	Primary	27(15.3)	150(84.7)	3.40[1.68, 6.876]*	3.58 [1.65, 7.77]*
	Secondary and above	21(13.7)	132(86.3)	3.85[1.85, 8.02]**	3.86 [1.73, 8.62]*
	No formal education	19(38)	31(62)	1	1
Sex of provider					
	Male	28(12.6)	195(87.4)	2.30[1.34, 3.93]	2.28 [1.281, 4.08]*
	Female	39(24.8)	118(75.2)	1	1
Mode of delivery					
	Normal	35(15.8)	187(84.2)	1.457[0.742,2.86]	2.368 [1.12, 4.99]*
	Cesarean section	17(19.3)	71(80.7)	1.139[0.523,2.48]	1.19[0.52, 2.68]
	Vacuum & forceps	15(21.4)	55(78.6)	1	1

NB: * statistically significant at p-value <0.05, ** statistically significant at p-value<0.01, 1=reference category

CHAPTER SIX: DISCUSSION

Women want a positive childbirth experience that fulfills or exceeds their prior personal and sociocultural beliefs and expectations. This includes giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from birth companion(s) and kind, technically competent clinical staff. Most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision making, even when medical interventions are needed or wanted.

This study indicates that about 82.4% of mother reported that they have received respectful maternity care, this result is consistent with study done in Kenya 80%, Tanzania 85%, Zanzibar 88.3% .(13)And it's greater than studies conducted in Nigeria 2% and Addis Ababa public health facility 22% this difference might be due to, time variation related with currently accelerated RH promotion activities and women friendly programs, different supportive trainings in some health institutions of the study area.(10,18)

The finding of this study revealed that average monthly income was found to be significantly associated with receiving respectful maternity care which is those who earn above the mean value that is >2282.24 ETB (65.7%) of the mothers receive better respectful maternity care (p-value= 0.035) is consistent with a study done in one public health facility and three adjacent health centers in Addis Ababa, respondents monthly income was significantly associated with a different level of disrespect and abuse (89.5% among those with a monthly income of <713 birr and 70.3% among those with monthly income of > 713 birr; p = 0.006).(10)

Being married were more than three times AOR 3.65 [95% C.I 1.59, 8.36]) more likely to receive respectful maternity care when compared with those who are not in marital union. This finding may be as a result of attitudinal problem resulted from having over confidence by their companion, which might have led to miscommunication with the health providers trying to keep the health facilities rule. A study done in Nigeria Mothers who are Married 420, 9 (2.1%) of them received respectful maternity care, while out of 26 Single/widowed mothers only 1 (3.8%) claimed to receive respectful maternity care.(18)

According to this study, mothers, who attended secondary education and higher, tend to receive almost four times AOR 3.86 [95% C.I 1.73, 8.62] better respectful maternity care than those who have no formal education, A study done in Enugu, southeastern Nigeria Educational status out of mothers who have no formal education 8 (1.8%) none of them 8 (100%) received respectful maternity care, those who attained Primary education 72 (16.1%) again none of them received respectful maternity care 72 (100%) whereas

those who attended Secondary education out of 200 (44.8%) respondents 3 (1.5%) claimed to receive respectful maternity care.(18)

Male health providers who attended deliveries give more than two times AOR 2.28 [95% C.I 1.281, 4.08] better respectful maternity care than female health providers, this result is consistent with a study done in Sub-Saharan African countries, especially urban Tanzania higher likelihood of performing high level of respectful maternity care was found among male providers vs. female midwives in facilities, implementing a quality improvement approach among laboring women accompanied by a companion.(20) and according to a study done in Ethiopia, this result is found to be consistent with the finding male providers were observed engaging in RMC practices more frequently than female providers. A clue from a study of nurses' abuse of patients in South Africa concluded that female nurses deployed violence against patients in their work as a means of creating social distance and maintaining fantasies of identity and power in their continuous struggle to assert their professional and middle class identity.(23)

Giving birth by normal delivery or spontaneous vaginal delivery is twice more likely 2.368 [95%C.I 1.12, 4.99] to receive respectful maternity care than those who deliver by instrumental delivery (vacuum extraction or forceps delivery), this might be because of the pain and suffering the mother faces till the child is born due to this reason she might not be able to do what the health providers ask her to do, so the providers might have used force or other unnecessary actions to offend her.

Strength and limitation of the study

Strength of the study

Because the study was done in immediate post-partum period in maternity ward, there was no problem concerning recall bias during data collection.

Limitation of the study

In excluding private health facilities, some important findings might be missed because of facility based service provision difference.

Social desirability bias may compromise the perceptions of the mothers on respectful maternity care.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

CONCLUSION

More than eighty two percent of the respondents or mothers in Addis Ababa public health facilities in immediate post-partum period receive respectful maternity care. Maternal income level, marital status, educational status, their mode of delivery and the sex of the provider were the independent predictors of respectful maternity care.

