Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study

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List of publications included in this thesis

- Adinew YM, Hall H, Marshall A, Kelly J. Disrespect and abuse during facility-based childbirth in central Ethiopia. **Global Health Action**. 2021;14(1):1923327.
- Adinew YM, Marshall A, Smith M, Kelly J. Care providers' perspectives on disrespect and abuse during facility-based childbirth in Ethiopia: a qualitative study. **International Journal of Women's Health**. 2021; 3:1181-95.
- Adinew YM, Kelly J, Marshall A. "I would have stayed home if I could manage it alone": a case study of Ethiopian mother abandoned by care providers during facility-based childbirth. **International Journal of Women's Health**. 2021; 13:501-7.
- Adinew YM, Kelly J, Marshall A. Women's perspectives on disrespect and abuse during facility-based childbirth in Ethiopia: a qualitative study. **BMC Pregnancy and Childbirth** (under review)

Conference presentations from this research

Research Conversazione: 2020 Adelaide Nursing School Research Conversazione, September 2019

- Oral presentation: Adinew YM, Hall H, Marshall A, Kelly J. Disrespect and abuse during facility-based childbirth in Ethiopia.

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- Poster presentation: Adinew YM, Kelly J, Marshall A, Smith M. Care providers' perspectives on disrespect and abuse of women during facility-based childbirth in Ethiopia: a qualitative study.

Abstract

Disrespect and abuse of women during facility-based childbirth is a violation of human rights and an indicator of poor quality of care. Disrespect and abuse have been identified as deterrents for women attending facility-based childbirth in developing nations; however, this barrier is poorly understood in the Ethiopian context. Thus, this project aimed to investigate the prevalence of disrespect and abuse, and women's and care providers' perspectives on disrespect and abuse, during facility-based childbirth in Ethiopia.

This thesis comprises four iterative and interconnected studies. In study 1, a community-based cross-sectional survey was conducted to quantify the frequency and categories of disrespect and abuse. Women who had given birth at a public health facility within the previous twelve months were recruited via health extension workers. All 435 participants reported at least one form of disrespect and abuse during childbirth. The types of disrespect and abuse were physical abuse, non-consented care, non-confidential care, abandonment/neglect, non-dignified care, discriminatory care and detention. Hospital birth, rural residence, monthly household income less than 1,644 Birr (USD 57) and being attended by female providers and midwives were positively associated with experiences of disrespect and abuse.

In study 2, qualitative in-depth interviews and focus group discussions were employed to collect data. The participants were 50 women who had given birth at a public health facility within the previous twelve months. The participants were invited to reflect on the acceptability of hypothetical scenarios about mistreatment during childbirth, rather than being asked to disclose personal experiences of mistreatment. While the women rejected disrespectful and abusive acts during childbirth generally, they considered some acts acceptable or necessary under certain circumstances. Four themes were identified: (1) disrespect and abuse is not acceptable, (2) disrespectful and abusive actions are only acceptable if intended to save lives, (3) disrespectful and abusive actions are an accepted part of everyday practice to prevent complications and adverse outcomes, and (4) disrespectful and abusive actions are necessary to discipline disobedient women.

In study 3, a testimony of a 28-year-old mother of two children, narrated in her own words, was used with her permission to form a case study. Five themes emerged from her narrative: denial of care; non-consented care; non-dignified care; taking a sick baby home without medical assistance; and loss of trust in care providers.

In study 4, qualitative in-depth interviews were used to collect data from 15 care providers (midwives, nurses, general practitioners and obstetricians) from selected health facilities with direct involvement in the care of women during pregnancy and labour. The care providers revealed that women are being subjected to disrespect and abusive treatment during childbirth. While the care providers generally considered disrespectful and abusive acts during childbirth unacceptable, they tended to consider some acts acceptable and a few necessary under certain circumstances. Four themes were identified: 1) disrespect and abuse breaches professional standards, 2) disrespectful and abusive actions are justified at times to save the mother and her baby, 3) disrespect and abuse is used as a tool to assert power, and 4) disrespect and abuse arise from health system deficiencies.

Conclusion: According to the accounts of the participants, the application of respectful care in everyday maternity practice in Ethiopia is insufficient. The findings highlight the urgent need for policy and practice interventions to address the issue, such as empowering women through education to reinforce their right to respectful care. It reflects the need for health professionals to be educated and trained on the importance of providing respectful care and how such care can be incorporated into daily practice. The underlying gender-related issues suggest the importance of interventions at a broader socio-political and community level, such as educating all adults about their right to respectful care and empowering them to report disrespectful practices.

Thesis declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint award of this degree.

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I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship.

Signed:

Date: 8/29/22

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Dedication

I dedicate this thesis to victims of disrespect and abuse.

Abbreviations

CRC	Compassionate and respectful care
HDA	Health development army
HDT	Health development team
HEW	Health Extension Worker
RMC	Respectful maternity care
WHO	World Health Organization
WRA	White Ribbon Alliance

Chapter 1: Introduction

This introductory chapter presents background information on maternal health in Africa and Ethiopia, respectful maternity care, disrespect and abuse, and the Ethiopian healthcare system and health policies. The research objectives, research questions, study outline and a brief summary of the remaining chapters of this thesis are also provided.

1.1 Background

1.1.1 Overview of maternal health in Africa and Ethiopia

Maternal health refers to the "health of women throughout pregnancy, childbirth and the postpartum period" (1). While this period in a woman's life is often a fulfilling, positive experience, for too many women in low-resource settings it is linked with life-threatening complications and death (2). Across Africa, and in Ethiopia specifically, labour and birth are critical events in a woman's life, often characterised by intense vulnerability which places the woman at a high risk of complications (3, 4). It is well recognised that poorer women living in low-income countries comprise 99% of global maternal deaths (5), with pregnancy and childbirth–related complications the main causes of death for women of reproductive age (6). The World Health Organization (WHO) has defined maternal death as the "death of a woman while pregnant or within 42 days after termination of pregnancy, irrespective of the site and duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (7). A study focused on saving lives of mothers and babies in sub-Saharan Africa has identified that improving access to approved interventions for 90% of families would spare four million African women and babies annually (8).

According to the WHO (9) and a discussion paper published by *The Lancet* on strategies for reducing maternal mortality (10), promoting facility-based childbirth is the most effective and cost-efficient strategy for reducing maternal and neonatal death in resource-limited settings, when compared to birthing at home, alone or with a traditional attendant. However, maternity care in low-income countries is not sufficiently accessible to many women for a range of reasons including, but not limited to: financial constraints, lack of accessible and reliable transportation, gender discrimination, traditional beliefs and preferences, and concern about whether they will be treated respectfully within a healthcare facility (11, 12).

Understanding and promoting women's access to obstetric care requires understanding the complexities involved. For example, women without access to education, particularly those in rural areas, have little understanding of the physiology of reproduction or how it can be altered and tend to accept pregnancy as divinely ordained (13). They are more likely to choose traditional practices and are less likely to seek professional health care, and as a result their labour and birth are usually not attended by trained health workers (14). Furthermore, many Ethiopian women have limited personal decision-making capacity and need approval from family members to seek professional assistance when birthing (15, 16). These decisions are usually made after labour has started, which may further delay or deter them accessing professional care (17). Even after deciding and receiving family approval to seek skilled attendance, women can experience a delay in identifying and reaching a medical facility due to physical and economic barriers. Unavailability of transportation is a major contributor to this delay (11). Furthermore, reaching a medical facility may not guarantee a woman adequate and appropriate care, as the quality of care is reliant on the availability of equipment and supplies, skilled human resources, motivation and the attitude of healthcare professionals (18).

1.1.2 Respectful maternity care

The United Nations international human rights framework identifies the mistreatment of women during childbirth as a key human rights issue (19-22), and highlights the importance of a human rights–based approach to birthing care (23). The WHO defines respectful maternity care as care organised for and provided to all women in a manner that ensures their dignity, privacy and confidentiality, maintains freedom from harm and exploitation, and enables informed choice and continuous support throughout maternity care (24). The White Ribbon Alliance (WRA) is an international coalition bound together by a common goal: to ensure that pregnancy and childbirth are safe for all women and newborns in every country around the world. WRA identifies that the "absence of abuse during care alone is insufficient to provide respectful maternity care; rather, positive staff attitudes and actions are required to improve women's satisfaction with their birthing experience" (24). Respectful maternity care (RMC) has been further defined by the Maternal and Child Health Integrated Program as a person-centred approach to care based on the ethical treatment and human rights of women, babies and families. It promotes procedures that ensure that all women have equitable access to care while also taking into account the woman's preferences and the needs of her infant (25).

Within African countries there is growing recognition that every woman has the right to the highest attainable standard of health, which includes the right to quality and respectful maternity care during childbirth (26, 27). The United Nations have identified that responsive and accessible maternity care should be timely, friendly, and abuse and discrimination free (28). Women should have the right to experience effective interactions with staff, receive clear and accurate information on the care they are receiving, have their privacy and confidentiality respected, be free from any form of mistreatment, and receive emotional support and their companion of choice (29).

In addition, the United Nations identifies that care providers' behaviour that reflects RMC includes creating good rapport with women, providing information, encouraging women to ask questions and responding to their questions, encouraging women to move around as they choose and have access to food, asking women their preferred birthing position and allowing them to choose this (30, 31). Pillay et al. further identified that women have the right to be comforted throughout childbirth and to have access to pain relief (32). However, a synthesis of evidence from 65 studies examining the barriers to skilled attendance in low- and middle-income countries with resource-limited settings has revealed that care providers do not always give women psychological support and are not always sensitive to women's privacy(10, 13).

1.1.3 The Respectful Maternity Care Charter and the White Ribbon Alliance

The Respectful Maternity Care Charter was produced by the White Ribbon Alliance through multi-stakeholder collaborations involving physicians, researchers and advocates and has been adopted by institutions and governmental and non-governmental organisations in a movement to promote respectful maternity care. The charter was created using internationally recognised human rights conventions including the International Covenant on Civil and Political Rights and the Convention on the Elimination of All Forms of Discrimination Against Women, to which many countries are signatories (24). The charter outlines seven basic rights of childbearing women. Since its inception, it has been translated into many different languages, adopted on a worldwide scale, and used to create awareness of the mistreatment of women, teach care providers about rights-based maternity care, and influence policy changes (33). Table 1 presents the maternal health rights of women in the right-hand column. The table also identifies seven categories of disrespect and abuse: physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, discrimination and detention (34). Each category has more than one verification criteria with "Yes" or "No" dichotomised responses.

According to WRA, verification criteria, or manifestations of disrespect and abuse, often fall into more than one category, so the categories are not intended to be mutually exclusive, rather overlapping (35).

Table 1: Categories of disrespect and abuse and the corresponding rights – The White Ribbon Alliance (24)

Category	Items (examples)	Corresponding rights
Physical abuse	Provider used physical force, slapped or hit the woman Provider roughly forced legs apart, fundal pressure for normal delivery Woman was physically restrained Baby was separated without medical indication Women did not receive comfort, pain relief as necessary Provider did not demonstrate culturally appropriate ways	Freedom from harm and ill treatment
Non-consented care	Provider did not introduce herself/himself Provider did not encourage the woman to ask questions Provider did not respond politely, truthfully and promptly Provider did not explain procedure and expectations Provider did not give periodic updates on status and progress Provider did not allow the woman to move during labour Provider did not allow the woman to assume position of choice Provider did not seek informed consent for procedures	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
Non-confidential care	There was no privacy (spatial, visual or auditory) Curtains and physical barriers were not used Drape or body covering was not used Too many staff members around Medical history disclosure to unauthorised person without consent	Confidentiality, privacy
Non-dignified care	Humiliation by shouting, blaming or degrading Provider did not speak politely Provider made insults, threats, etc. Provider used abusive language	Dignity, respect

Discriminatory care	Provider used language difficult to understand Provider showed disrespect based on specific attributes like social class, ethnic group, age, HIV status, marital status, educational level	Equality, freedom from discrimination, equitable care
Abandonment or denial of care	Facility closed despite being 24/7, or if open, no staff could provide care Provider did not encourage the woman to call if needed Provider made woman feel alone or unattended Provider did not come quickly when needed Provider denied support during labour Woman left unattended during second stage of labour, Provider failed to intervene when medically indicated. Provider failed to grant woman's requests.	Right to timely health care and to the highest attainable level of health
Detention in facilities	Not releasing mother or baby or accompanying family member until bill is paid	Liberty, autonomy, self-determination and freedom from coercion

1.1.3 Why I am doing this research

In 2016, I travelled to Ethiopia's Somali region as part of a study group to evaluate an accelerated midwifery program. We planned to interview the healthcare providers who worked at one of the selected health centres on a Sunday morning. On our way to the health centre, however, we were stopped by people who were grieving the loss of a woman. We waited until the individuals who had assembled to say their final goodbyes to the woman finished the traditional rite. In the meantime, I got out of the car and struck up a cordial conversation with some children. The children informed me that the 18-year-old primipara woman had died the day before while giving birth at a health institution. On further enquiry, I learned that she died in a facility we were heading to. According to what I was told, the only care provider in the delivery room left her alone on the delivery couch while he went to watch a football game.

After I arrived at the health facility, I confirmed that the information was true and that the abandonment of the woman during labour led to the death of both mother and foetus. I had the opportunity to speak with a couple of women seeking birthing care at the health centre, and they were anxious and not sure of what to expect; they had already heard what happened the previous day in the same delivery room. They informed me that the negligence and unfriendly approach of the care providers is deterring women from seeking lifesaving obstetric care.

Care providers I talked with informed me that the responsible care provider who left the labouring woman unattended to watch a football game said he instructed her to keep pushing on his way out, only to find her dead when he came back. Care providers expressed their disappointment in their unsupportive and biased managers and explained how that was contributing to disrespect and abuse of women. I have observed on several occasions that managers do not treat members of all professions equally and care providers of one cadre undermine the role of the others in the team. This leads to lack of professional respect and feelings of superiority between different health cadres.

After I returned home, I kept hearing disturbing news from different sources including the mainstream media that women are avoiding facility-based childbirth mainly because of their dissatisfaction with the care. As a result, I wanted to explore women's experience of facility-based childbirth and conducted study to explore why some women who had previous experience of facility-based childbirth gave birth at home to their most recent child by in-depth understanding of women's previous facility-based delivery experience, perspective towards

health facilities and service providers regarding birthing care (15). The study participants described a range of experiences they had during childbirth at health facilities that forced them to choose home birth in their most recent delivery. Women participants identified the abusive and disrespectful treatment they experience in their previous birthing care as a major deterrent to skilled attendance at birth.

I wanted to read more on disrespect and abuse of women during facility-based childbirth and the driving factors but could not find much literature. Specifically, there were only a couple of studies conducted in Ethiopia. That is when I decided on my PhD project to investigate the prevalence of disrespect and abuse during facility-based childbirth and explore care providers' and women's perspectives.

I am a native Ethiopian and have worked in the academia and health care sector for over a decade. Furthermore, my education (reproductive and child health) and research experience in maternity care have enabled me to understand the norms around childbirth in Ethiopia and traditions in the health care system. These have helped me to carry out this project.

1.1.4 Disrespect and abuse of women during facility-based childbirth

There is increasing recognition that disrespect and abuse in healthcare facilities is a widespread issue with varying degrees of severity and impact and unique drivers (36). Research from across the world has identified that disrespect and abuse is a major barrier to pregnant women seeking facility-based childbirth (13, 15). Disrespectful and abusive behaviour of care providers is seen as a significant indicator of poor quality of care (37) and many women do not seek a skilled attendant at birth due to fear of being disrespected and/or abused (38). As a result, the proportion of women attending a health facility for childbirth has not improved in many low-income countries. This low rate of attending a facility for birthing contributes to greater maternal mortality (39) as maternal mortality mostly occurs during childbirth and the immediate postpartum period (40). The situation is intensified in developing countries where an inadequate number of care providers serve a high volume of clients (26).

In Ethiopia, there is mounting evidence that women are suffering disrespectful and abusive care in birthing facilities. Negative, harmful and abusive events occur so commonly within health facilities that they may be accepted as part of the culture in Ethiopian health care (41, 42). Furthermore, Ethiopian women are more likely to be subjected to disrespect based on their specific attributes such as unmarried marital status and low economic status (43).

Reports from Ethiopia have identified that women are avoiding facility-based childbirth because of their or other women's negative experiences during maternity care (17, 44, 45). These experiences include providers' poor attitude (46), refusal of a birth companion (44, 46), disrespectful and abusive care (47), women not being allowed to make informed decisions (45), unwelcoming health facilities (44), breaches of privacy (44, 46), hostile staff (48), and poor readiness of health facilities (48). Such behaviours and the system barriers that contribute to such poor experiences are identified as disrespect and abuse. Nevertheless, there is no globally established definition of disrespect and abuse, as behaviours that are acceptable to women in some settings may be unacceptable to women in different contexts.

1.1.5 The Ethiopian context

Recently the government of Ethiopia has made a significant investment in the education of healthcare providers and in infrastructure to meet sustainable development goals. These efforts have resulted in improved primary healthcare coverage (49, 50). The proportion of Ethiopian women who report having difficulty accessing health care has decreased from 96% in 2005 to 70% in 2016 (51). The country is trying to maintain and improve quality under an unprecedented scale-up of services. However, improving communities' access to maternity care has not in itself been sufficient to encourage all pregnant women to utilise delivery services (52). According to the 2019 Ethiopian Demographic and Health Survey 50% of births in Ethiopia were not supervised by a skilled birth attendant and 48% of births occurred outside a health facility (53). Consequently, improving maternal and child health remains a challenge for a nation where 401 women died per 100,000 live births in 2017 (54), and 1 in every 30 children die within the first month (53). Ethiopia's maternal death rate is unacceptably high compared to an estimated average in other developing countries of 230 maternal deaths per 100,000 live births in 2013 (55). Studies have suggested that one of the main challenges to lowering maternal mortality is the low use of maternal healthcare services, particularly during childbirth (56, 57). This indicates a significant gap still exists in delivery of care that needs to be addressed now to reduce morbidity and mortality (58).

Ethiopia aims to reduce its maternal mortality ratio to less than 70 per 100,000 live births by 2030 in order to achieve the United Nations Sustainable Development Goal 3 (59). The Sustainable Development Goals are the blueprint to achieve a better and more sustainable future for all. Sustainable Development Goal 3 is about "Good Health and Well-Being" and is one of the 17 Sustainable Development Goals established by the United Nations in 2015.

Ensuring access to quality obstetric care is essential as it has the potential to reduce up to 75% of preventable deaths (60, 61). Improving respectful maternity care has been flagged as an important potential strategy for reducing preventable maternal mortality and morbidity, which could help accelerate progress towards meeting the Sustainable Development Goal targets for improving maternal health (62).

1.1.5.1 Rural and remote access

Ethiopia's 2015–16 Health Sector Transformation Plan highlighted maternal health as a priority along with skilled attendance at birth. The national reproductive health program goal of reducing 90% SBA and MMR of 199 per 1000,000 lives birth was not achieved by 2020 (49). Furthermore, 78% of Ethiopian women live in rural areas and have always found it more difficult to access health care than urban residents because of distance, tough topography and lack of transportation. This is why home births are common (79%), primarily in hard-to-reach areas, despite efforts to promote institutional births (51). There has been rapid increase in the size of Ethiopia's health system. The fact that many of Ethiopia's initiatives and facilities are new is a particular challenge for the country. The country is trying to maintain and improve quality under an unprecedented scale-up of services.

Even when women attend a health facility, they may not receive services that meet their needs. In most cases, the facilities fall short of the necessary resources including skilled healthcare providers, medical supplies and essential drugs. Most high-level specialised health professionals prefer to live in urban areas. As a result, the overall quality of care in rural and remote areas where the majority lives is often below internationally accepted standards (51). Many women have to take time off work, and spend their time and money only to find no, or substandard, care and this may deter them from seeking health care (63).

Ethiopia currently has inadequate skilled maternal healthcare providers to meet the essential needs of the population. According to a 2020 report from the Federal Ministry of Health (64), the country had only 19,620 midwives and plans to increase that number to 29,686 by 2025. If the current pace is sustained, Ethiopia will be able to meet the minimum threshold of health professionals to population ratio of 2.3 per 1000 population, the 2025 benchmark set by the WHO for sub-Saharan Africa. This could possibly address the shortage of midwives in rural areas and improve the accessibility of maternity care.

1.1.5.2 Overview of Ethiopia's healthcare system

Ethiopia is the second most populous African country, and ranks fourteenth in the world with an estimated 2019 population of 110.14 million (65). The nation is a diversified country that speaks more than 80 endemic languages and has an annual population growth rate of 2.6%. The federal system is constituted of two city administrations and eleven regional states (66). Ethiopians are mainly rural residents, who often live on subsistence agriculture and have poor access to health care, even when compared to other low-income countries (67).

Healthcare providers are assigned centrally by the Ministry of Health, based on their expertise and demand from local health bureaus, regardless of language and cultural differences. As a result, a care provider may end up working in a new environment where s/he is new to the geographical area, culture, and language. This may lead to a culture clash and misunderstanding between the care provider and patients (68).

Ethiopia's health service is structured into a three-tier system (primary, secondary and tertiary levels), connected to each other by a referral system (69) (Figure 1).

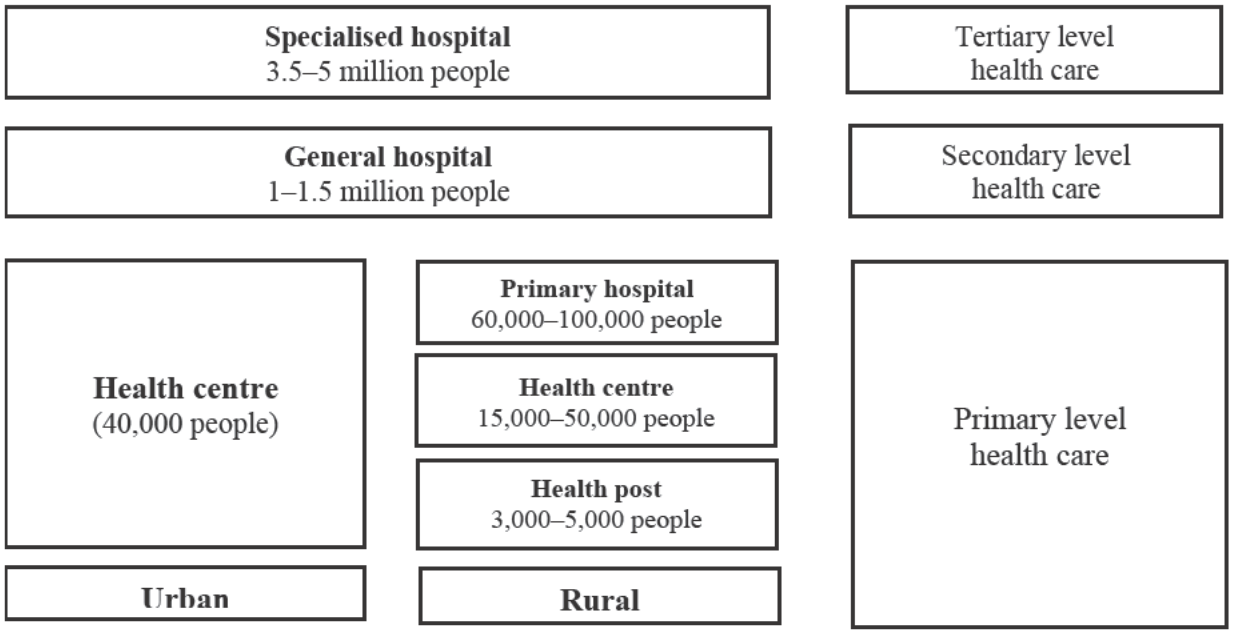

Figure 1. Ethiopian healthcare delivery system (70)

Tertiary level: specialised hospitals

At a tertiary level specialised hospitals provide specialised care for about 5,000,000 people and are referral centres for general hospitals (69, 71). The government is the main health service provider in Ethiopia, but there is also a private sector that contributes significantly in urban areas (72) and this has contributed to improved access to maternity care in urban areas.

Secondary level: general hospitals

At a secondary level there are general hospitals which provide a range of non-specialised health services for 1,000,000 people. These hospitals serve as referral centres for primary hospitals and are training centres for emergency surgeons, health officers, midwives, and nurses. New constructions and upgrading of primary hospitals are increasing the number of general hospitals resulting in more accessible maternity care.

Community level: Primary Health Care Units

Each geographical area has a Primary Health Care Unit, which includes one primary hospital, one health centre and five satellite health posts. Primary hospitals provide ambulatory and inpatient services to approximately 100,000 people, receive referrals from health centres and are a practical training centre for nurses, midwives and other paramedical health professionals (73).

Health centres are staffed with an average team of 20 middle-level healthcare providers, (nurses, midwives and health officers) who provide a range of general services including maternity care to approximately 25,000 people. Health officers are trained for four years with a bachelor's degree and work as clinicians in the rural centres (74).

Health posts serve about 5000 people or 1000 households and are staffed by health extension workers (HEWs). Health extension workers are females who received one year of formal pre-service training after completing 10^{th} grade of formal education. They provide basic health promotion, disease prevention services like basic health promotion, disease prevention, family planning and antenatal, and selected curative care in health posts in every kebele, the lowest administrative unit of Ethiopia. They do not provide birthing care.

There is a further network that provides crucial links between the primary healthcare system and community members. A small group of six members (households) form what is referred to

as a “one-to-five” network. Five “one-to-five” networks are then grouped to form health development teams (HDTs) involving 30 households. Health development teams in the same neighbourhood then collectively form a health development army (HDA) (69). All “one-to-five” networks and HDTs have their own respective leaders selected by their own membership, enabling a level of community-based leadership. The HDA is coordinated by HEWs and the leader of the kebele (the smallest administrative unit) (75).

Gender of healthcare providers

Poverty and underdevelopment in developing countries has meant that a large number of children do not have access to education, with greater disadvantage for females (76). Even when there is a similar proportion of girls and boys beginning school, the number of females attending higher levels of education rapidly decreases (77). More girls drop out of school than boys due to early marriage, household labour, and fear of abduction or rape on the way to or from school (78). Therefore there are fewer women in higher education and the professions (79). The healthcare system is similarly male dominated as a result of women having been denied educational opportunities for so long (68). Therefore, in Ethiopia, there are disproportionately more male health professionals than female.

This study focuses on one specific aspect of component of care provision which influences women accessing care – disrespect and abuse of women giving birth within a healthcare facility. Significant efforts are being undertaken by the Ethiopian government to improve access. Improving the proportion of facility-based childbirth requires overcoming barriers to access, as well as the poor quality of care at the facilities (80, 81). Respectful maternity care is a core indicator of the quality of care (26). Thus, understanding disrespect and abuse will help change the practice and culture of maternity care. However, its prevalence is not well documented in Ethiopia. Therefore, this research will provide a comprehensive view of women’s experiences of and care providers’ perspectives on disrespect and abuse during facility-based childbirth. The project will contribute to quality and safety in maternity care by creating an evidence base to inform education and training, policy and future research.

1.1.5.3 Current strategies for RMC in Ethiopia

Two key success factors have enabled Ethiopia to successfully adopt concepts of respectful care into the health system, with specific emphasis on maternity care. These are creating demand for respectful maternity care and political support for improving respectful maternity

care (82). To accomplish this, three specific tactics have been used: advocacy, community sensitisation and strong political support.

Evidence has emerged from an accountability mechanism (the complaints system), involving a large number of complaints (83, 84), the majority of which focused on maternity care. In addition, the media has covered numerous high-profile disrespect and abuse cases. Some health workers initially resisted complaints as criticism (85), but the data was so compelling that the public identified that disrespect and abuse was a significant problem and demanded action. A nationwide Compassionate and Respectful Care (CRC) Strategy was developed and launched in response to this public discontent; however there has yet to be a national assessment to assess the strategy's impact (82).

Since the unveiling of Ethiopia's CRC plan in 2016, there has been a massive community mobilisation activation, with events hosted throughout the nation. Most districts have a CRC focal person. The plan has been extensively covered in print and on social media, promoting community understanding of healthcare rights and keeping people informed about government and health professional association initiatives to ensure the health system recognises and respects these rights. CRC focus points are responsible for conveying messages to clients regarding key features and concepts of CRC at the health facility level. This initiative has broken larger messages down into smaller constituent elements, and designated weeks to celebrate justice, privacy and respectful strategies such as addressing clients by their name.

Having significant governmental support for respectful maternity care has been critical to making progress in Ethiopia. A change in terminology from "disrespect and abuse" to "respectful maternity care" has substantially aided in shifting the communal attitude surrounding the issue from blame, defensiveness and lack of acceptance to collaborative responsibility and a need for improvement. This shift in language has been critical in building long-term support among government officials and other key stakeholders at the national level. Senior lawmakers and key stakeholders, including high-level government ministries, religious leaders and professional organisations, have expressed strong support for the CRC plan in Ethiopia. The CRC Strategy is being directed by a deputy minister, who is responding well to public demand for more compassionate and respectful treatment. The policy environment is thought to be quite favourable to CRC, which will be prominently featured in the next national Health Sector Transformation Plan (86). Current and comprehensive evidence on the level of disrespect and abuse would strengthen government commitment to the issue.

1.1.5.4 Interventions to promote respectful maternity care in Ethiopia

Ethiopia has adopted an accelerated approach to respectful maternity care, announcing its national Compassionate and Respectful Care Strategy in 2016 (87) despite the lack of substantial evidence from within the country. Ethiopia's speed in implementing the respectful maternity care agenda might be a result of massive public outcry and complaints about poor maternity care. In Ethiopia, compassionate and respectful care is currently included in pre-service health professional education curricula, and it is even designated as the first learning outcome for the midwifery curriculum (88). External partners have assisted in equipping midwifery faculties to enable them to teach respectful maternity care properly. Compassionate and respectful care has also been included in the country's continuous professional development program. The program is a requirement for re-licensing every three years, and it has lately been a requirement that 5% of the needed continuing education points be related to respectful care and professional ethics. Respectful care e-learning tools for continuing education were launched in 2020 (89).

Financing

Because of the high degree of political will linked to the program, CRC is funded by the national health budget in addition to support from international donors. Because of the Ministry of Health's funding, the CRC Strategy in large part reflects strong national support for the issue. As the concepts of CRC are aligned with the health-related Sustainable Development Goals, development partners have made financial contributions as well. Nevertheless, not all regional governments have the financial resources to apply the initiative. Thus, to strengthen national ownership of and commitment to the initiative, regional governments and health facilities have to allocate a budget to supplement the national effort. A few health institutions are determined to integrate CRC into their current systems without demanding extra resources, but this inspiration is yet to emerge in others.

Health workforce development

As a result of Ethiopia's CRC Strategy, every health institution now has a CRC focal person who sends out weekly CRC messages to facility workers and service consumers. Public recognition is given to CRC sites that achieve high levels of success. In Ethiopia, several health professionals and their leaders have expressed opposition to the execution of the CRC approach. Some health practitioners were initially concerned because of a misunderstanding

that the program was intended to punish those who did not integrate CRC into their work. However, it is believed that the initiative is yielding benefits, with improvements in health professionals' behaviour and client satisfaction, thanks to supportive supervision (82). The supportive supervision strategy is implemented through the Ministry of Health's flagship Catchment-Based Mentorship program, in which professional organisations give support through the formulation of guidelines and training materials, as well as the availability of mentors (90). Although clinical skills are the major focus, respectful care is also addressed.

In Ethiopia, there are efforts underway to challenge beliefs about individuals who choose to be a health worker. The selection criterion for entry into a health worker education program used to be entirely based on academic merit, but the ministries of health and education are presently discussing revising the criteria to include an emphasis on the person's values and enthusiasm for the profession as well. Compassionate and respectful care is also included in the life skills curriculum for elementary and high school students, with the twin goal of (a) teaching future generations about their healthcare rights, and (b) educating future care providers about its value. The intention is to educate the next generation that a career in the health field should be viewed as a profession that demands a passion for respectful care and academic strength.

1.2 Research aims

The overall aim of the research is to investigate the prevalence of and factors associated with disrespect and abuse, and to explore women's and care providers' perspectives on disrespect and abuse, during childbirth in Ethiopia.

The specific objectives of the study are:

- to determine the prevalence of disrespect and abuse during facility-based childbirth
- to identify factors associated with disrespect and abuse during facility-based childbirth
- to explore women's perspectives on disrespect and abuse during facility-based childbirth
- to explore care providers' perspectives on disrespect and abuse of women during facility-based childbirth.

The following research questions were addressed:

1. What is the self-reported prevalence of disrespect and abuse among women who gave birth in a health facility?
2. What are the factors associated with disrespect and abuse during facility-based childbirth?
3. What are women's perspectives on disrespect and abuse during facility-based childbirth?
4. What are care providers' views on the disrespect and abuse of women during facility-based childbirth?

1.3 Research outline

Four studies were conducted side by side as part of a larger mixed-methods study with both quantitative and qualitative data collected simultaneously. Four research articles were written (three are published and one is under review), and these articles form the consecutive results chapters of the thesis. The first article was produced from a quantitative cross-sectional survey with women, the second article is a qualitative study produced from in-depth interviews and focus group discussions with women, and the third article is a case study produced from an interview with a woman who was abandoned by care providers during facility-based childbirth. The case story was not planned but written when the case was found. The fourth article was a qualitative study produced from in-depth interviews with care providers (Figure 2). Figure 2 shows the sequence of the studies and their publication outcomes.

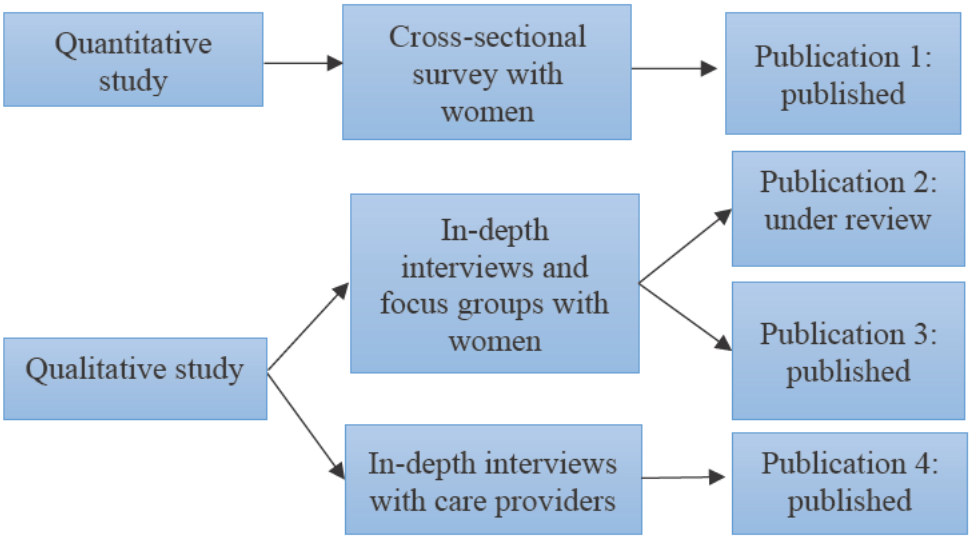

Figure 2: Outline of the study and publication outcomes

1.4 Thesis outline

This thesis contains eight chapters including this introductory chapter.

Chapter 2 presents a broad literature review performed to inform this thesis. This literature review identifies the magnitude of disrespect and abuse primarily in sub-Saharan Africa and associated factors. It also explores the existing literature on the perceptions and understandings of care providers regarding disrespect and abuse.

Chapter 3 describes the overall approach used to answer the project questions. This chapter details the conceptual framework used, the study design, participant recruitment, how the variables were measured, and the data collection and analysis procedure.

Chapter 4 presents publication 1 produced from a survey of women which investigated the prevalence of disrespect and abuse and associated factors among women who have given birth in a public health facility. This article was published in the international peer-reviewed journal *Global Health Action* (Impact Factor: 2.662).

Chapter 5 presents publication 2 produced from in-depth interviews and focus group discussions with women who have given birth in a public health facility. This chapter focuses on women's perspectives on disrespect and abuse during facility-based childbirth. This article is under review in *BMC Pregnancy and Childbirth* (Impact Factor: 3.105).

Chapter 6 presents publication 3 which narrates one woman's story of being a victim of disrespect and abuse in a health facility. This article was published in the peer-reviewed *International Journal of Women's Health* (Impact Factor: 2.77).

Chapter 7 presents publication 4 and focuses on care providers' perspectives on disrespect and abuse during facility-based childbirth. This chapter presents a detailed exploration of how providers perceive various actions that could be classified as mistreatment by an independent observer, researcher or advocate. This article was published in the peer-reviewed *International Journal of Women's Health* (Impact Factor: 2.77).

The final chapter of this thesis presents a general discussion of the findings, practical and policy implications, and overall conclusions of the study.

Chapter 2: Literature review

This literature review identifies and evaluates current studies on women's experiences of disrespect and abuse at health facilities, identifies research gaps, and provides the justification for undertaking the project. It also provides background to the in-depth study of women's experiences of disrespect and abuse in maternity care facilities. This literature review is structured into three sections: (1) The magnitude of disrespect and abuse at the continental level, particularly in the sub-Saharan African region. (2) Potential contributors of disrespect and abuse and how care providers perceive disrespect and abuse during facility-based childbirth, and (3) Consequences of disrespect and abuse.

It is important to document the steps of a literature review in order to assess its quality (91), and this includes establishing a coherent structure (92). Zorn and Campbell suggest four characteristics of a good literature review (93): (1) an introduction that defines the purpose of the literature review; (2) topics that are relevant to the project; (3) an explanation and critical review of the results; and (4) a conclusion. This literature review therefore outlines the search strategy and provides an interpretation and critique of the studies as well as the results based on themes that are relevant to this project.