RECOMMENDATIONS .

To Federal Ministry of Health and Addis Ababa health office

Arrange regular supervision to the health facilities and health providers to make services respectful and more women friendly which could help to reduce maternal morbidity and mortality.

To equip the health facilities with the necessary instruments and materials needed to give appropriate service.

The health administrators should promote and institutionalize locally contextualized respectful maternity care standards (guidelines) to protect women's rights.

To Addis Ababa public health facilities administration and medical directors

Ensure a respectful and dignified working environment for those who are providing care by acknowledging and training the staff especially female health providers, should also be considered inorder to avoid disrespect and abuse.

To support quality improvements and valuing the preferences of the women should be kept in mind regarding the birthing position, curtains to ensure privacy, choice of companion, and availability of other necessities.

To researchers

Pure qualitative studies should be conducted to explore findings concerning provision of respectful maternity care from the mothers' perspective.

Comparative studies should be conducted between private and government health institutions inorder to identify the difference and similarity of respectful maternity care given.

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Annexure I

Nature and extent of reported disrespect and abuse by health providers in facility-based Child birth among women attending PNC in public health facility of Addis Ababa, Ethiopia

WRITTEN CONSENT FORM

UID: ----------

Hello, I am ----------. I am a student of Master of Public Health/Reproductive Health in Jimma University for Health Science Studies. I am going to do a study on women of Addis Ababa town who have delivered in public health facility. I want to collect some information about the experiences, the positive especially negative experiences women had in the health facility during their delivery time at the facility.

About the study:

A total of 380 women will be interviewed in this study. Hence, including you in the study

I will ask you few questions regarding your experiences during your last delivery and the type of care you received at the facility. This would take approximately 30-45 minutes of your valuable time. I may contact you again if I have any clarifications related to the information collected during the present interview.

Benefits:

You will not get direct benefits from the study. But, the information provided by you will help us

To understand the type of care women receive during delivery and hence, the improvements needed at the facilities.

Confidentiality:

Your name, address and any other personal information shall not be disclosed to anybody anytime and later no one will come to know the answers given by you, including me.

Voluntary participation:

Your participation in this study is voluntary and you have the right to withdraw your participation at any time during the interview without any explanation. Refusal to participate will not cause any harm to you. There might be certain questions which you may find stressful. You can choose to decline answering these questions.

If you have any additional questions about this research, you may contact me at the given Number: ----------

……...

Are you willing to participate in this study? ❑ Yes ❑ No

Name of the participant: _____

Signature/ left thumb impression of the participant

Name and signature of witness (in case of verbal consent)

---------- ----------

Signature of interviewer Date

---------- -----/-----/----------

Annexure II

Nature and extent of reported disrespect and abuse by health providers in facility-based Child birth among women Addis Ababa, Ethiopia

Serial number (for personal use only): | | | |

Interview Schedule for the survey						
Code	**Code for personal use only**					**Main code- P**
P1	Participant's ID No.					
P2	Date of interview	**dd**	**mm**	**yy**		
P3	Start time	**HH**	**MM**		**AM/ PM**	
P4	End time	**HH**	**MM**		**AM/ PM**	
P5	Contact number of the participant					

Section 1: Background characteristics					**Main code- B**
I would like to ask you some questions about yourself and your health					
S.No	**Sub- code**	**Questions**	**Response**		
1	**B1**	What is your age? (In completed years)	----------		
2	**B2**	Have you ever attended school? If 2, go to #4.	**1**	**YES**	
			2	**NO**	
3	**B3**	What is your highest level of educational qualification?	**1**	Primary	
			2	Secondary	
			3	Higher education	
			4	Non- formal education	
			5	Others (specify)	
4	**B4**	What is your occupation? status over the past 12 months? (mention all that applies)	**1**	House wife	
			2	Daily wage earner	
			3	Salaried employment	

			4	Self-employed	
			5	Student	
			6	Others (specify)	
5	**B5**	What is your religion?	**1**	Muslim	
			2	Orthodox Christian	
			3	Protestant	
			4	Catholic	
			5	Others (specify)	

6	**B6**	What is your current marital status?	**1**	Married	
			2	Widowed	
			3	Divorced	
			4	Separated	
			5	Others (specify)	
Section: 2 Socio-economic status				**Main code- H**	
7	**H1**	What is the type of your house? (record observation)	**1**	Condominium	
			2	Mud house	
			3	"korkoro" house	
8	**H2**	How much is your average monthly income?	**1**	----------	
9	**H3**	Is it easy or difficult for you to meet the monthly household Expenditures?	**1**	Easy	
			2	Neither easy nor difficult	
			3	Somewhat difficult	
			4	Difficult	