This literature review focused on the disrespect and abuse of women during facility-based childbirth, and includes studies published between 1990 and 2022. This start date was chosen for the search because maternal health came onto the global agenda in 1987 as a result of the Safe Motherhood Initiative convened by the World Bank, WHO and UNDP (94). Furthermore, the Millennium Development Goals were established in 1990 and the importance of quality of care in maternity services was identified (55). Peer-reviewed primary articles and systematic reviews using a variety of methodological techniques, including qualitative, quantitative, mixed-methods and intervention studies, were included in the review. Grey literature, such as government records and reports, was also incorporated.

The search utilised the following databases: African Index Medicus, CINAHL, Embase, PubMed, Scopus and Web of Science. Furthermore, key organisations' websites like the African Union, International Confederation of Midwives, White Ribbon Alliance and WHO were searched. The reference lists of the obtained literature were manually searched to ensure a thorough search and identification of related literature. A librarian at the University of Adelaide was also consulted for their expertise on the search strategies for all databases visited.

Key terms used for the search were disrespect and abuse; obstetric violence; mistreatment; women; childbirth; facility-based childbirth; and care providers. Synonyms of the keywords were also combined or utilised independently.

2.1 The prevalence of disrespect and abuse during facility-based childbirth in Africa

Evidence suggests that it is problematic to measure the prevalence of disrespect and abuse in health facilities. (95, 96). This section describes the burden of disrespect and abuse in sub-Saharan Africa, with a focus on Ethiopia, the study's location.

The WHO has identified in its statement released in 2014 on the prevention and elimination of disrespect and abuse during facility-based childbirth that disrespect and abuse is a global problem women experience in maternity centres (26). Similarly, Bohren et al., in their systematic review on the mistreatment of women during childbirth in health facilities, which included qualitative, quantitative and mixed-methods studies across the globe, identified that women's maternity care experiences show a grim picture, despite worldwide efforts to reduce maternal death (97). Disrespect and abuse in maternity care has been defined by the Center for Reproductive Rights as denying women the right to make informed decisions and reprimanding them for exercising that right (98), and denial of pain relief when conducting and repairing episiotomies (99). Labour pain is a normal physiological event; disrespect and abuse are not. The time of pregnancy and childbirth are important in the lives of women and their unborn children (100). Regardless of their vulnerability during this period, many women throughout the world continue to receive substandard treatment in the form of disrespect and abuse, according to the WHO (26).

A 2015 study of disrespect and abuse in maternity care facilities in East and Southern Africa (Ethiopia, Kenya, Madagascar, Rwanda and Tanzania) used the White Ribbon Alliance's Respectful Maternity Care Charter as an observation checklist to identify different forms of disrespect and abuse occurring during maternity care (101). The findings highlighted that the right to information, respect for women's choices and informed consent were the respectful maternity care practices that were least observed by care providers. Delay of care and abandonment of women were reported to be the most prevalent types of disrespect and abuse across all five countries.

Two separate Tanzanian studies compared disrespect and abuse during childbirth by conducting immediate postpartum interviews and community follow-up interviews with the same women. The studies revealed that women reported a significantly higher prevalence of disrespect and abuse in the follow-up community interviews than when they were interviewed within the facility in the immediate postpartum period. Kruk et al. reported 28.2% prevalence in follow-up interviews in the community compared to 19.5% in the immediate postpartum period (102). Similarly, Sando et al. identified a significantly higher prevalence of disrespect and abuse (70%) in the community follow-up interviews compared to 15% reported by postpartum women when they were interviewed within the facility (103). The difference in disrespect and abuse prevalence depending on the time of the survey could possibly be because women interviewed in the facilities felt compelled to give positive responses if they thought the interviewers were affiliated with the health facilities, which could have influenced the reported prevalence.

Similarly, two community-based studies in Nigeria revealed a significantly higher prevalence of disrespect and abuse. Cross-sectional studies from Enugu and River States of Nigeria conducted to determine the prevalence and pattern of disrespectful and abusive care during facility-based childbirth revealed that 98% (104) and 70.8% (105) of women experienced at least one form of disrespect and abuse during their last delivery, respectively. It is probable that the survey's timing (six weeks following childbirth) influenced the survey's notably high prevalence figures. This is evidenced by a relatively lower prevalence of disrespect and abuse reported by women in a hospital-based studies in Nigeria where 27.8% (106) and only about a tenth 11.3% (107) of women participants reported an experience of bad attitudes of the hospital staff. According to the findings of the studies, postpartum women tend to underreport their experiences with disrespect and abuse when interviewed in a health facility. They were most likely under pressure or feared retaliation from the providers. When interviewed in their homes, the same women reported more disrespect and abuse because they felt more at ease telling their stories. As a result, community-based studies are more appropriate and have the potential to report the true level of disrespect and abuse because women can tell their facility-based childbirth stories more comfortably.

The existence of these levels of disrespect and abuse is supported by descriptive secondary analysis of respectful maternity care from Malawi conducted in 2017 using existing data from direct clinical observations of 2,109 birthing women from the Helping Babies Breathe evaluation conducted in 2013. This study found that 82.3% of women were not allowed a

companion (95), the majority of women were discouraged from enquiring about their care (73.1%), their privacy was breached (58.2%), and 13.9% were not appropriately welcomed by care providers.

This area was under researched in Ethiopia at the start of my study and has become a growing area of research and importance. More studies have been published after I commenced the PhD. Research exploring women's experiences during childbirth in different parts of Ethiopia over the past decade has shown increased evidence of disrespect and abuse in maternity care. Two qualitative studies conducted to understand barriers to skilled attendance in the northern (42) and southern (15) parts of Ethiopia identified that many women suffer more from the disrespect and abuse than from the labour pain itself and are avoiding professional maternity care as a result.

Facility-based cross-sectional studies conducted in Addis Ababa, the capital of Ethiopia, involving maternity care providers and women to investigate their personal observations and experiences of mistreatment during childbirth reported higher prevalence. Care providers observation reinforces the women's perspectives, revealing that 50.3% of care providers reported absence of consent prior to procedures, 25.9% reported having ever witnessed physical abuse, and 34.5% reported observing a breach of privacy (108). Women, on the other hand reported that three-quarters (78.6%) of them had experienced at least one form of disrespect and abuse during childbirth (43). Another facility-based study that explored the frequency and factors associated with disrespect and abuse in four rural health facilities in Ethiopia through direct observation of client–provider interaction and exit interviews with women identified that 83.9% of observed care providers failed to ask the women their preferred birthing positions whereas 21.1% of interviewed women reported experiencing at least one form of disrespect and abuse (109). The observation, like previous comparable research, found more occurrences of disrespect and abuse than the women reported.

Community-based cross-sectional studies from northern parts of Ethiopia, Amhara and Tigray regions, investigated the prevalence of disrespect and abuse involving postpartum women. More than three fourth 67.1% (110) and 22% (111) of the women participants reported disrespect and abuse respectively. The difference in prevalence across these studies suggests further studies are required.

In conclusion, this review of the literature found that women across the sub-Saharan African countries report similar forms of disrespect and abuse. The high frequency of disrespect and

abuse in this part of the world presents a troubling picture. The Bowser and Hill (96) disrespect and abuse framework was employed in the majority of the reported studies, although establishing a full comparison of the outcomes may be difficult. Various methodological concerns such as different disrespect and abuse definitions and typologies, the period of maternal care examined, and the research instruments used may have an impact on the prevalence estimations. Sampling and recall bias may have influenced the prevalence estimates in the studies. These limitations could restrict the generalisability of the findings. The table below summarises the characteristics of the studies included in this section.

Table 2: Characteristics of studies included in the prevalence section

Author and Year	Location	Participants	Framework used	Methodological description strength/limitation
Rosen H Et al (2015)	Ethiopia, Kenya, Madagascar, Rwanda, and Tanzania	Women and care providers	Bowser and Hill's landscape evidence review framework	The observation checklist did not include the last stages of childbirth, which may have led to an underestimation of the actual prevalence of disrespect and abuse. Furthermore, the involvement of health professionals as observers may also have affected the result since their professional presence may have introduced bias
Kruk M, Et al (2018)	Tanzania	women	Bowser and Hill's landscape evidence review framework	The study used a structured questionnaire, interviewed women who had delivered in health facilities upon discharge and re-interviewed a randomly selected subset 5–10 weeks later in the community.
Sando D, Et al (2016)	Tanzania	Women	Bowser and Hill's landscape evidence review framework	the observation checklist did not include the last stages of childbirth, which may have led to an underestimation of the actual prevalence of disrespect and abuse. Furthermore, the involvement of health professionals as observers may also have affected the result since their professional presence may have introduced bias
Okafor I, Et al (2015)	Nigeria	Women	Bowser and Hill's landscape evidence review framework	

Sethi R Et al (2017)	Malawi	Women	Bowser and Hill's landscape evidence review framework	The observation checklist was not developed for assessing disrespect and abuse, and the data collection tool was validated in Kenya. This could have had an impact on the study's data.
Gebremichael MW Et al (2018)	Ethiopia	Women	Bowser and Hill's landscape evidence review framework	The authors used a negative binomial regression model for analysis. However, the appropriate model for count outcome variables is a Poisson regression and this could have affected the findings of the study.
Wassihun B (2018)	Ethiopia	Women	Bowser and Hill's landscape evidence review framework (but didn't properly acknowledge)	
Asefa A (2018)	Ethiopia	Maternity care providers	Bowser and Hill's landscape evidence review framework	The small sample size limits the study's power to report associations between key variables and the lack of standardised measurement for disrespect and abuse indicators may compromise the validity of the data collection tool.
Banks KP (2018)	Ethiopia	Women	Bowser and Hill's landscape evidence review framework	Experiences of women who delivered in facilities were captured by direct observation of client-provider interaction and exit interview at time of discharge. However, this study has a number of limitations acknowledged by the authors: 1) Health facilities included in the study were purposively selected as they were part of a quality improvement initiative.

				Thus, it is possible that the study sites were more accustomed to professional standards which could underestimate the prevalence of disrespect and abuse. (2) The exit interviews were done three to six hours post-partum. This may be too soon to interview women, as they may be exhausted, not wanting to engage and more focused on the status of their infant. Interviewing women in a medical facility may have further enhanced the likelihood of politeness bias. It is also conceivable that women were afraid to disclose unfavourable experiences at the health centre for fear of reprisal from employees and medical professionals. (3) Some instances of disrespect and abuse are entirely subjective and may not be captured by a third-party observation. Further the tool used for observation did not formally operationalise how to observe each item of disrespect and abuse and it is likely that it introduced observer bias. (4) The presence of the observer by itself may influence the behaviours of care providers. As a result, the data might not provide an accurate picture of the observed prevalence of disrespect and abuse. These limitations make it impossible to directly compare the total prevalence from women's reports to the overall observed prevalence.

Gebremichael MW (2018)	Ethiopia	Women	Bowser and Hill's landscape evidence review framework	The authors misclassified some categories of disrespect and abuse and their respective verification criteria. For example, all the studies included in this review classified denial of preferred birthing position under physical abuse whereas this study classified it under non-consented care. This would have affected the prevalence estimate of each of the forms of disrespect and abuse.
Asefa A Et al (2015)	Ethiopia	Women	Bowser and Hill's landscape evidence review framework	The tool employed in the study was designed to measure quality improvement, and it is possible that it did not adequately capture disrespect and abuse.
Adinew YM 2017	Ethiopia	Women	Not applicable	The qualitative nature of the study may limit the representativeness and generalizability of the findings.

2.2 Potential contributors to disrespect and abuse during facility-based childbirth in developing countries

This section of the thesis utilises Bowser and Hill's landscape analysis framework developed by a USAID-funded Translating Research into Action Project (TRAction), which explored the evidence of disrespect and abuse during facility-based childbirth in 2010 (96). The framework explains "contributors to and impact of disrespect and abuse in childbirth on skilled care utilization". It consists of five domains: (1) individual and community, (2) national laws and policies, (3) human rights and ethics, (4) governance and leadership, service delivery, and (5) providers.

While disrespect and abuse of women during facility-based childbirth has not been exhaustively studied, contributing factors such as individual, cultural, structural and system-related factors including national laws and policies, leadership and governance are increasingly being identified. Both individual providers and the whole health system are thought to be involved in disrespect and abuse and deviation from the accepted standards of care (96). Disrespect and abuse of women may occur before, during or after childbirth, with labour and birth identified as particular times of vulnerability (13).

2.2.1 **Individual and community factors**

There are two themes emerging from the literature related to socioeconomic factors. One is that disrespect and abuse in facility-based childbirth is so normalised in many facilities in developing countries that it is accepted as part of the culture. The other is that many women do not know they are entitled to respectful maternity care (112). These considerations were explored in a facility-based cross-sectional study conducted in Jimma zone of Ethiopia in 2014 involving 403 women who had given birth during the 12 months prior to the survey in randomly selected public health facilities. The study reported high client satisfaction with maternity care because the women did not say they were mistreated either because they did not want to disclose or they considered the abusive treatment as the norm (113). The fact that the study was conducted in health facilities among clients receiving care could have influenced the reported satisfaction rate. The participants might have been influenced to give positive responses if they thought the interviewers were affiliated with the health facilities.

The social status of a woman is emerging as a crucial aspect of the way she is treated in health care and in society as a whole. An article that explores conceptual problems in socio-

demographic studies of the status of women describes that a woman's status is often defined in terms of her earnings, work, education, health and fertility, as well as her position in the family, community and society (114). Another study that explored structural disadvantage, gender and the health status of women in a society discussed that the social status of women reflects societal views. Women's status is often impacted by men's and women's positions in society (115). A cross-national analysis of maternal mortality, women's status and economic dependency in less developed countries stated that in these countries, where maternal mortality rates are high, women's social position is poor and their needs have been subjugated to men's since childhood (116). For many woman marriage and motherhood are considered their destiny from birth; and failure to accomplish this would lead to stigma (117). A book that examines woman's role in economic development discussed that many women in developing countries will have very little education and no prospect of inheriting the family land on which they work, nor the house in which they live (118). Furthermore, an exploratory study of women's perspectives on facility-based childbirth in rural Ethiopia identified that poor and socially disadvantaged women have few rights and are therefore at more risk of experiencing disrespect and abuse (15).

The economic status of a woman and her family can also be a considerable deterrent to accessing quality care. Qualitative research that involved 68 women from south Ethiopia who gave birth to their most recent child at home despite their previous experience of facility-based childbirth identified that poor and rural women are more likely to be subjected to disrespect and abuse during facility-based childbirth than women with higher incomes. As a result of their previous bad experience in maternity care these women were opting for home births (15). Similar findings were reported by studies conducted in other parts of Ethiopia as well where rural residence (119) and being poor (110) significantly increase women's experience of disrespectful and abusive care during facility-based childbirth.

2.2.2 National laws and policies, human rights, and ethics

The WHO statement on advancing safe motherhood through human rights published in 2001 states that ratification and enforcement of laws and policies are vital components of approaches to reduce disrespect and abuse in birth care and to facilitate accountability among care providers (120). The WHO identified in its statement released in 2014 on the prevention and elimination of disrespect and abuse during facility-based childbirth that many countries lack or do not enforce existing national laws and policies (26). When policies are not in place health

care providers may not understand the expected care, managers will find it very difficult to enforce standards of respectful maternity care at birth and lawyers will not be able to support legal redress measures (121).

2.2.3 Leadership and governance & Service delivery

Lack of leadership, regulation and governance of respectful birthing care has also been identified as one of the reasons for widespread abuse in maternity care (96). An article in the *Bulletin of the WHO* published in 2010 described the development of a tool that uses human rights concepts and methods to improve relevant laws, regulations and policies related to sexual and reproductive health to improve awareness and understanding of governments' human rights obligations. The article identified the importance of committed leadership at the national and regional levels in the process of reducing and eventually eliminating disrespect and abuse. The existence of policies can generate demand for quality care among the public and increase a sense of responsibility among care providers (122).

Another factor impacting maternity care is that evidence-based clinical care standards are prioritised over respectful maternity care standards such as consented care, privacy, dignified care and protection from physical abuse. In their report of a landscape analysis that explored evidence for disrespect and abuse in facility-based childbirth, Bowser and Hill identified that many countries have weak administration to ensure basic standards of clinical care, let alone standards of respectful maternity care. Lack of supervision at the service delivery level makes identification of disrespect and abuse even more difficult, particularly as overstretched care providers will cover up for one another (96).

The need for effective accountability mechanisms to address disrespect and abuse has long been identified. However, a mixed-methods study from Nepal's rural primary healthcare system that investigated why service users do not complain elaborated the lack of accountability mechanisms in developing countries (123). Another mixed-methods study from Bangladesh that examined patient feedback systems at primary healthcare centres identified that there are few complaint boxes, patient charters, and practices supporting patients' complaints registration or incident reports by staff (124). Amnesty International identified that not all reported cases of disrespect and abuse are brought to justice due to lack of effective law enforcement (125). Miller and Lalonde noted in their article on the global epidemic of abuse

and disrespect during childbirth that abusive medical personnel are rarely held accountable, if ever (126).

The lack of community participation and oversight in health care is another barrier to quality care. The health system has to be inclusive of the community to promote respectful care. A report that summarises the findings of an evaluation of a quality assurance project that implemented 35 collaboratives in 14 developing and middle-income countries reinforces that communities' participation and engagement in management of health services improve demand for quality care and make care providers and managers more accountable (127).

2.2.4 Providers

Women are more likely to be disrespected and/or abused in a birthing facility when the care provider is judgmental. A systematic review conducted by Mannava et al. on attitudes and behaviours of maternal healthcare providers in interactions with clients in low-income countries confirmed that provider prejudice is linked with disrespect and abuse in birthing facilities. Discriminatory behaviours against certain sub-groups of women may be associated with providers' responses to their specific attributes such as age, ethnicity, race, HIV sero-positive status, and financial and education status. Adolescent girls are more likely to experience discrimination based on young age during childbirth (128). This review considered quantitative, qualitative and mixed-methods studies, and individual studies included have inconsistent sampling methods, study populations and measurement tools. Therefore, while informative, there may be some inconsistencies in interpretation of the data.

According to a qualitative study from South Africa that explored why nurses abuse women in maternity care, providers are socially distant from their clients. Provider distancing can result from harsh and punitive training. Sometimes provider training may even encourage a culture of social distance between client and provider. Such training is designed to give providers a new identity that sets them apart from their communities (129). A study from the Dominican Republic that assessed the quality of birthing care using document review, facility inventory and observation of client–provider interactions identified that provider training itself is contributing to disrespect and abuse of women by creating separation between the care provider and receiver as it overlooks interpersonal care (130). This underlines the importance of revising the pre- and in-service training curricula of maternity care providers to promote dignified, non-abusive maternal care (131).

Health providers' approach to patients can be impacted by the level of support and resources available to them, and their positions within health services. In most developing countries the health system is not well financed (132), health facilities are not adequately staffed (133) and care providers do not receive adequate professional development opportunities (134). A new report by the Center for Reproductive Rights and the Women Advocates Resource and Documentation Centre has illustrated that working in under-equipped and overburdened health systems has a negative impact on provider enthusiasm and is frequently identified as an important contributor to mistreatment of women (135). Similarly an Ethiopian study focused on job satisfaction of nurses identified that negative attitudes of providers toward patients is attributed in part to being underpaid and overworked (136). This study involved nurses working across all wards of three public hospitals, and therefore the findings may not necessarily reflect the attitudes of healthcare professionals within maternity care. Furthermore, another study conducted in public health facilities of Addis Ababa to assess the job satisfaction of midwives identified that midwives working in delivery units were less satisfied than those working in other units [AOR = 0.04 (95%CI:(0.001–0.45))] (137). This could be because the invasive nature of the delivery room procedure increases the risk of contamination, stress, and exhaustion. Caring for a laboring mother also necessitates a conscious, alert state of mind, as well as an extended hour of care, which may predispose to excessive tiredness. A Pakisani study discovered that midwives were dissatisfied with their working conditions, remuneration, and extremely high levels of tiredness (138).

Providers' status and the respect they receive has been found to impact the quality of care they provide. A qualitative study on gender-based barriers to primary healthcare provision in Pakistan based on the experience of female providers identified that lower-level clinicians who are mistreated by their managers or higher-level doctors are more likely to vent their frustrations on patients (139). The study identified abusive hierarchical management structures; disrespect from male colleagues; lack of sensitivity to women's gender-based cultural constraints; conflict between domestic and work responsibilities; and poor infrastructural support as key issues. Women's educational levels in Ethiopia are generally lower than men's because they have been denied education opportunities for so long. As a result, most female caregivers in Ethiopia's health-care system are at the bottom of the pyramid. Women face cultural disadvantage throughout their lives, and they face workplace violence from male colleagues and managers. Furthermore, the traditional belief that males are capable of handling stressful situations places female providers as a second choice for care seekers. Women prefer

male providers over female providers because they are perceived to be more competent. This could frustrate them and affect their passion to provide respectful care. No study known to the author was found that examined this in the Ethiopian context.

How care providers perceive disrespect and abuse during facility-based childbirth

Globally studies have confirmed that care providers recognise the occurrence of disrespectful and biased practices against women in maternity centres (99, 108, 140, 141). However, they did not perceive practices like threats and abandonment as abuse of women but a means to assert power. Similarly, a study from South Africa reports that care providers use disrespect and abuse to express authority over women (129). Nevertheless, in a study from Sao Paulo, Brazil on institutional violence, medical authority and power relations in maternity hospitals, some care providers believed that violence against women during facility-based childbirth happens only because of a few "rotten apples" in the healthcare system (129, 142). This highlights the complexities in understanding healthcare providers' perspectives on their own and each other's actions.

According to research conducted in Ghana, student midwives perceive respectful maternity care as treating every woman with respect, regardless of her background or capacity to pay for medical expenses (143). However, the student midwives believed there are circumstances where disrespect and abuse are necessary to save a mother and her baby during childbirth. Similar findings were reported by other studies across the globe that explored care providers' perspectives on disrespect and abuse. Care providers believe that harsh measures are necessary to elicit compliance, particularly from uncooperative women. Abusive practices such as slapping women were not seen as dehumanising by health professionals, but rather as a way to save a woman and her baby during childbirth (99, 129, 140, 143, 144).

Likewise, a mixed-methods study that examined the experiences of disrespect and abuse in maternal care from the perspectives of both midwives and women at four health facilities in Debre Markos, Ethiopia revealed that care providers demonstrated a good understanding of privacy, consent and confidentiality, but they lacked training in respectful maternity care and counselling principles (145). Similarly, a qualitative study from South Africa exploring the quality of care provided to women at the time of birth from the perspectives of women, care providers and managers reported that care providers believe that women are incapable of making informed decisions regarding their own health care. As a result, they felt compelled to

make decisions for women, prioritising the care over informed consent (146). These studies suggest that caregivers acknowledge that decision-making and choice are important rights, yet do not provide them to women. Furthermore, the care providers put clinical skill ahead of good rapport. For instance, offering women health information was seen as a technique to achieve medical procedures rather than to build rapport (146).

Moreover, the findings of a study in Tanzania on care providers' perspectives on disrespect and abuse revealed that care providers recognised that it is unacceptable to discriminate against HIV-positive women in the workplace. Yet, a few of the care providers stated that there is a need to isolate HIV sero-positive women (147). Furthermore, Balde et al. found that the majority of care providers expressed satisfaction with the quality of maternity care they provide to women, with only a few believing that women are being mistreated (148). Only two reports of "shared experiences" and four descriptions of "lived experiences" emerged from the replies of care providers who referred to abuse of women. This suggests that the majority of care providers described cases in which they had witnessed mistreatment rather than those in which they had done it.

Care providers in Nigeria described situations in which they had witnessed a co-worker mistreating woman or been directly involved in the mistreatment of women in health institutions. Because women were generally perceived to be obstinate and resistant during labour, they saw actions like slapping as an essential means of gaining compliance and ensuring safe birthing. They believed that women's disobedience could risk the lives of their unborn children, and hence such measures were required (99). This study used qualitative methods to explore women's and providers' experiences and perceptions of mistreatment during childbirth in health facilities. However, the involvement of medical personnel as research assistants could have influenced participants' responses.

Another study from Abuja, Nigeria explored whether care providers accept different scenarios of mistreatment in health facilities (140). Care providers considered the scenarios of disrespect and abuse as acceptable and necessary to get compliance from women and ensure a safe delivery. Other study conducted in Nigeria have reported likewise, revealing the need for more research to understand the perspectives of care providers in different contexts (99, 140). The care providers also stated that they had no intention of mistreating women during childbirth, but that working stress could sometimes lead to such scenarios (99). Similarly, care providers in Ethiopia – midwives and midwifery students – stated that disrespect and abuse of women in

health facilities is mostly not intentional, but rather results from inadequacies in the healthcare system (145). d'Oliveira et al., on the other hand, reviewed research on forms of violent abuse by doctors and nurses and concluded that violence against women in institutions is deliberate (149). This demonstrates the need for further studies to better understand care providers' perspectives on disrespect and abuse of women during facility-based childbirth.

Care providers' perspectives on the causes of mistreatment of women in maternity facilities have been established in previous studies from Ethiopia and elsewhere (99, 145). Disrespect and abuse have been cited by health professionals as a result of flaws in the healthcare system, which include overcrowding, understaffing and inadequate equipment. Medical supplies shortages have been described as a key disincentive to care providers carrying out their duties (147). In a qualitative study from Tanzania which aimed to describe the weaknesses in the provision of quality care through the accounts of women who have suffered obstetric fistula, nurse-midwives working in maternity units and local community members identified that care providers hold similar sentiments, claiming that a lack of supplies and medications affects the quality of care provided to women (150). The findings suggest that care providers may not be able to provide services to women during labour and delivery if they lack the appropriate medical supplies. The absence of essential materials contributes to the disrespectful and abusive care women experience during childbirth in health facilities. This is a significant factor for low-income countries like Ethiopia where health facilities suffer chronic supply shortages.

Furthermore, in a qualitative study of health system barriers to accessibility and utilisation of maternal and newborn healthcare services in Ghana with 185 mothers and 20 healthcare providers (151), and a global mixed-methods systematic review on the mistreatment of women during childbirth in health facilities (97), care providers described how under-staffing can lead to poor provider behaviour including disrespectful and abusive care. Staffing shortages can result in extended waiting times for women seeking care. As a result, labouring women may feel neglected. Studies from South Africa and Ethiopia that explored care providers' perspectives on disrespect and abuse reported that care providers perceive staffing shortages as a serious issue that results in neglect of women in maternity care (146, 151).

In their report of a landscape analysis that explored evidence for disrespect and abuse in facility-based childbirth, Bowser and Hill suggest that staff demoralisation and negative attitudes toward women are also caused by ineffective staff management (96). Similarly, in a study from Kenya conducted in both facility and community settings involving women, men,

care providers and policy makers, care providers indicated deep unhappiness with their working conditions, reporting a feeling of powerlessness due to a lack of supportive supervision and motivation. The majority believe that care providers, particularly those who are inexperienced or poorly trained, give poor quality care during childbirth due to a lack of proper supervision (144).

The Tanzanian study mentioned above identified that health personnel may operate at their own leisure in the lack of competent supervision, resulting in disrespectful care such as longer waiting times, neglect and desertion. Furthermore, several of the caregivers said that they were forced to work in maternity wards as a kind of punishment rather than because of their expertise (150). This emphasises the importance of healthcare personnel oversight, particularly in circumstances where the health system is under-resourced.

This section examined how care providers perceive disrespect and abuse during facility-based childbirth. However, the studies' methodological considerations, such as the operational definition and forms of disrespect and abuse evaluated, study aims, settings and data collection techniques are inconsistent. These factors may have influenced the findings. This section also includes information from other nations regarding care providers' perspectives on disrespect and abuse in health facilities, as there has been limited research on this topic within Ethiopia. To fill this gap in the disrespect and abuse literature, the current study explores the viewpoints of health care providers.

In summary, individual, cultural, structural or system-related factors have been identified to be associated with disrespect and abuse. Both individual providers and the whole health system are responsible for disrespect and abuse when circumstances in health institutions deviate from the accepted standards of care.

2.3 Consequences of disrespect and abuse

Previous sections have discussed prevalence and the contributors of disrespect and abuse. This section will highlight the consequences disrespect and abuse, its impact on women's health and use of maternity services. Evidence suggests that disrespect and abuse during facility-based childbirth can either directly or indirectly affect the mothers, their newborns and the community at large (43, 97, 152, 153).

2.3.1 Impact on women's health

For many women, labour and delivery may be a painful, but also life-changing experience (154). Women may experience severe pain if no pain relief are available during labour or when episiotomies are performed. Women's inability to pay for their medical treatments are presented as a reason for their refusal of pain relief during labour (154, 155). Women who have been subjected to disrespect and abuse in the form of slapping or striking may endure both psychological and physical distress (99). According to studies from Denmark (153), Egypt (156) and Guinea (148), depriving women of access to medications and psychological assistance, as well as subjecting them to physical violence during labour and childbirth, can result in great pain and suffering.

An article focused on the global epidemic of abuse and disrespect during childbirth indicated that abuse can cause women to have a distorted sense of well-being, characterised by dread and despair. Regardless of the type of disrespect and abuse, women who are abused during health care are more likely to have thoughts and concerns that show as panic episodes (126). A qualitative study that involved purposively selected women who had reported substantial suffering as a result of a previous experience of abuse within the healthcare system from a Danish sample of a multinational cohort study on negative life events among pregnant women described that women's lack of confidence in health professionals is caused by their fear of being abused, and this has an impact on patient–provider relations. Another negative consequence of abuse in health care on women's reproductive health is a lack of respect for and negative feelings about their bodies (153). Women who had been abused found it difficult to accept their femininity and sexuality, which resulted in problems in their sexual life. These women considered adopting children or having caesarean sections rather than vaginal births in the future. Studies in Northern European nations have found that women who have experienced abuse in health care are more likely to prefer a caesarean section because of the intense fear of vaginal delivery (153, 157). A preference for a caesarean section may not be the case for women in other parts of the world who have limited access to obstetric surgery, unlike the participants in these studies who have better access to alternative care to choose from.

Women may be angry or upset as a result of their disrespectful experiences. For example an Ethiopian survey identified that most mothers are unhappy because their care providers did not inform them about the progress of their labour or about their children's health (43). Furthermore, post-delivery, the psychological impact maybe so significant that it can lead to

post-traumatic stress disorder (158). Postpartum depression is another sequela of disrespect and abuse of women during facility-based childbirth as identified by a nationally representative survey from the United States (159).

The evidence described in this section demonstrates that disrespect and abuse can have long-term psychosomatic impacts on women's physical, emotional and psychological health. It reveals that there are few studies on the effects of disrespect and abuse on women's health and well-being, highlighting the need for more research.

2.3.2 Impact on use of maternity services

There is solid evidence from several countries that disrespectful care has a detrimental influence on the utilisation of facility-based birthing. Disrespect and abuse during labour is a key deterrent to facility-based birthing, according to an evidence synthesis of research from 16 low- and middle-income countries and China (13). Additionally, studies from Afghanistan (160), Bolivia (161), India (162), Ghana (163), Tanzania (164), Malawi (165), Kenya (166, 167) and Ethiopia (15, 168) have clearly reported abusive care at birth as a powerful deterrent to choosing facility-based birthing. Some women opt to travel to distant health facilities in search of quality services (169, 170), indicating that disrespectful care is a powerful deterrent to seeking skilled birth care together with geographic inaccessibility and financial constraints (96).

Access to and use of obstetric care could avert most pregnancy- and childbirth-related complications and deaths (97). However, studies from a number of countries have identified that many women do not utilise skilled birthing care as a result of disrespect and abuse during maternity care (153, 170, 171). Women's trust in and utilisation of health services can be affected by disrespect and abuse during delivery (164). Other data indicate that abuse might have a detrimental impact on maternal health-seeking behaviour and women's preferences for birthing facilities. As a result, women who have been mistreated are more likely to avoid health facilities (99, 172, 173). Similarly, a Peruvian study found that most pregnant women are reluctant to utilise obstetric care facilities because health workers neglect them, making them feel abandoned (174). As evidenced by research, disrespect and abuse play a significant role in deterring women from accessing obstetric care.

Furthermore, with subsequent pregnancies, women may want to prioritise supportive home deliveries (15, 99, 175). A mixed-methods study that examined why Ugandan women continue

to choose home births (81) and a qualitative study that explored inequities in skilled care at birth among migrant population in the metropolitan city of Addis Ababa, Ethiopia (176) identified that women who have been subjected to disrespectful and violent methods may prefer home deliveries, where they can deliver in the position of their choosing and scream out in agony without fear of being physically restrained or assaulted. Two qualitative studies from Ghana that focused on health system barriers to accessibility and utilisation of maternity care reported that women may opt to seek treatment from traditional birth attendants, who will treat them with more respect than qualified health professionals and only seek medical help in case of severe complications that the birth attendants cannot treat (151, 175).

While the impacts of disrespect and abuse on women in health facilities may vary depending on individual socio-demographic features, treatment expectations and geography, the impact on women, children, communities and health systems cannot be overemphasised. As a result, additional research is needed to understand the impacts as well as strategies to address disrespect and abuse.

To summarise this section, disrespect and abuse have been reported as barriers to maternal care in various research studies. Disrespect and abuse have far-reaching consequences for women's general wellness, in addition to impairing their relationship with care providers. Only a few research studies have looked into the negative effects of disrespect and abuse on women's health and overall well-being. While the detrimental impacts of mistreatment of women in health facilities may vary depending on individual socio-demographic features, treatment expectations and geography, the impact on women, children, communities and health systems cannot be overemphasised. As a result, more research is needed to understand the impact of disrespect and abuse as well as the mitigation strategies. Specifically in Ethiopia, there is a paucity of studies that explore disrespect and abuse during facility-based childbirth.

Effective implementation of policies, modification of practice and improving standards of care require comprehensive data on disrespect and abuse of women during childbirth (177). However, the experience of disrespect and abuse and its manifestations are less well understood. Thus, the aim of this project is to gain insight into disrespect and abuse during facility-based childbirth in North Showa Zone of Ethiopia. Specific research questions that will be addressed include: what is the prevalence of disrespect and abuse and factors associated with it, and what are women's and care providers' perspectives on disrespect and abuse during facility-based childbirth in Ethiopia?

Chapter 3: Methods

This chapter presents the philosophical perspective, study design, theoretical framework, participant sampling, data collection, variables, measurements, ethical considerations and related methods employed to address the specified research questions.

3.1 The philosophical perspective in this study

Philosophical viewpoints are essential in research because they form the epistemology, ontology, and technique of the researcher (178). The use of a philosophical stance in research changes the approach used to generate knowledge (179). This means that philosophical principles influence how researchers see a phenomenon and the methods they use (180). As a result, some writers contend that it is really difficult for a researcher to perform a study without an epistemological and ontological viewpoint (181). There are several philosophical orientations based on a researcher's ontological and epistemological perspective. Positivism, interpretivism, and pragmatism are some of the common philosophical viewpoints (178).

Positivism holds that knowledge may be gained via scientific investigation (182, 183). One of positivism's main arguments is that there is a single form of reality that exists independently of the researchers (184), and that they do not interact with the study setting and vice versa (181). As a result, positivists frequently employ quantitative research designs to investigate correlations between variables and test hypotheses using methods such as closed-ended surveys and statistical data analysis (183). This philosophical stance is inappropriate for the current study since women's maternity experiences, particularly disrespect and abuse, are subjective and vary in terms of setting, personal expectations, and perspectives (185). The positivist approach inhibits its ability to incorporate the subjectivity of women's experiences, health care providers' views, and provide understanding of disrespect and abuse.

Interpretivism, in contrast to positivism, asserts that an individual can receive knowledge through the social construction of a reality (186). Interpretivists think that the social world has numerous realities and interpretations, and that as a result of these different realities, a researcher can get subjective insight into a social occurrence (180). As a result, this viewpoint is frequently applicable in qualitative research. However, it is not applicable in quantitative research that inquire correlations between variables and test hypotheses.

This project applied a mixed methods design and thus, rather than using positivism or interpretivism, the researcher chooses the best appropriate theoretical stance that allows for adoption of any data gathering method that is appropriate for the study aims, pragmatism (183). Pragmatism, lies between interpretivism and positivism (183). Pragmatists believe that rather than the application of positivism or interpretivism, a researcher can adopt a theoretical standpoint that is most appropriate for a study (183, 187). The philosophical foundation of pragmatism allows the possibility of the integration of both quantitative and qualitative methods/data/designs. Pragmatism assumes that knowledge is generated and founded on mind-independent reality as a result of person-environment interaction, and it emphasizes the instrumental aspect of theories in inquiry (188-190). According to the pragmatist position, both the mind-independent physical world and the constructed social and psychological world exist, and reality is complex and multiple (188, 189); social scientific research is value-oriented (189).

3.2 Study setting

Ethiopia is located in East Africa, bounded by Djibouti, Eritrea, Kenya, Somalia and Sudan. Addis Ababa is the capital of Ethiopia, and the country has a total area of 1,104,300 km^2. Ethiopia is a predominantly agricultural country, and more than 80% of the population lives in rural areas. According to the Federal Ministry of Health, in 2017 the total population was estimated to be 105 million, making the country the second most populous in Africa. The male to female ratio is 1.03, and the total fertility rate is 4.6. The population growth rate of the country is 2.58, and the total life expectancy is 64.8 (191).

Ethiopia has eleven administrative regional states and two city administrations. Oromia regional state is the largest region and has 17 zones and 180 woreda or districts. The study was conducted in North Showa zone of Oromia regional state. It is located 110 km to the north of the capital Addis Ababa. The zone has 15 districts, and its capital town is Fitche (Figure 3). Based on the 2007 Census conducted by the Central Statistical Agency of Ethiopia, this zone had a projected total population of 1.5 million in 2016, of whom 48% were women. North Showa zone has an area of 10,322.48 square kilometres and a population density of 138.66 (192). Three hospitals, 62 health centres and 268 health posts are currently functioning in the zone.