Section: 3 Delivery characteristics					Main code-D
Now I am going to ask you some questions about your recent delivery in this health facility					
10	**D1**	How many total numbers of deliveries you had from the following?(including still births/ neo-natal deaths)	**1**	At home ----------	
			2	At health facility--------	
			3	Others----------	
				Total----------	
11	**D2**	What was the type of facility where you had your last delivery? If you can mention full the name of the health facility, note it.	**1**	Primary Health Centre	
			2	District Hospital	
			3	Private Hospital	
12	**D3**	Did delivery take place in the first health facility approached for delivery? If 2, go to #15.	**1**	Yes	
			2	No	

13	**D4**	What were the reasons for choosing this facility where you had your delivery? (mention all that applies)	**1**	Affordable	
			2	Close by	
			3	Well connected by transport	
			4	Have adequate drugs and equipment	
			5	Preference for the type of health provider	
			6	Attitude of health provider	
			7	Facility where respondent usually goes	
			8	Safer than home delivery or other facilities	
			9	Health worker recommended	
			10	Incentives given	
			11	Others	
14	**D5**	What was the reason for approaching the current facility?			

15	**D6**	Have you ever used this facility for Yourself before this delivery? If 2, go to #17	**1**	Yes	
			2	No	
16	**D7**	What was the purpose of visiting the facility earlier? (mention all that applies)	**1**	Out-patient care for self	
			2	Previous delivery for self	
			3	In-patient care for self	
			4	Others	
17	**D8**	Did you ever come to this facility as a companion for others?	**1**	Yes	
			2	No	
18	**D9**	Did you arrive at the facility with Somebody when you come to deliver? If 2, go to #21.	**1**	Yes	
			2	No	
19	**D10**	Who accompanied you to the facility when you came for the last delivery?	**1**	Family members (other than husband)/ friend (s)	
			2	Husband	
			3	Local Health Worker/ Others	
			4	Family members (other than husband)/ friend (s) and Local Health Worker/ Others	
			5	Husband and Local Health Worker/ Others	
			6	Family members (other than husband)/ friend (s) and Husband	
			7	All	
20	**D11**	Were there any companions (family members/ friends) during your delivery?	**1**	Yes	
			2	No	

21	**D12**	What was the profession of the main provider conducting your delivery?	**1**	Doctor	
			2	Midwife	
			3	Others specify ----------	
			4	Nobody	
22	**D13**	What was the age group of the provider attending your delivery?	**1**	Youth	
			2	Adult	
			3	Elderly	
			4	Others specify ----------	
23	**D14**	What was the sex of the main Provider conducting your delivery?	**1**	Male	
			2	Female	
24	**D15**	What was the mode of your last delivery?	**1**	Normal delivery	
			2	Caesarean delivery	
			3	Vacuum extraction/ forceps delivery	
			4	Delivery by episiotomy	
25	**D16**	Did you stay in the hospital after delivery? If 2, go to# 27	**1**	Yes	
			2	No	
26	**D17**	For how many days did you stay in the hospital?	**1**	One day	
			2	Two days	
			3	More than two days to one week	
			4	More than a week	
27	**D18**	Were there any complications during your last delivery?	**1**	Yes (for self)	
			2	Yes (for baby)	
			3	Yes (both self and baby)	
			4	No	

Section: 5 Disrespect and abuse during the last childbirth					Main code-R
Some women tell us that when they give birth they are treated poorly or with disrespect. I would like to know how common this problem is, so I would like to ask you about your own experiences with childbirth. There is no right or wrong answer to these questions. It is only important to know your experiences. Nothing you tell will be linked to your name, your children's names, or the ability of you or your family members to access health care in the future. Some of these questions may be stressful or upsetting. As I said before, you can skip any question you are not comfortable answering, and you can stop the interview at any point.					
27	R1	At any point during your stay in this facility for this delivery were you treated in a way that made you feel disrespected?	1	Yes	
			2	No	
28	R2	What exactly happened?			
Section: 5.1 Non-confidential care					**Main code-NCF**
29	NCF1	Health providers discussed your private health information in a way that others could hear.	1	Yes	
			2	No	
30	NCF2	Your body was seen by other people (apart from health providers) during delivery	1	Yes	
			2	No	
Section: 5.2 Non-dignified care					Main code-ND
31	ND1	Health providers shouted at or scolded you	1	Yes	
			2	No	
32	ND2	Health providers made negative comments about you.	1	Yes	
			2	No	
33	ND3	Health providers threatened to withhold treatment because you could not pay or did not have supplies.	1	Yes	
			2	No	