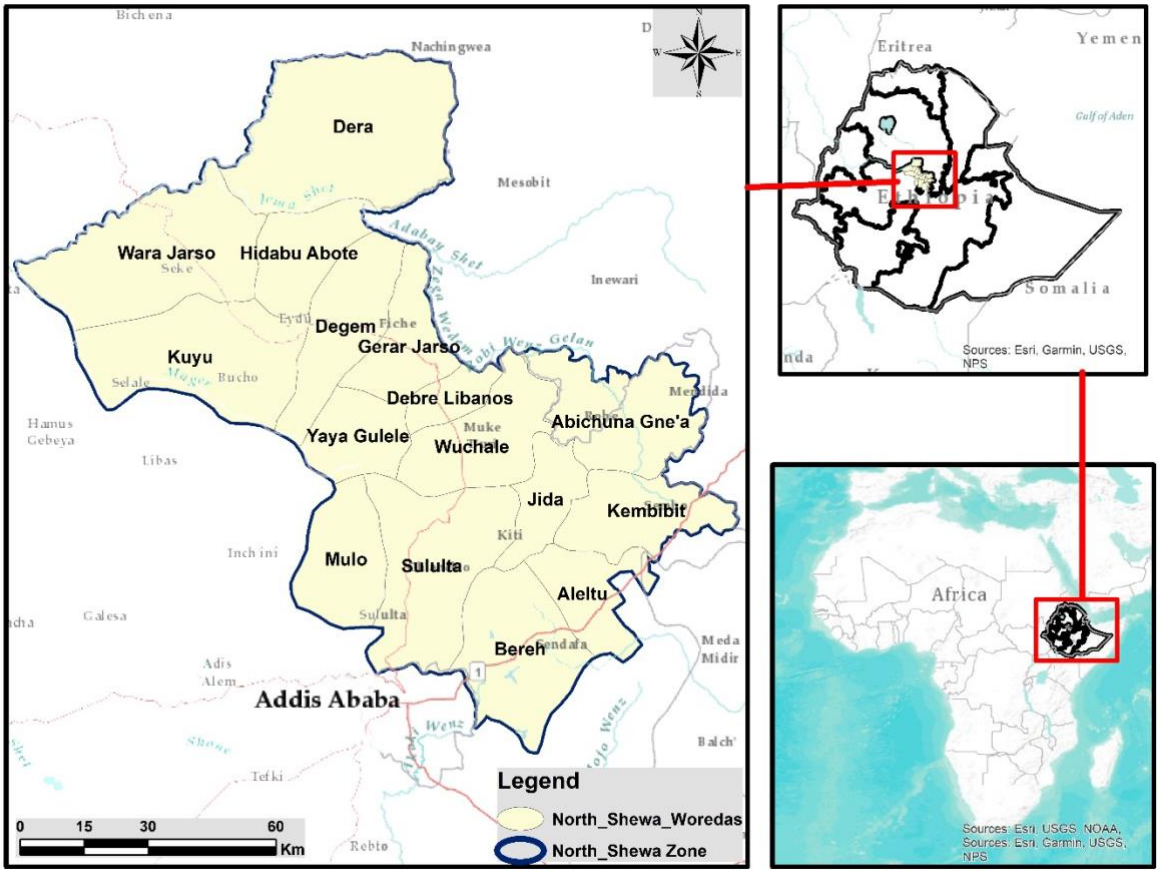

Figure 3: Central Statistical Agency and EthioGIS 2013 map of Ethiopia developed by arc GIS. Lower right: map of Africa, upper right: map of Ethiopia, left: map of the study area, North Showa zone.

3.2 Theoretical framework

The framework used for this research is based on the Bowser and Hill's landscape analysis developed by a USAID-funded Translating Research into Action Project (TRAction), which explored the evidence of disrespect and abuse during facility-based childbirth in 2010 (96). The framework categorises disrespect and abuse in to seven categories: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities. Furthermore, the framework explains "contributors to and impact of disrespect and abuse in childbirth on skilled care utilization". It consists of five domains: individual and community, national laws and policies, human rights and ethics, governance and leadership, service delivery, and providers (Figure 4).

The report was prepared using a literature review, individual interviews with a sample of maternal health policymakers and senior program planners proposed by USAID, URC, and participants at the Women Deliver and March 2010 meetings, and structured group discussion with a sample of women from the Women Deliver Conference 2010 convened by the TRAction Project. A diagram was created to describe the recognized categories of disrespect and abuse in facility-based childbirth, as well as to show both the contributors to disrespect and the negative impact of disrespect (together with other deterrents) on skilled care usage. This framework is so dominant in the literature on disrespect and abuse that it has been employed in the majority of research done in Ethiopia (111, 145, 193) and elsewhere (95, 102, 194).

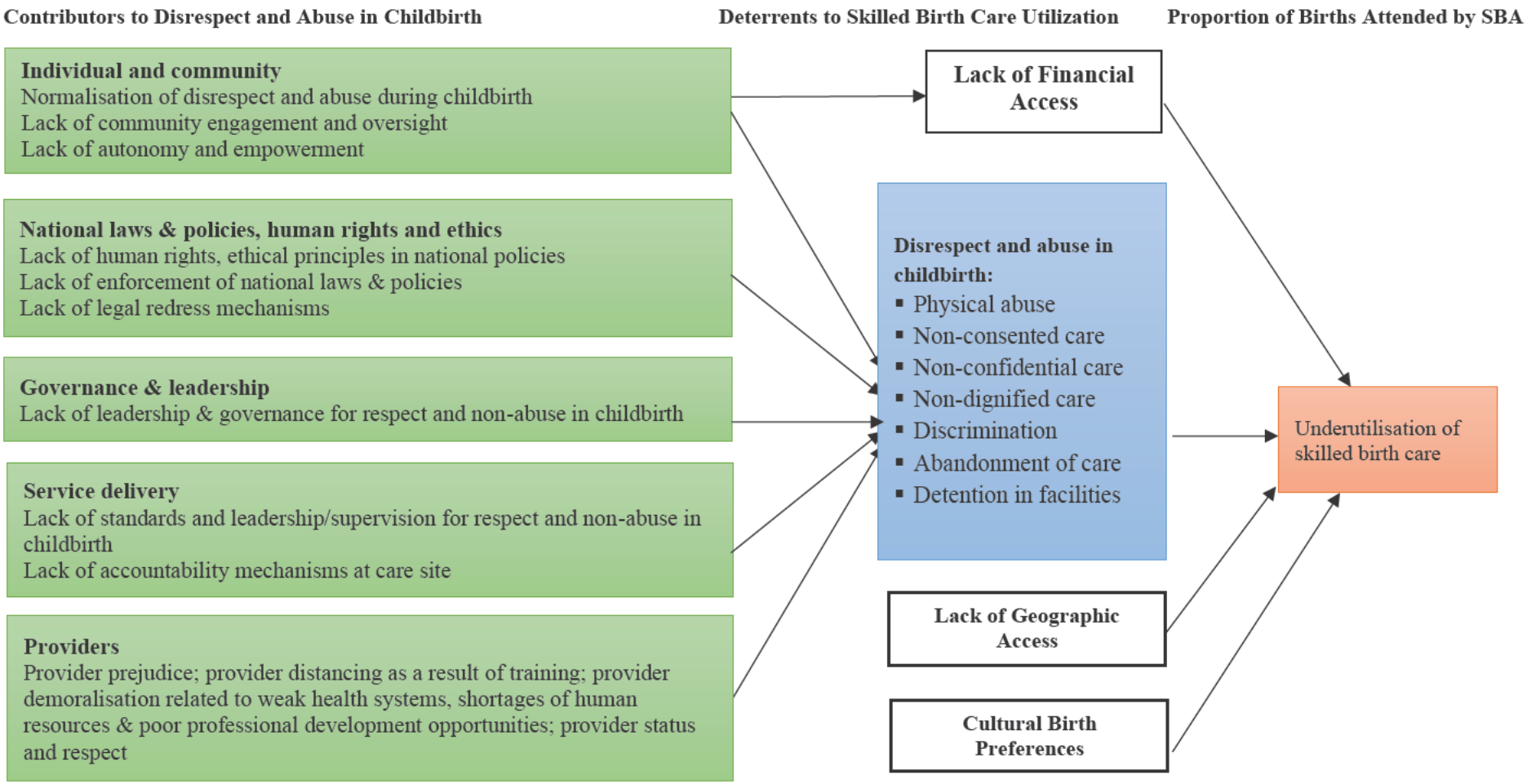

Figure 4: Potential contributors to and impact of disrespect and abuse in childbirth on skilled care utilisation (96)

3.3 Study design

A "concurrent" mixed design in which both quantitative and qualitative data were simultaneously collected was implemented to address the specified research questions. A mixed-methods design provides strengths that offset the particular weaknesses of either quantitative or qualitative research (195). It also allows the specified research questions to be comprehensively researched by providing more evidence to understand complex health problems (196). (Figure 5)

3.3.1 The quantitative study

A community-based cross-sectional study was conducted from 5 October 2019 to 25 January 2020. This study was conducted by using digital/tablet-based tools in face-to-face interviews with women who had given birth within the twelve months prior to the survey.

3.3.1.1 Participants and sampling

Participants of the study were women who gave birth in public health facilities in the twelve months preceding the survey. The participants were enrolled in the study from across all districts (rural and urban areas) of North Showa zone via a registry held by health extension workers.

The sample size was calculated using a single population proportion formula with assumptions of 78.6% proportion of disrespect and abuse, (43) 4% precision and 95% level of confidence.

$$n = \frac{(0.786)(1 - 0.786) * (1.96)^2}{(0.04)^2}$$

After allowing for a 10% non-response rate, the final sample was 443.

A list, including contact details, of women who gave birth at public health facilities is maintained by health extension workers. Using this list as a sampling frame, 443 eligible women were selected by computer- generated random numbers in a Microsoft Excel spreadsheet. Selection and initial contact were made in person by the health extension workers and women were invited to choose time and place of survey (Appendix A1 and A2).

3.3.1.2 Inclusion and exclusion criteria

Women who had given birth at public health facilities of North Showa zone during the twelve months preceding the survey, regardless of the birth outcome, were included in the study. Separate sample was selected for the survey and the interviews and focus groups. Women who gave birth at home, severely sick and mentally ill women and those with disability which hindered their ability to talk to provide the researcher with information were ineligible to participate.

3.3.1.3 Data collection and tools

A validated questionnaire adopted from previous literature (43, 197) was used to address the specified research objective (Appendix B1 and B2). The tool consisted of three parts. The first part contained seven questions and was used to assess the socio-demographic characteristics of the participants. The second part contained 10 questions focusing on the participants' obstetric history and experience of maternity care utilisation, and the third part included the seven categories of disrespect and abuse along with the 48 verification criteria used to measure experiences of disrespect and abuse. The English version of the questionnaire was translated into Amharic and Afan Oromo languages and was back translated into English by a language expert to check the reliability of the translations. The local version of the tool was used for the survey after being pretested on women in the zone who are not included in the survey. Participants were surveyed in their homes or another preferred location and were accompanied by a person of their choice during the survey. Data were collected using a digital, tablet-based tool, Open Data Kit Collect. The tool was programmed and uploaded to tablets for the survey.

All health extension workers involved in data collection were female, and had attended a one-year formal pre-service training conducted through a collaboration between the Ministry of Health and the Ministry of Education (198). The HEWs split their time between health posts and community settings; they are not directly connected to any birthing facilities (199). The data collectors had prior experience of tablet-based survey implementation. The principal investigator provided them theoretical and practical training regarding the data collection tool, the data collection procedure including research ethics and rights of the participants. Digital, tablet-based data collection improves the quality of the data as it allows predetermined options only. The data collectors also practised collecting data using the tablets in order to familiarise themselves with the tool prior to data collection. The data collectors were all females to make

sharing ideas easier, as the topic is sensitive. The principal investigator closely supervised the entire data collection process.

3.3.1.4 Variables and measurement

Based on the literature and the theoretical framework, data concerning the following variables were collected.

Independent variables: The independent variables were age, residence, education, income, marital status, occupation, walking distance of health facility from home in minutes, total number of live births, number of births at health facilities, antenatal follow-up for recent pregnancy, antenatal care and childbirth in same facility for recent birth, type of health facility visited for birth, method of birth for recent childbirth, number of babies in most recent childbirth, profession of provider who attended the birth, and sex of provider who attended the birth.

Dependent variable: The outcome variable was disrespect and abuse of women during facility-based childbirth. We measured disrespect and abuse using the seven categorise of developed by White Ribbon Alliance (24) based on Bowser and Hill's framework (96). Prevalence was calculated for each category. Each category has more than one verification criteria with "Yes" or "No" dichotomised responses. A respondent was considered to have been disrespected and/or abused for the specific category if she reported "Yes" to at least one of the verification criteria in that category (43).

3.3.1.5 Statistical analysis

The data were exported to SPSS for Windows version 21. Descriptive statistics were used to describe the study population in relation to relevant variables. To identify predictors of each disrespect and abuse category, bivariate logistic regressions with each potential covariate were conducted, and variables that had a p-value of < 0.2 were included in the final multivariable binary logistic regression models. Then, four multivariable logistic regression models (one model for each category of disrespect and abuse, except for physical abuse, non-consented care and detention) with a 95% confidence interval were fitted. Physical abuse and non-consented care were reported by too many participants, whereas the number of women who reported detention was too small. As a result, these three categories were excluded as the researcher

could not perform further statistical analyses. Adjusted odds ratios and their 95% confidence intervals were computed, and statistical significance was declared at p-value of < 0.05.

3.3.2 Qualitative studies

Three qualitative studies were conducted as part of this thesis. Two were conducted among women and care providers separately to explore how they perceive health care professionals conduct that could be classified as mistreatment by an independent observer, researcher, or advocate. The third was a single interview with a woman that was not recruited directly but referred by women participants to share her story.

3.3.2.1 Participants and sampling

The study participants were women who had given birth at public health facilities in North Showa zone during the twelve months preceding the study, regardless of the birth outcome. Initial recruitment and information about the study was provided by health extension workers, when visiting women in their homes. Interested women then chose whether to be involved in either of a structured survey, a semi-structured interview or a focus group discussion at a time and place of their choice. While individual interviews allow the researcher to listen to individual stories and experiences in depth, group discussions provide space to examine and explore differences and similarities in opinions and views, giving participants space to comment on each other's experiences Purposive sampling was used to include participants across a range of ages, parity and economic circumstances. Information saturation (when ideas started to be repeated and no more new ideas emerged) was used to determine the final number of in-depth interviews and focus group discussions.

For the study that involved care providers, midwives, nurses, general practitioners and obstetricians working at maternity units of selected health facilities with direct involvement in the care of women during pregnancy and labour were enrolled. A project information flyer was posted in maternity units and the project eligibility criteria were presented to staff, following permission from administrators (Appendix C1 and C2). Interested care providers contacted the investigator, provided informed consent and participated in semi-structured interviews (Appendix D1 and D2). Purposive sampling was used to enrol participants across a range of health professions and experiences. Information saturation (when ideas started to be repeated and no more new ideas emerged) was used to determine the final number of in-depth

interviews. Participants worked in two hospitals and three health centres with urban and rural areas included.

3.3.2.2 Inclusion and exclusion criteria

Women who gave birth at home, those who were acutely unwell physically or mentally and those with a disability that would prevent them talking to a researcher were excluded.

Healthcare providers who do not work at the maternity ward of the study facilities were ineligible to participate. Health posts were not included as they do not provide birthing care.

3.3.2.3 Data collection and tools

The research team, consisting of the principal researcher and his supervisors, utilised the findings of a systematic review (97) to develop scenarios of different types of mistreatments women may experience during childbirth in Ethiopia (43). Scenarios has been previously used by other studies to elicit participants perspective (99, 104). The team conducted a prioritisation exercise to ensure these scenarios were understandable, clear and concise, and accessible and understandable for potential participants from very different cultural and geographical backgrounds. Nine scenarios were developed (see Appendix E1, E2, F1 and F2). The English version of the interview guide was translated into the local languages Amharic and Afan Oromo by the principal investigator because the residents of the study area speak either of these languages. During interviews and focus groups, participants were presented with each scenario and asked when, if ever, this scenario would be acceptable. Participants were invited to reflect on the "acceptability" of each hypothetical mistreatment during childbirth generally, rather than being asked to disclose personal instances of mistreatment. This approach aimed to prevent re-traumatising women or expecting them to share highly personal information in a group setting.

Fifteen in-depth interviews and five focus group discussions were conducted with women, and fifteen in-depth interviews were conducted with care providers from 5 October 2019 to 25 January 2020. Women were interviewed in their homes or another preferred location and were accompanied by a person of their choice. Care providers, on the other hand, were interviewed in private rooms in health facilities during working hours to avoid disturbance, enable recording and to protect their privacy. Participants were informed their participation involved audio recording and all interviews were recorded using an audio recorder with their consent.

Each participant was given a code to keep the interview anonymous. Interviews lasted approximately 50 minutes. Focus groups took place in a community setting and lasted about 180 minutes. The entire data collection was conducted by the principal researcher who had prior experience of qualitative data collection and analysis. The audio-recorded data were transcribed verbatim and were cross-checked with the audio recording. Subsequently they were translated into English for analysis.

3.3.2.4 Data analysis

The two qualitative studies that involved women and the care providers are presented in line with consolidated criteria for reporting qualitative studies (COREQ) guidelines (200). Data files in Word documents were imported to Open Code software version 4.0.2.3 for thematic analysis. Data analysis was guided by Braun and Clarke's six steps of thematic analysis experiences (201). First, two researchers familiarised themselves with the data by reading and re-reading through the translated data. Then, initial ideas were noted, codes were identified, and similar codes were combined into sub-themes and themes. The principal researcher conducted data coding. A report was produced based on the final themes and subthemes. Transcripts of the interviews were not returned to the participants as the study was anonymous and thus individual transcripts could not be identified.

3.3.2.5 Rigour

The researcher spent six months on data collection, and the research team included experts in maternity care and qualitative research. The team had regular meetings to discuss and debrief on the progress of data collection. A study protocol with a detailed data collection procedure was developed, and data coding was checked for accuracy by the research team to maintain the dependability of the research. Reliability testing was conducted in two stages: two Ethiopian researchers jointly coded five transcripts and then independently coded four transcripts and discussed coding decisions until they reached consensus. A subset of the coded transcripts was reviewed by an independent researcher to check the reliability of the coding. The research members checked the codes and themes that emerged, and the findings were reviewed by a panel who were familiar with the Ethiopian context. The use of purposive sampling and operationally defined data saturation ensured the transferability of the study.

3.4 Ethical considerations

3.4.1. Ethical clearance

The project was conducted according to the National Statement on Ethical Conduct in Human Research, Australia and the Ethiopian National Health Research Ethics guidelines. The basic principles of human research ethics were respected in the process of this research. Ahead of commencement of the research, ethics approval was obtained from the University of Adelaide Human Research Ethics Committee (approval number: H-2019-153) and Salale University, Institutional Health Research Ethics Review Committee (approval number: A/G/H/S/C/768/11) (Appendix G1). A formal letter was written to all concerned authorities and permission was secured at all levels before commencing data collection (Appendix G2). Informed written consent was obtained from each respondent after explaining the purpose and procedure of the studies (Appendices H1-H8). The researcher attended necessary training and did a lot of studying on qualitative research to acquire research skills relevant to this study (202)

3.4.2. Informed consent

Participants were given sufficient information about the study, including the freedom and choice to participate or decline without persuasion or coercion. The right to participate voluntarily after understanding the research purpose. All participants were verbally informed of the study's purpose and were given the consent form and participant information sheet. The participant information sheet explained the study's purpose, the data collection process, and the right to freely accept or refuse participation. They were given some time to read the participant information sheet and decide whether or not they wanted to participate in the study. The consent form was used to determine whether or not they had received and read the participant information sheet, had the opportunity to ask questions, understood their right to accept or refuse participation, and agreed to participate in an interview. It also asked for their permission to use their names in the study and to be audio-recorded. To indicate their agreement, all participants willingly signed the form.

3.4.3. Confidentiality, anonymity and privacy

When conducting research, anonymity and confidentiality are critical ethical issues to protect participants' information and identities. The interviews and focus groups with women were held in their homes, whereas the care providers were interviewed in a room at a health facility,

with "Do not disturb" written on a placard and placed outside the door to limit access for others. Participants of the focus groups were oriented to keep the points of discussion and views of other participants to themselves and refrain from sharing with those not part of the focus group to ensure their confidentiality. Anonymity was maintained in this study in a variety of ways. During data collection, analysis, presentation of findings, and publication, participants were identified using code numbers. The data was transcribed using headphones in a private room to prevent other people from hearing the audio recordings. During the transcription, any information that could be used to identify any of the participants was removed. Any socio-demographic information provided by participants was solely for research purposes. All participants were informed that any socio-demographic information they provided would be used for data analysis and findings presentation. Apart from the supervisory team, no other individuals or organizations received the collected data. This ensured the information was kept private. As a result, confidentiality and anonymity were maintained throughout the study as much as was possible.

3.4.4. Safeguarding the women

Participants may become distressed, anxious, or even upset when sharing their experiences due to the sensitive nature of the research topic. Because of the sensitive nature of the study, the researcher had anticipated that participants would become emotionally distressed. Counsellors at the health facilities were readily available through contact with the gatekeepers to provide support if participants became distressed or uncomfortable while sharing their experiences. During data collection with women (FGDs and semi-structured interviews), the researcher looked for signs of emotional distress, such as long pauses or crying. If participants showed signs of distress, the researcher was prepared to pause the discussion and ask if they wanted to stop or speak with a counsellor. If participants felt compelled to continue or discontinue after the break, the researcher would have complied. Furthermore, if a participant requested to stop, the researcher was prepared to inform them of the option of seeking help by speaking with a counsellor at the health facility. Furthermore, during the interviews, all participants were given the option of being accompanied by a person of their choice. However, no one in this study showed signs of emotional distress, no one asked to leave, and everyone willingly shared their perspectives.

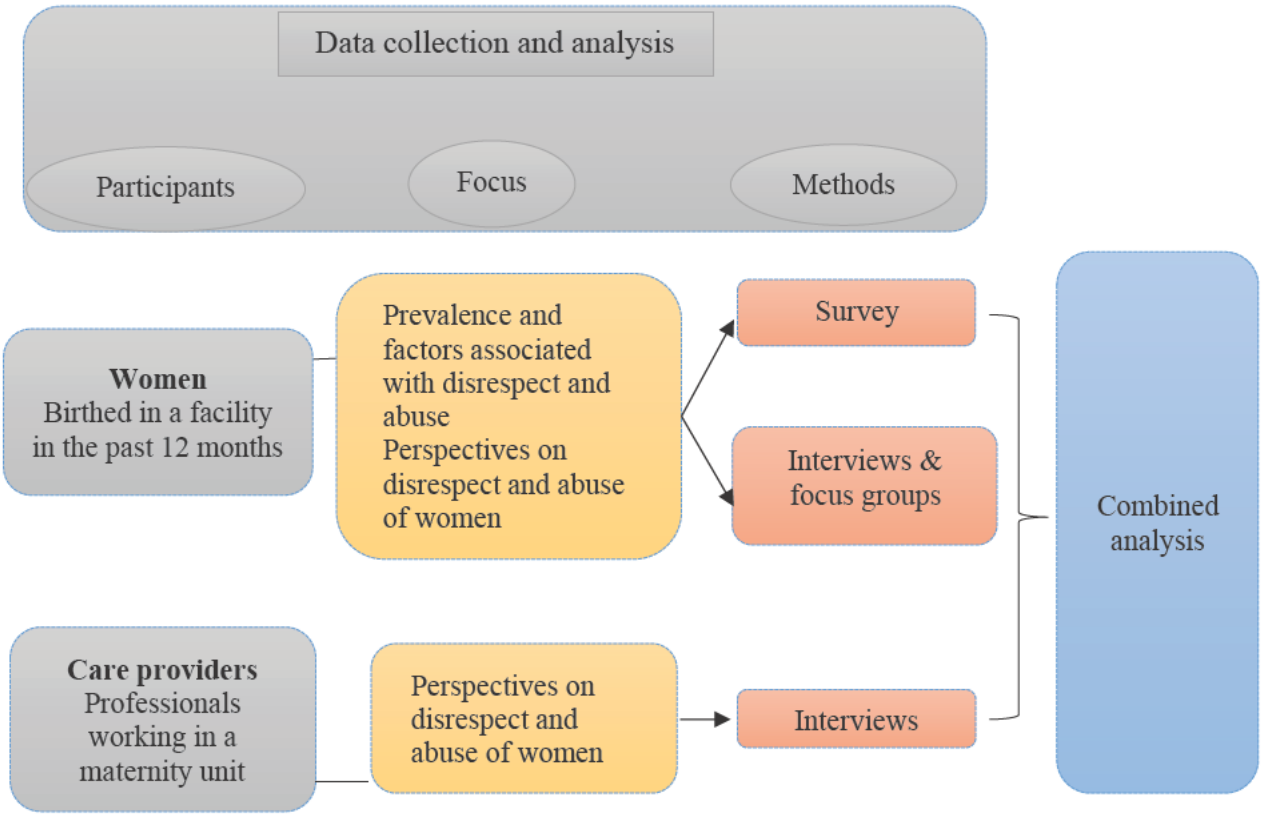

Figure 5: Methods of data collection and analysis

Chapter 4: Disrespect and abuse during facility-based childbirth in central Ethiopia

This chapter covers the first objective of the project, prevalence of disrespect and abuse and associated factors. The participants were women who have given birth at health facilities within the past twelve months. The study employed a quantitative design to quantify self-reported prevalence of disrespect and abuse and identify factors associated with experiencing disrespect and abuse.

The prevalence of disrespect and abuse was 100%. All participants reported at least one form of disrespect and abuse during childbirth. Physical abuse (disallowed preferred birthing position and denied anaesthesia during episiotomy or suturing) were the most commonly reported types of disrespect and abuse followed by non-consented care (non-consented vaginal examination). Detention in health facilities due to inability to pay hospital bills was the least reported category of disrespect and abuse. Women who gave birth in hospitals and assisted by female providers.

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Disrespect and abuse during facility-based childbirth in central Ethiopia

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ABSTRACT

Background: Respectful maternity care is a fundamental human right, and an important component of quality maternity care.

Objective: The aim of this study was to quantify the frequency and categories of D&A and identify factors associated with reporting D&A among women in north Showa zone of Ethiopia.

Method: A cross-sectional study was conducted with 435 randomly selected women who had given birth at public health facility within the previous 12 months in North Showa zone of Ethiopia. A digital (tablet-based) structured and researcher administered tool was used for data collection. Frequencies of D&A items organised around the Bowser and Hill categories of D&A and presented in the White Ribbon Alliance's Universal Rights of Childbearing Women Framework were calculated. Multivariable logistic regression was used to identify the association between experience of disrespect and abuse and interpersonal and structural factors at p-value <0.05 and odds ratio values with 95% confidence interval.

Results: All participants reported at least one form of disrespect and abuse during childbirth. Types of disrespect and abuse experienced by participants were physical abuse 435 (100%), non-consented care 423 (97 2%), non-confidential care 288 (66.2%), abandonment/neglect (34.7%), non-dignified care 126 (29%), discriminatory care 99 (22.8%) and detention 24 (5.5%). Hospital birth [AOR: 3.04, 95% CI: 1.75, 5.27], rural residence [AOR: 1.44, 95% CI: 0.76, 2.71], monthly household income less than 1,644 Birr (USD 57) [AOR: 2.26, 95% CI: 1 20, 4 26], being attended by female providers [AOR: 1.74, 95% CI: 1.06, 2.86] and midwifery nurses [AOR: 2.23, 95% CI: 1.13, 4.39] showed positive association with experience of disrespect and abuse.

Conclusion: Hospital birth showed consistent association with all forms of disrespect and abuse. Expanding the size and skill mix of professionals in the hospitals, sensitizing providers consequences of disrespect and abuse could promote dignified and respectful care.

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Background

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

Ethiopia aims to reduce its maternal mortality ratio to less than 70 per 100,000 live births by 2030 in order to achieve the United Nations Sustainable Development Goal 3 [6]. The Sustainable Development Goals are the blueprint to achieve a better and more sustainable future for all. Sustainable Development Goal 3 is about 'Good Health and Well-being' and is one of the 17 Sustainable Development Goals established by the United Nations in 2015. Ensuring access to quality obstetric care is essential as it has the potential to reduce up to 75% of preventable deaths [7,8]. The proportion of Ethiopian women who report having difficulty accessing health care decreased from 96% in 2005, to 70% in 2016 [9]. However, only 48% of women gave birth at health facility in 2019. Improving respectful maternity care has been flagged as a potential strategy for reducing preventable maternal mortality and morbidity, and to accelerate progress towards meeting the Sustainable Development Goal targets for improving maternal health [10].

Respectful maternity care is a key element of quality maternity care [11]. It is an approach that stresses positive interpersonal interactions between providers and women, throughout maternity care [12]. Women's right to respectful and dignified health care throughout pregnancy and childbirth has become a central focus in intervention strategies that seek to reduce maternal mortality [13]; disrespect and abuse (D&A) affects women's trust in care providers and the health system deterring them from seeking and using maternity care [12]. This highlights the need for maternity care to be competent and respectful if women are to use it [11].

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Disrespectful treatment ranges from denial of a woman's right to make informed decisions and being scolded for demanding their rights [14], to denial of anaesthesia while performing and repairing episiotomies [15]. The White Ribbon Alliance categorise D&A in childbirth into seven categories: physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, discrimination, and detention. Each category has more than one verification criteria with 'Yes' or 'No' dichotomized responses. According to White Ribbon Alliance, verification criteria/manifestations of D&A often fall into more than one category, so that categories are not intended to be mutually exclusive. Rather categories should be seen to be overlapping along a continuum [16]. International human rights frameworks highlight D&A of women during childbirth as a key human rights issue [17–20], and a human rights based approach to birthing care has become a primary concern [21].

Research from different parts of Ethiopia has identified growing evidence of disrespectful and abusive care during labour and childbirth regardless of women's socio-demographic characteristics, such as age and level of education. However, some groups of women, such as unmarried women, women from low economic status and women with HIV sero positive status are more vulnerable to D&A based on these specific attributes [22–34]. Comprehensive information regarding D&A of women during childbirth is needed in order to more effectively implement policies, change practice, and culture and improve standards of care [35]. However, the experience of D&A and its determinants are not well understood. Thus, the aim of this study is to quantify the frequency and categories of D&A during facility-based childbirth and identify factors associated with reporting D&A among women in north Showa zone of Ethiopia.

Methods

Study design and setting

This study was conducted as part of a larger mixed methods study that examined disrespect and abuse of women during facility-based childbirth in Ethiopia. A community-based cross-sectional study (conducted in community settings rather than in a facility or institution) was conducted from 5 October 2019 to 25 January 2020 in North Showa zone of Ethiopia. The zone is located 110 km to north of the capital Addis Ababa. Based on the 2007 Census conducted by the Central Statistical Agency of Ethiopia, the Zone has a projected total population of 1.5 million in 2016, of whom 48% were women. North Showa zone has an area of 10,322.48 square kilometers and population density of 138.66 [36]. Three hospitals, 62 health centers, 268 health posts are currently functioning in the zone. Health posts were not included in the study as they do not provide birthing care. Women from across all districts (rural and urban areas) of the North Showa zone were included via a registry held by health extension workers.

Study population and eligibility

Participants were women who had given birth at public health facilities of North Showa zone during the last 12 months preceding the survey, regardless of the birth outcome. Women who gave birth at home, those who were acutely unwell physically or mentally and those with disability which would prevent them talking to a researcher were excluded.

Study variables

The dependent variables of this research were the seven categories of D&A women experience during facility-based childbirth (physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, discrimination, and detention) organised around the Bowser and Hill categories of D&A and presented in the White Ribbon Alliance's Universal Rights of Childbearing Women Framework [16]. The independent variables of this research were sociodemographic variables (age, residence, marital, education, occupation and monthly household income), obstetric history and experience of maternity care utilization (walking distance of health facility from home, total number of live births, number of birth at health facility, antenatal care checkups, antenatal and childbirth in same facility, type of health facility visited for birth (health center vs hospital), method of birth and number of babies in most recent childbirth, profession and sex of providers who attended the birth).

Sample size determination and sampling procedures

A single population proportion formula was used to calculate the sample size with assumptions of 78.6% proportion of disrespect and abuse [22], 4% precision, 95% level of confidence and a 10% non-response rate, the final sample size was 443. A list, including contact details, of women who gave birth at public health facility is maintained by health extension workers. Using this list as a sampling frame, 443 eligible women were selected by computer generated random numbers in Excel spreadsheet (Microsoft Corporation, 2013). Selection and initial contact was made in person by the health extension workers and

women were invited to choose time and place of survey.

All health extension workers involved in data collection are female, have attended a one-year formal pre-service training conducted by trainers [37] Through a collaboration between the Ministry of Health and the Ministry of Education. The training includes didactic and clinical training regarding (1) family health services, disease prevention and control, (3) hygiene and environmental sanitation, and (4) health education and communication [38]. The main responsibilities of HEWs include health promotion, disease prevention, and treatment of uncomplicated and non-severe illnesses, such as cases of malaria, pneumonia, diarrhea, and malnutrition in the community. HEWs split their time between health posts and community settings; they are not directly connected to any birthing facilities [39].

Data collection tool and procedures

Data were collected using digital, tablet-based tools, Open Data Kit Collect. A validated tool was programmed and uploaded to tablets for the survey [22,40]. The tool consisted of three parts. The first part contained seven questions and was used to assess the sociodemographic characteristics of participants. The second part contained 10 questions focusing on the participants' obstetric history and experience of maternity care utilisation, and the third part included the seven categories of disrespect and abuse along with the 48 verification criteria used to measure experience of D&A. The tool was designed in English and translated to the local language, Amharic, and then back to English by a third person to check for internal consistency. The Amharic version of the tool was piloted and used to collect data face to face. Participants were surveyed in their homes or another preferred location and were accompanied by person of their choice during the survey.

Measurement

We measured D&A using a framework developed by Bowser and Hill [41]. The D&A were categorised into seven groups and prevalence was calculated for each specific category. Each category has more than one verification criteria with 'Yes' or 'No' dichotomised responses. A respondent was considered to have been disrespected and/or abused for the specific category if she reported 'Yes' to at least one of the verification criteria in that category [22].

Data quality assurance

Digital, tablet-based data collection improves quality of the data as it allows predetermined options only. Health extension workers with prior experience of tablet-based survey implementation conducted the survey following 2 days of intensive training. The health extension workers also practiced collecting data using the tablets in order to familiarize themselves with the tool prior to data collection. The data collectors were all females to make sharing ideas easier, as the topic is sensitive. The principal investigator has closely supervised the data collection process.

Data processing and analysis

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

Results

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

Participants' obstetric history and experience of maternity care utilisation

More than half of the participants, 248 (57.0%) walk between 30 to 60 minutes to reach the nearest health facility. The majority, 316 (72.6%), had prior experience of giving birth at a health facility. Most, 395 (90.8%), of the study participants had antenatal care follow-up for their recent pregnancy, of which, 345 (87.3%) gave birth

Table 1. Sociodemographic characteristics of participants (N = 435).

Variables		Frequency	Percentage
Age in Years	18–19	14	3.2
	20–24	78	17.9
	25–29	179	41.1
	30–34	90	20.7
	35+	74	27.0
Residence	Urban	304	69.9
	Rural	131	30.1
Marital status	Single	25	5.7
	Married	378	86.9
	Divorced	24	5.5
	Widowed	8	1.8
Level of education	No formal education	105	24.1
	Primary education	124	28.5
	Secondary education	106	24.4
	Tertiary education	100	23.0
Occupational status	Housewife	201	46.2
	Government employee	99	22.8
	Private employee	113	26
	Farmer	22	5.1
Monthly household income	≥ 1,644	77	17.7
	Less than 1,644	358	82.3
Spouse occupation	Unemployed	16	3.7
	Private employee	137	31.5
	Farmer	45	10.3
	Government employee	180	41.4

*1 USD was equivalent to 28.85 ETH birr during the study period and then multiplied by poverty line income (1.9/day).

Table 2. Obstetric history of participants (N = 435).

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

in same facility where they received antenatal checkups. About half, 223 (51.3%) gave birth in health centres. Midwives/nurses attended 255 (58.6%) of the women during birth. Approximately half 217 (49.9%) of women participants reported they were attended by male care providers Table 2.

Forms of disrespect and abuse reported by participants

Frequencies of D&A items organised around the Bowser and Hill categories of D&A and presented in the White Ribbon Alliance's Universal Rights of Childbearing Women Framework were calculated. As a result, the prevalence self-reported D&A ranged from 100% for physical abuse to 5.5 for detention in health facility (Figure 1).