34	ND4	Health providers threatened for any other reason. Please specify			
Section: 5.3 Neglect and Abandonment					**Main code-NA**
35	NA1	Health providers ignored or abandoned you when you called for help.	1	Yes	
			2	No	
36	NA2	You delivered without any assistance.	1	Yes	
			2	No	
Section: 5.4 Non-consented care					**Main code-NCC**
37	NCC1	Was tubal ligation done?	1	Yes	
			2	No	Skip to 38
38	NCC2	Was the Tubal ligation (tying the fallopian tubes) done without your permission	1	Yes	
			2	No	
39	NCC3	Was Caesarean section done?	1	Yes	
			2	No	Skip to 39
38	NCC2	Was Caesarean section done without your or your relative's permission?	1	Yes	
			2	No	
39	NCC3	Was Hysterectomy done?	1	Yes	
			2	No	Skip to the next section
39	NCC3	Was Hysterectomy (getting your uterus removed) done without your or your relative's permission.	1	Yes	
			2	No	

Section: 5.5 Physical abuse					**Main code-PA**
40	PA1	Health provider(s) hit, slapped, pushed, pinched or otherwise beat you?	**1**	Yes	
			2	No	
41	PA2	Used force as a restrain during	**1**	Yes	

		labor/ delivery/ examination?	**2**	No	
42	PA3	Procedures were done without anesthesia or other forms of pain relief? Specify the procedure.	**1**	Yes	
			2	No	
Section: 5.6 Discrimination					**Main code-DS**
43	DS1	Were you treated poorly because of poverty?	**1**	Yes	
			2	No	
44	DS2	Were you treated poorly because of Your religion, your age or your marital status?	**1**	Yes	
			2	No	
45	DS5	(If answered 1 for any #43/ 44) What happened?			
Section: 5.7 Inappropriate demands of money and detention in facilities					Main code-M
46	M1	Were you or your baby not allowed to leave the health-facility due to failure to pay?	1	Yes	
			2	No	
Section: 5.8 Others					**Main code-O**
47	O1	Did anything else disrespectful happened to you that I did not ask you about?	1	Yes	
			2	No	
49	O2	What exactly happened?			

Section: 6 Reaction to abuse	Main code-RA

52	RA1	For the majority of the negative experiences that you told, what was the sex of the abuser?	1	Male	
			2	Female	
			3	Both male and female	
			4	Others	
53	RA2	Now, for your experiences you talked about above, tell me what had been your response	1	Took no action	
			2	Complained to the nurse/ doctor in charge or other staff person	
			3	Formally filed a complain	
			4	Others (specify)	
54	RA3	Can you tell me how severe the experiences that we talked about were to you?	1	Mild	
			2	Moderate	
			3	Severe	
			4	Extreme	

Section: 7 Looking forward				Main code-L	
Now I want to ask you about your plans to choose health care facilities in the future					
55	L1	Do you plan to have more children? If 2, go to #65.	1	Yes	
			2	No	
56	L2	Where do you plan to deliver your next child? If 2/3/4 go to #64	1	Same facility	
			2	Another facility (specify)	
			3	Home	
			4	Others (specify)	
57	L3	Why do you not want to deliver your next child at the same facility?			

58	L4	How much will your experience during your last delivery influence your decision on where to deliver in the future?	1	Very likely	
			2	Somewhat likely	
			3	Somewhat unlikely	
			4	Not at all likely	
			99	DK/ NR/ RF*	

59	L5	How likely are you to recommend the facility where you had your last delivery to other women for delivery?	1	Very likely	
			2	Somewhat likely	
			3	Somewhat unlikely	
			4	Not at all likely	
60	L6	How likely are you to bring your child/ children to the facility where you had your last delivery for health care in the future?	1	Very likely	
			2	Somewhat likely	
			3	Somewhat unlikely	
			4	Not at all likely	
61	L7	If you were a manager and could choose to do one thing to improve the care women get in the facility you used for your last delivery, what would it be?			

Thank the respondent; take permission to contact again, if required.

_____

Signature of the PI

Note: # denotes question number

Annexure III

In-depth Interview guides (Key informant interview)

Interview guide for health professionals

1. What is your profession?

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2. How long have you been working with your profession?

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3. How long have you been working in the current health facility?

---

4. How do you find working in your profession?

---

5. What is the most difficult part? Examples? (Practical skills, Priorities, Information)

---

6. Are there any guidelines concerning women friendly care?

---

7. How do you consider the relevance of the guidelines for your work in the health facility?

8. How is receiving trainings relevant for you in your daily work?

9. Could you describe what it means to be respected and supported during labour? What you believe the meaning of respected and support during labor means?

10. What are the things that you will need from your employers or government in order to make this kind of respectful and supportive care available?

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11. What are those things that you think you will need from your supervisor at this time inorder to provide respectful and supportive care?

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12. What is the most challenging part of your work and why?

-- 13. Do you feel valued in your work?

--

Thank you for your cooperation

PI signature