All women have reported at least one form of D&A during birth care. Physical abuse was found to be the most prevalent (100%) category. Among the verifications of physical abuse, 413 (94.9%) women reported that they were not allowed to give birth in their preferred birthing position; whereas for 381 (87.6%) women an episiotomy was given or sutured without anesthesia. Non-consented care was the second most common category of D&A reported by 423 (97.2%) of participants. A vast majority of participants, 362 (83.2%) reported that care providers had conducted a vaginal examination without their consent. In addition, 92 (21.1%) participants reported that intrauterine device was inserted without their consent. Two-thirds, 288 (66.2%) of participants reported confidentiality of their care was breached, of which 220 (50.6%) reported absence of curtains/

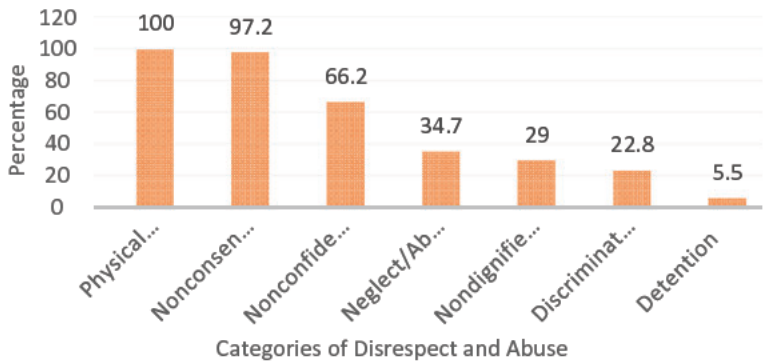

Figure 1. Categories of disrespect and abuse reported by women (N = 435).

partitions or other measures to provide privacy. Likewise, 204 (46.9%) of participating women said vaginal examinations were not conducted privately. About one-third (34.7%) of participants felt abandoned or neglected. More than one in ten (12.9%) women said providers were not present when the baby was born. Non-dignified care was the fifth most common D&A reported by 126 (29%) participants. Among verifications of non-dignified care, 75 (17.2%) of women said providers threatened them if they did not comply and indicated that they or their baby would have a poor outcome. Similarly, 71 (16.3%) of participating women reported that healthcare providers had shouted/screamed at them during labour or birth. Nearly quarter, 99 (22.8%) of participants reported that they felt discriminated against. Discrimination amongst this group included 51 (11.7%) respondents stating healthcare providers made negative comments regarding their HIV seropositive status, whereas 37 (8.5%) women received negative comments regarding their age. In addition, 24 (5.5%) of respondents said they were detained in the facility against their will, of which, 17 (3.9%) were detained due to inability to pay hospital bills, while 13 (3.0%) were instructed to clean up their own blood or other fluid after birth (Table 3).

Table 3. Experiences of disrespect and abuse during facility-based childbirth, Ethiopia, 2020 (N = 435).

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

Predictors of disrespect and abuse

Four logistic regression models were constructed to examine the relationship of interpersonal and structural factors with each of the four different categories of D&A. Three forms (physical abuse, non-consented care and detention) were excluded since bivariate analysis revealed that further statistical analyses could not be performed due to the number of women who reported these categories being either too high or too small Table 4.

The type of health facility at which childbirth takes place, monthly household income, profession and sex of providers were found to be significantly associated with most of the D&A categories. The type of health facility at which childbirth takes place was found to be the most important statistically significant predictor of all forms of D&A; those who gave birth at hospitals were three times more likely to experience disrespect or abuse [AOR: 3.04, 95% CI: 1.75, 5.27] than those who gave birth at health centers. Experiences of disrespect or abuse were 1.4 times more likely to be reported by rural women than their urban counterparts [AOR: 1.44, 95% CI: 0.76, 2.71]. Women who have monthly household income less than 1,644 Birr (USD 57) were about two times more likely to experience disrespect or abuse [AOR: 2.26, 95% CI: 1.20, 4.26]. Regarding sex and profession of care providers, those women who were attended by female providers [AOR: 1.74, 95% CI: 1.06, 2.86] and midwives/nurses [AOR: 2.23, 95% CI: 1.13, 4.39] were more likely to

Table 4. Bivariate and multivariate logistic regression analysis output of factors associated with disrespect and abuse during facility-based childbirth, North Showa zone, Ethiopia, 2019.

Variables with categories	Non-dignified care AOR [CI]	Non-confidential care AOR [CI]	Discriminatory care AOR [CI]	Abandonment AOR [CI]
Level of education				
Tertiary	1	1	1	1
No education	1.41 (0.61–3.26)	2.12 (0.96–4.67)	1.59 (0.72–3.51)	1.08 (0.51–2.27)
Primary	2.04 (0.90–4.62)	2.15 (1.01–4.55)*	0.89 (0.39–2.01)	1.15 (0.55–2.37)
Secondary	1.58 (0.69–3.65)	2.24 (1.09–4.60)*	1.60 (0.75–3.44)	1.42 (0.69–2.90)
Residence				
Urban	1	1	1	1
Rural	3.65 (2.11–6.32)*	1.44 (0.76–2.71)	1.07 (0.59–1.92)	1.77 (1.04–3.02)*
Household monthly income				
≥1644	1	1	1	1
Less than 1644	5.29 (1.94–14.42)*	2.26 (1.20–4.26)*	2.82 (1.11–7.11)*	1.73 (0.83–3.56)
Type of health facility visited for birth care				
Health center	1	1	1	1
Hospital	1.75 (1.04–2.94)*	3.04 (1.75–5.27)*	2.16 (1.24–3.77)*	2.58 (1.57–4.25)*
Profession of provider attended birth				
Doctor	1	1	1	1
Midwifery nurse	2.23 (1.13–4.39)*	3.43 (1.90–6.18)*	2.49 (1.14–5.46)*	0.87 (0.45–1.59)
I don't know	1.95 (0.84–4.54)	4.00 (1.79–8.93)*	3.91 (1.59–9.58)*	0.50 (0.23–1.10)
Sex of provider attended the birth				
Male	1	1	1	1
Female	1.74 (1.06–2.86)*	4.21(2.52–7.03)*	0.78 (0.47–1.30)	4.0 4(2.51–6.50)*

*Significantly associated at p value of <0.05.

report disrespect or abuse compared to those who were attended by male providers and doctors, respectively.

Discussion

Disrespect and abuse during facility-based childbirth is a global problem with varying degrees of severity and differing drivers in different contexts [42]. It is often a greater problem in developing countries where inadequate number of care providers serve large proportion of clients [43]. There is growing evidence in Ethiopia that women are experiencing disrespect and abuse in birthing facilities [44,45]. Thus, this study sought to quantify the frequency and categories of D&A and identify factors associated with reporting D&A among women in north Showa zone of Ethiopia.

Respectful maternity care is a universal right of every childbearing women; however, this study reveals that D&A are common in health facilities. Every woman who participated in this study has experienced at least one form of D&A, and this rate is higher than for any other study. This disparity is attributed to the comprehensiveness of the current research which used 48 verification criteria for the seven categories of disrespect and abuse, whereas other studies used only 25 or less [22,24–26,28,32,34], which may have led to under reporting of disrespectful and abusive care. However, two studies from Arbaminch, Ethiopia and Enugu, Nigeria have reported almost similar rate 98.9% [33] and 98% [46] of D&A.

Physical abuse is the most prevailing category with 100% prevalence. From these, 413 (94.9%) women were not allowed to give birth in their preferred birthing position and for 381 (87.6%) women an episiotomy was given or sutured without anesthesia. Whereas 34 (7.8%) and 12 (2.8%) participants were pinched/kicked/slapped and hit with an instrument, respectively. Other research from Ethiopia reported level of physical abuse that ranged from 2% to 75.2% [22,24–26,29,31,32,34].

When interventions become necessary, service providers should provide the mother with sufficient information in a language she can comprehend so that she can knowingly refuse or consent to the intervention [47]. However, this study found that 97.2% of participating women reported non-consented care. This finding is higher than findings of previous research across all contexts [26,32,48]. Most, 362 (83.2%) of women who reported at least one vaginal examination also reported that they did not provide consent, and a significant proportion 152 (34 · 9%) reported that vaginal examinations were not conducted privately. A cross-sectional study conducted in four African countries with labour observations and community-based surveys reported that among women with at least one observed vaginal examination, at their first vaginal examination 847 (59 · 0%) did not provide consent, whereas 2611 (59 · 4%) vaginal examinations were done without consent across all women [48]. Best practice is that providers respect the privacy and confidentiality of every childbearing woman during counseling, physical examinations, and clinical procedures, as well as in the handling of patients' medical records and other personal information. However, two-thirds of women who participated in this study had experienced a breach in confidentiality. Studies from other parts of the country have similarly revealed a high level of non-confidential care; common examples

include the lack of privacy curtains and women not being appropriately covered during intimate examinations and/or labor and birth [22,24,32].

Every woman is a person of value and is worthy of respect. All words, actions, and non-verbal communication of providers must honor the dignity of each woman. Unfortunately, in this study, 29% of women reported non-dignified care. Previous studies have documented similar result elsewhere in Ethiopia [22,24,32,34]. Likewise, Firew at al. found non-dignified care in agreement with these findings that 31.4% were shouted at, 13.7% experienced threat of withholding treatment and 17.2% were blamed or intimidated [26]. Non-dignified care and insults may drive women away from healthcare facilities towards less trained providers who treat them with dignity and respect [46]. Service providers must acknowledge that women have the right to be treated with respect and consideration. In this study, however, a number of women reported negative comments regarding their HIV seropositive status, age and literacy were 11.7%, 8.5% and 5.1%, respectively.

Attentive care is the right of each client and a woman should never feel abandoned during labour or immediately after birth. However, our study demonstrated that 40% of participating women felt ignored/abandoned and 12.9% of women reported healthcare providers were not present when the baby was born. This finding is in line with a study conducted in the southwest of Ethiopia [32]. Furthermore, women should be able to have a birth companion of their choice. However, more than half of the women in this study reported that this was disallowed. The mere presence of a birth companion can ensure respectful care [49], whereas restricting the presence of a birth companion is reported to be a significant barrier to humanized birth care [26,50,51]. This suggests that healthcare providers know the way they behave in the absence of a companion is inappropriate and treat a client differently when a companion of the client is present [52].

Freedom from detention is the right of each childbearing woman and a woman or her baby or her companion should never be forcibly kept in a facility. Detention is the least-reported category by participants, and this is similar to rates reported in other studies from Ethiopia [22,24,26,30,32–34] possibly because maternity services are free of charge in Ethiopia and detention due to unaffordable service bills are rare. The economic status of women has been identified as a significant barrier to quality care. Unlike financially secure families, poor women are more likely to experience disrespectful birthing care [53]. Similarly, women of low economic status were more likely to experience D&A in the current research. This indicates the prevailing social attitudes towards people from lower socioeconomic backgrounds. Studies from different contexts have also revealed likewise [26,54].

Women who gave birth at hospitals reported higher level of D&A compared to those who gave birth at health centers. Hospitals generally belong to the secondary and tertiary levels in Ethiopian three-tier healthcare system. They serve as referral sites for health centers, which are primary level. Many women prefer hospitals over health centers as they are higher-level and are expected to give better medical care [27]. Increased client volume and insufficient staffing may impede the provision of respectful maternity care in hospitals [55]. Previous studies have identified that working in under-equipped and overwrought health systems affects provider enthusiasm and is often labelled as significant contributor to D&A in facilities [56]. Local studies have similarly reported higher incidence of D&A among women who gave birth at hospitals [22,25,26,31,33].

Another predictor for experience of D&A was type of professional who attended the birth. Some professions were reported to disrespect and abuse women than the others. Women who were attended by midwives/nurses were more likely to experience disrespect and abuse compared to those who were attended by doctors. A study from Nigeria revealed that midwives found more of the presented scenarios of mistreatment to be acceptable practices, compared to doctors [14]. Middle and lower level care providers, midwives/nurses, work the entire shift, whereas higher level (doctors) are mostly called to the labor ward to handle complications or cesarean delivery. Attending to the highly eventful and sensitive process of labor and delivery for long hours in poor working conditions may lead to providers burnout [57] and increase their likelihood of inappropriate treatment of mothers. Negative attitudes of providers towards women is attributed in part to being overworked [58]. Evidence shows that if lower level providers are the victims of D&A by managers or higher level providers, then it is more likely that they will use D&A as a tool to ascertain power [59].

Female care providers are presumed to treat women better. Unexpectedly, women who were attended by female providers had a greater likelihood of experiencing D&A in this study. Similar findings have been indicated in a study from Mozambique where higher odds of D&A were reported among women attended by female care providers [60]. On the other hand, rural residence was associated with increased likelihood of experiencing D&A. Similarly, in study from Mozambique, the occurrence of disrespect and abuse was much higher in the district hospitals compared to the central hospital [60].

Limitation of the study

Only women who had given birth at a health facility were included. This possibly excluded women who might have chosen not to visit the health facility due to previous experiences of D&A.

Conclusion

The level of disrespect and abuse reported by participants is high. The drivers and enablers include both structural and interpersonal factors. Hospital birth showed consistent association with all forms of disrespect and abuse. Expanding the size and skill mix of professionals in the hospitals, sensitizing providers and health managers regarding the magnitude and consequences of D&A could decrease the workload and possibly promote more dignified and respectful maternity care, respectively.

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Author contributions

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

Ethics approval and consent to participate

Ethical approval was obtained from The University of Adelaide human research ethics committee H-2019-153 and Salale University College of health sciences research ethics review committee A/G/H/S/C/768/11. Women meeting the eligibility criteria were provided with information about the study and those who agreed to participate consented and were enrolled. All women provided written consent. Participants were provided contact details of the study coordinator for any questions or concerns. To reduce the possibility of emotional distress due to describing past sensitive painful experiences, participants chose a convenient time and environment for the survey. In addition, they were accompanied by the person of their choice during the survey. No personal identifiers were used in the analysis to ensure anonymity.

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Paper context

Disrespect and abuse of women during facility-based childbirth includes the way care providers act, behave or treat childbearing women and is against the basic human right of childbearing women. There are seven categories of disrespect and abuse and each category has its own verification criteria. No study known to the authors has been done on this issue in the study area so far. The authors surveyed mothers who had given birth at health facility to share their experience. The level of disrespect and abuse reported is high compared to previous studies.

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Chapter 5: Women's perspectives on disrespect and abuse during facility-based childbirth in Ethiopia

This chapter covers women's perspectives on disrespect and abuse during facility-based childbirth. The study involved women who had given birth at public health facilities of North Showa zone during the twelve months preceding data collection. In-depth interviews and focus groups were used to explore how women perceive health care professionals' conduct that could be classified as mistreatment by an independent observer, researcher, or advocate, in order to bring women's voices into the maternal health quality improvement agenda. Inductive thematic analysis was employed to identify the themes.

Four themes were identified, and women did not consistently hold the same viewpoint across all scenarios, rather they offered different perspectives depending on each scenario. While they generally considered disrespectful and abusive acts during childbirth as unacceptable, some acts presented in the scenarios were accepted by the women to be or deemed necessary, under certain circumstances.

This paper is under review in the journal *BMC Pregnancy and Childbirth,* an open access, peer-reviewed journal that considers articles on all aspects of pregnancy and childbirth. The journal welcomes submissions on the biomedical aspects of pregnancy, labor, maternal health, maternity care, trends and sociological aspects of pregnancy and childbirth.

Women's perspectives on disrespect and abuse during facility-based childbirth in Ethiopia: a qualitative study

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Abstract

Objectives: This study explored women's perspectives on disrespect and abuse during facility-based childbirth in Ethiopia.

Methods: A qualitative descriptive design using five focus group discussions and fifteen in-depth, semi-structured, interviews was conducted with women between October 2019 to January 2020 in north Showa zone of Oromia region, central Ethiopia. Using purposive sampling, women who had given birth at public health facilities of North Showa zone during the twelve months preceding data collection were recruited, regardless of birth outcome. Inductive thematic analysis using Open Code software was used to explore the perspectives of participants.

Results: While women rejected disrespectful and abusive acts during childbirth generally, they tended to consider some acts as acceptable and or necessary under certain circumstances. Four emerging themes were identified. (1) Disrespect and abuse is not acceptable, (2) Disrespectful and abusive actions are acceptable only if intended to save lives, (3) Disrespectful and abusive actions are an accepted part of everyday practice to prevent complications and adverse outcomes, (4) Disrespectful and abusive actions are necessary to discipline disobedient women.

Conclusion: Women's perceptions of disrespectful and abusive acts of care providers is deeply rooted within the context of violence in Ethiopia and the societal hierarchies that have systematically disempowered women. Given the pervasiveness of disrespect and abusive actions during childbirth, policymakers must take these essential contextual and societal norms into account and devise a comprehensive intervention that addresses the root causes.

Keywords: women, human rights abuses, respect, birthing centers, Ethiopia

Strengths and Limitations of this study

This study was conducted in North Showa zone and findings in this study may not reflect the perceptions of women in other parts of Ethiopia. However, participants with diverse age, education and parity were involved in the study from rural and urban areas, which contributes to the diversity of perspectives included.

Background

Childbirth is one of the most important and memorable events in the lives of women (1). For women in developing countries however, pregnancy and childbirth places women at a substantial risk of suffering, ill-health and even death (2). Complications from pregnancy and childbirth are the leading causes of mortality and morbidity for women of childbearing age in developing nations (3). To reduce maternal and neonatal mortality, low resource countries are encouraging women to give birth in a health facility with the assistance of a skilled birth attendant. This is considered the most effective and cost-efficient strategy (4).

Globally, there is recognition that every woman has the right to the highest attainable standard of health, which includes the right to quality and respectful maternity care during childbirth (5, 6). Respectful maternity care (RMC) has been defined by World Health Organization (WHO) as "care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice, and continuous support during labor and childbirth" (7). Violations of these principles has been recognized as a priority issue by the WHO in improving maternity care quality and utilization (5).

Previous studies identified that women's experiences of disrespectful and abusive care while in childbirth facilities has significantly impacted their utilization of these services (8-12). Some women opt to travel to distant health facilities in search of quality service (13, 14), indicating that disrespectful care may be a more powerful deterrent to seeking skilled birth care than geographic inaccessibility and financial constraints (15).

Evidence suggests that many women in Ethiopia may experience mistreatment during childbirth (16, 17). Women themselves report that poor provider attitudes influences their use of maternal health services and that fear of mistreatment is discouraging them from seeking lifesaving maternity care at health facilities (18). Reducing maternal morbidity and mortality remains a key health challenge for Ethiopia where 401 women died per 100,000 livebirths, in 2017 (19). As a result of the increasing need of client-centered care, Ethiopia has incorporated compassionate and respectful maternity care in its latest health sector strategic plan (20).

There has been a growing consensus that client's perspectives of the maternity care they receive in facilities are critical for maintaining and monitoring the quality of health care (21). Exploring women's perspectives enables the strengths and gaps in care to be identified, inform more responsive and culturally acceptable care, leading to an increase in service utilization and better

health care outcomes (22). Studies have identified that satisfied clients are more likely to return in the future (22), adhere to care provider's recommendations (23), and recommend the institution to their friends and relatives, effecting an increased demand for the service (24).

Community-based studies that report on women's perspectives on disrespectful and abusive care are still lacking in Ethiopia. Most previous studies were conducted in health facilities, where social desirability bias and fear of retaliatory action could potentially influence women's response. Therefore, this community-based study aimed to explore how women perceive health care professionals' conduct that could be classified as mistreatment by an independent observer, researcher, or advocate, in order to bring women's voices into the maternal health quality improvement agenda.

Methods

Study design

Interviews and focus group discussions were conducted with women as part of a larger mixed methods study that examined disrespect and abuse of women during facility-based childbirth in Ethiopia from the perspectives of women and health care providers. A qualitative description design (25, 26) was used to investigate women's perspectives of disrespect and abuse in public facility based birthing services. The perspectives of care providers are reported in a separate paper (27).

Study setting

This study was conducted in north Showa zone of Oromia region, central Ethiopia, located 110km north of the capital Addis Ababa. The total population is approximately 1.5 million and 48% are women(28). Afan Oromo and Amharic are the main languages spoken. There are three hospitals, 62 health centers and 268 health posts in this zone.

Recruitment of study participants

Participants were women who had given birth at public health facilities of North Showa zone during the twelve months preceding the study, regardless of the birth outcome. Women who gave birth at home, those who were acutely physically or mentally unwell and those with a disability that would prevent them talking to a researcher were excluded. Initial recruitment and information about the study was provided by health extension workers, when visiting women in their homes. Interested women then choose whether to be involved in a semi structured interviews or a focus group discussion at a time and place of their choice. Purposive sampling was used to include participants across a range of ages, parity, and economic circumstances. Information saturation (when ideas started to

be repeated and no more new ideas emerged) was used to determine the final number of in-depth interviews (IDIs) and focus group discussions (FGDs).

Patient and Public Involvement

No patient involved

Data collection tool and procedures

The research team consisting of a PhD student and three supervisors utilized the findings of a systematic review (29) to develop scenarios of different types of mistreatments women may experience during childbirth in Ethiopia (30). A prioritization exercise was conducted in Ethiopia to ensure these scenarios were understandable, clear and concise, and accessible and understandable for potential participants from a variety of different cultural and geographical backgrounds. Nine scenarios were developed **(see table 1).**

Table1: Sample Disrespect and Abuse questions

No.	Questions
1.	If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
2.	If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
3.	If a health worker was mean and refused to help a woman during her delivery, would this be acceptable? When would it be acceptable?
4.	If a health worker physically held a woman down during her childbirth, would this be acceptable? When would it be acceptable?
5.	If a health worker threatens a woman by unfavorable procedure like CS or referral or bad outcome for her or her baby during her childbirth, would this be acceptable? When would it be acceptable?
6.	If a health worker disallowed a woman to deliver in a position of her choice during her childbirth, would this be acceptable? When would it be acceptable?
7.	If a health worker performs a procedure without getting consent during her childbirth, would this be acceptable? When would it be acceptable?
8.	If a health worker forcefully opens a woman's leg during her childbirth, would this be acceptable? When would it be acceptable?
9.	If a health worker disallowed a woman birth companion during her childbirth, would this be acceptable? When would it be acceptable?

During interviews and focus groups, participants were presented with each scenario and asked when, if ever, this scenario would be acceptable. Women were invited to reflect on the 'acceptability' of each hypothetical mistreatment during childbirth generally, rather than being asked to disclose personal instances of mistreatment. This approach aimed to prevent re-traumatising women or expecting them to share highly personal information in a group setting.

Fifteen in depth interviews (IDIs) and five focus group discussions (FGDs) were conducted from 5 October 2019 to 25 January 2020. Individual participants were interviewed in their homes or another preferred location and were accompanied by a person of their choice. Interviews lasted approximately 50 minutes. Focus groups took place in community settings and lasted about 180 minutes. Care was taken to maintain confidentiality of study participants by allocating interview and focus group codes and maintaining privacy during interviews. The interviews and focus groups were audio (voice) recorded with permission, with field memos also taken.

Data analysis

IDIs and FGDs were conducted in a local language (Afan Oromo or Amharic) by the primary author, translated and transcribed simultaneously by the primary author and reviewed by another Ethiopian based bilingual researcher. De-identified transcripts were stored on a password protected computer. An inductive thematic analysis approach as described by Braun and Clarke (2006) was used to identify key themes, richly describe large bodies of qualitative data and highlight similarities and differences in experiences (31). Open coding of transcripts was performed line-by-line. Codes were then analysed alongside field memos. Themes were identified and representative quotes were selected to illustrate the range of voices in each theme.

Reliability testing was conducted in two stages: (1) two Ethiopian researchers jointly coded five transcripts and (2) then independently coded four transcripts and discussed coding decisions until consensus. A subset of the coded transcripts was reviewed by another independent Ethiopian researcher to check reliability of the coding. Open Code software version 4.0.2.3 was used for the data analysis. This paper is reported according to the consolidated criteria for reporting qualitative research (COREQ) (32) (see supplementary material).

Results

A total of 15 IDIs and five FGDs were included in this analysis. Table 2 reports sociodemographic characteristics of participants **(Table 2)**.

Table 2: Sociodemographic characteristics of in-depth interview and focus group discussion participants, North Showa zone, Ethiopia, 2021.

Characteristics		IDIs participants	FGD participants	Total
Age (years)	<30	8	15	23
	30–39	6	13	19
	40-49	3	5	8
Marital status	Married	14	34	48
	Single	1	1	2
Education	No education	8	13	21
	Primary	3	11	14
	Secondary	3	8	11
	Above secondary	1	3	4
Residence	Rural	6	14	20
	Urban	9	21	30
Number of children	1	4	14	18
	2-3	8	14	22
	>=4	3	7	10

Views regarding acceptability of disrespect and abuse during facility-based childbirth

While women generally considered disrespectful and abusive acts during childbirth as unacceptable, some acts in the scenarios presented were considered acceptable or necessary by the women, under certain circumstances. Women did not consistently hold the same viewpoint across all scenarios, rather they offered different perspectives depending on each scenario. Women's responses and perspectives are presented under four main themes, and then are discussed within the context of violence and societal hierarchies that have systematically disempowered women in Ethiopia.

The four emerging themes are: (1) Disrespect and abuse is not acceptable, (2) Disrespectful and abusive actions are sometimes acceptable if intended to save lives, (3) Disrespectful and abusive actions are an accepted part of everyday practice to prevent complications and adverse outcomes, (4) Disrespectful and abusive actions are necessary to discipline disobedient women. Figure 1 shows the identified themes **(Figure 1).**

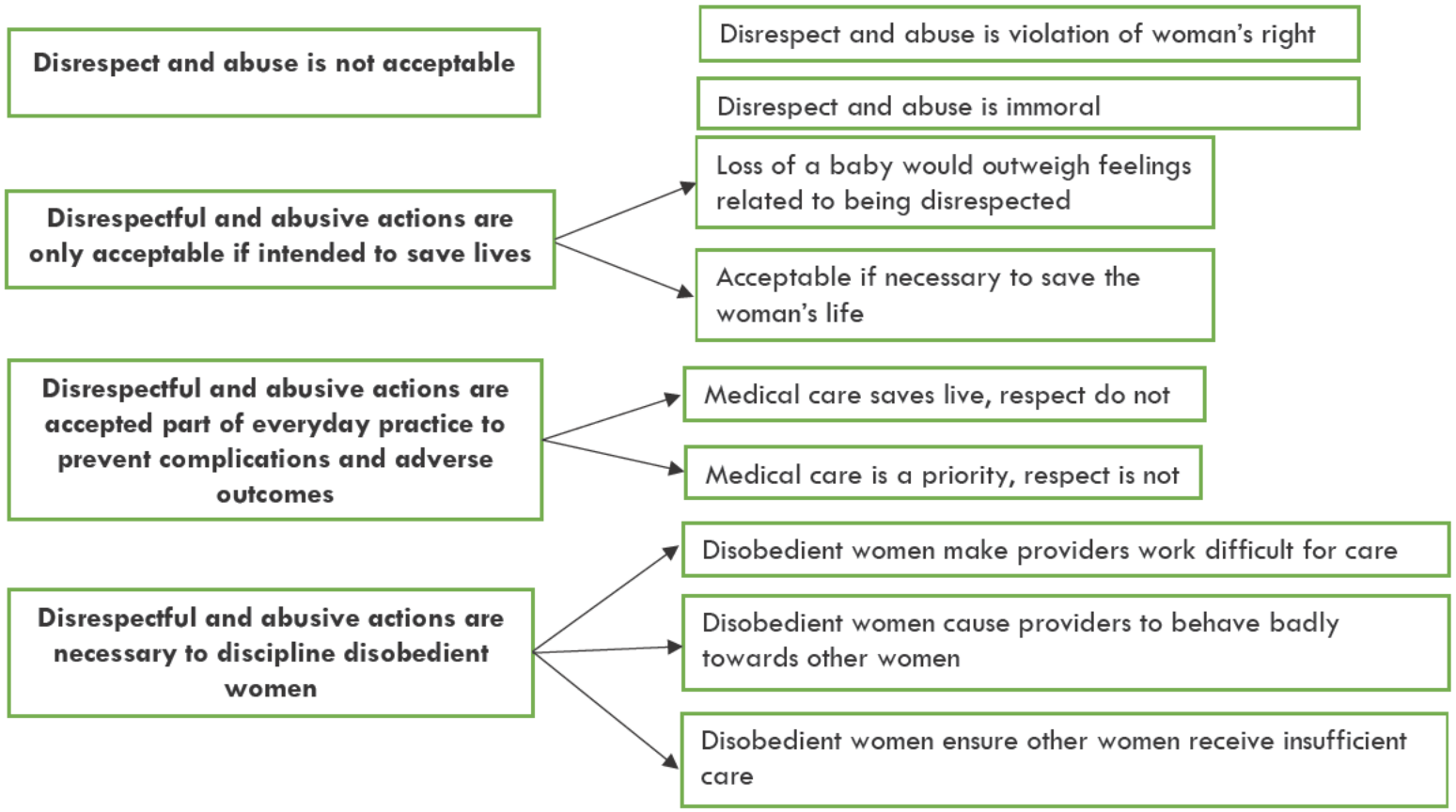

Figure 1: Schematic presentation of the identified themes and subthemes

1. **Disrespect and abuse is not acceptable**

Disrespect and abuse is violation of woman's right and is never acceptable

Physical abuse

Participants were invited to reflect on acceptability of women being slapped or pinched by providers during childbirth. Most participants agreed that pinching or slapping laboring women could never be justified. Regardless of how a woman behaves or how busy the provider is, pinching or slapping a laboring woman was considered to be unacceptable and a violation of her rights.

> *"No reason can justify slapping of a laboring woman. It is a clear violation of woman's right and have to be actively discouraged." (Urban FGD)*

Forcefully holding down women onto the delivery bed was another scenario presented to the women and some women considered this an abuse of women's freedom of movement. These participants believed that a woman should be free to leave the delivery couch if she wanted to do so.

> "*Women should be allowed to move around. Holding them down against their will violates their right.*" (Rural IDI)

When asked if it is acceptable for providers to forcefully open women's legs in order to assist them, some participants identified that women may refuse to open their legs due to fear of disclosing their most private body parts to providers, or they may spontaneously close their legs during labor due to pain. Most participants considered forcefully opening women's legs unacceptable for any reason, even to save life. One woman in a rural IDI explained,

> "*It is never acceptable to forcefully open a woman's legs even if it is to save her baby. The only thing the provider can do is to tell her the importance of opening her leg. If she does not comply, it is better to involve her family to convince her than forcefully opening her leg. It is against her rights.*" (Rural IDI)

Verbal abuse

Some participants considered providers' yelling or shouting at a laboring woman as unacceptable, irrespective of the intention behind the act. They believed that care providers must not raise their voice when they communicate with a laboring woman, and providers who yell or shout at women lack self-control and should not be involved in birthing care. One participant from an urban area said;

"Raising a voice to someone is a sign of disrespect and a laboring mother does not deserve it. It is never acceptable for a provider to yell or shout at a laboring woman. A provider who has no respect for a woman should not be allowed in the birthing care." (Urban IDI)

Another example presented to the women participants was the acceptability or non-acceptability of threatening women with an unfavorable procedure, or referral or predicting a bad outcome for her or her baby. Some participants considered it unacceptable for a health care provider to threaten women under any circumstance. These participants believed that threatening a woman is not part of the care the women came for and therefore should not be practiced.

"It is totally unacceptable to threaten a laboring woman for whatever reason. Women visit health facility to receive care not a threat. I believe it is counterproductive and violates her rights." (Urban IDI)

Birthing options

Performing a procedure without obtaining consent was another example of disrespect and abuse presented to participants to discuss. The majority of participants considered this unacceptable. They believed that consent must be sought prior to any procedure despite its medical indication and emergency nature of the situation.

"No women must undergo any procedure without her informed consent. Women have the right to know and willingly consent to or refuse a procedure. The procedure might be important, but her consent is necessary." (Urban IDI)

Participants were invited to reflect on whether disallowing of a birthing companion is acceptable, and the majority considered it unacceptable. They stated that having a birthing companion is a right of every childbearing woman and disallowing is a violation of her rights.

"Women have the right to be accompanied by person of their choice during childbirth and denying them a birth companion is unacceptable and violation of their basic rights." (Urban FGD)

Participants were asked if it is acceptable for a health worker to refuse to help a woman during childbirth. No participant considered refusal of care acceptable for any reason and under any circumstance. The majority of participants not only rejected withholding or refusal of care but also condemned it.

"Withholding care is a murder, I do not see any difference in between. It is an act of evil, no decent human can do so. It is a gross crime to refuse assisting a laboring woman in a facility." (Urban IDI)

Participants reflected the same view on disallowance of preferred birthing position, no participant considered it acceptable. Even if most of the participants prefer the traditional lithotomy position for childbirth, they believed that women who prefer other positions must be supported.

> "*It is women's right to choose a birthing position suitable to them. The role of the provider is to assist accordingly, not disallowing them their rights.*" (Urban IDI)

Disrespect and abuse is immoral

For some participants the presented scenarios were not only unacceptable, they were also viewed as immoral.

In relation to whether it is acceptable for a care provider to slap or pinch a woman during childbirth, one participant replied.

> "*It is immoral for a care provider to raise hand on a laboring woman. It is never acceptable, providers are supposed to do better.*" (Rural IDI)

Similarly, shouting and yelling was considered morally unacceptable by one participant.

> "*Why would a provider yell at a woman giving birth? It is immoral and unacceptable behavior.*" (Urban FGD)

Threatening women with an unfavorable procedure, or referral or predicting a bad outcome for her or her baby was also considered morally unacceptable behavior.

> "*Providers can do better than threatening a birthing woman. Threatening does not go with moral values of professionalism.*" (Urban IDI)

Similarly, denial or refusal of care

> "*It is unfair and immoral for a provider to get in to conflict with a laboring woman and deny her care.*" (Rural FGD)

and forcefully holding women to the delivery bed.

> "*Forcefully holding a laboring woman to the bed against her will is immoral and unacceptable behavior. Providers have to let her free to move around.*" (Urban IDI)

2. Disrespectful and abusive actions are only acceptable if intended to save lives

Some participants considered that some of the care provider's behaviors presented in the scenarios may be acceptable if the intention were to save the life of the woman and or her baby.

For these participants, the intention of the provider and the level of threat to the lives of the mother and baby determines the acceptability or unacceptability of the action undertaken by health care providers. The action has to contribute to safe delivery to be considered acceptable.

Loss of a baby would outweigh feelings related to being disrespected

Some participants considered the presented scenario may be acceptable if the intention were to save life. These participants focused on the reason or intention behind the behaviour and perceived those complications in labour and potential loss of a baby would outweigh feelings related to disrespect or pain a woman may feel by being slapped or pinched.

> "*It is ok if a provider pinches or slaps a woman on her thigh and encourage her to push. Developing complications or loss of a baby is more painful than being slapped or pinched. What is not acceptable is slapping a woman as a punishment.*" (Rural IDI)

Similarly, some participants considered that forcefully opening women's legs could be acceptable if it was necessary to save the baby's life. They were concerned that the baby may be suffocated if the mother closes her legs while the baby's head is engaged.

> "*I consider forcefully opening woman's legs acceptable only if it is an act to save her child. It is nothing compared to lose of a baby. If they [providers] use force, it must be for the good of the mother.*" (Urban FGD)

Acceptable if necessary to save the woman's life

Likewise, participants expressed a viewpoint that the only time verbal threatening may be considered acceptable was if it is done to save life of the mother as well as her baby.

> "*Threatening of a woman is acceptable only if it is aimed to save the life of the mother or her baby. Otherwise, it is unacceptable to threaten women.*" (Rural FGD)

Some women also considered performing a procedure without first getting consent was acceptable if it were to save lives. These participants considered that emergency situations may not give providers sufficient time to explain procedures and obtain consent, rather the woman's circumstance may compel them to rush to life saving procedure.

> "*Performing a procedure without getting consent is acceptable in case of emergency. Provider's primary aim is to save the woman and her baby.*" (Rural IDI)

3. Disrespectful and abusive actions are an accepted part of everyday practice to prevent potential complications and adverse outcomes

A large number of participants from both rural and urban areas considered that the presented examples may be a necessary everyday part of providing care, and that health professionals employ these strategies to prevent potential adverse outcomes.

<u>Medical care saves live, respect does not</u>

For some women, forcefully holding a woman to a delivery bed is considered an acceptable and potentially a lifesaving act. This was based on a belief that if a woman leaves the bed, she may suffer awful consequences.

> "*Why would a woman leave the delivery bed once she started pushing? She may loss her baby to the ground and experience genital tear. The provider in charge has to forcefully hold her down to the delivery bed.*" (Rural IDI)

A few participants proposed that forcefully opening a women's legs was not only necessary to save a baby's life, but also an acceptable behavior due to the authority and knowledge of the care provider. These participants discussed that women must comply with providers orders once they are on the delivery couch because the providers know what works for the women. Thus, use of force to open women's legs is considered necessary to save the baby.

> "*I consider forcefully opening women's legs* necessary. Because c*losing legs during labor could kill the baby. Thus, providers have to forcefully open women's legs and takeout the baby*" (Rural FGD)

The majority of the participants normalized providers' yelling or shouting at a woman as an act to save life. They perceived that providers raise their voice to warn the woman so that she can concentrate and comply with their orders. Some expressed a viewpoint that if the provider does not raise their voice, then the woman may not understand the seriousness of the situation.

> "*Providers raise voice to make woman actively comply with orders and avoid complications. It is for the good of the mother, it saves life.*" (Rural FGD)

Similarly, some participants considered threatening women was acceptable and that women would not suffer negatively from these threats, but rather may benefit when taking the threats seriously. They considered threatening is like an alarm that alerts women to danger.

> "*Threatening has no harm, rather it makes woman more focused and escape possible complications. Providers threaten women to avoid unforeseen problems and I consider it saves life.*" (Rural IDI)

Medical care is a priority, respect is not

Some participants considered that a provider can perform a procedure if it is medically indicated, without the woman's consent. These participants perceived that medical indication for a procedure could override the need for woman's consent, based on a belief that providers know best what is needed for the woman, and that her consent is a lower priority.

> "*The provider is a professional who has the knowledge to do the right thing and can decide what to do and when. The woman [does not have this knowledge], and her opinion and consent are not a priority*." (Rural FGD)

4. Disrespectful and abusive actions are necessary to discipline disobedient women

Some participants discussed the scenarios and what they considered to be acceptable or expected behaviors in relation to the workload of care providers, and the implications for other birthing women if one woman was [perceived to be] disruptive or disobedient.

Disobedient women make providers' work difficult

Some participants discussed that some women may ask too many questions, argue with providers or refuse a procedure. They perceived these women's behaviors could be viewed as difficult, uncooperative, and/or disobedient and that slapping or pinching them in these circumstances may be necessary. Upon further enquiry, participants offered an explanation that "disobedient" women irresponsibly put their and the baby's lives at risk. They felt that health care providers' primary responsibility is to deliver a live baby to a healthy mother and if women are uncooperative, the health care provider may be justified to slap or pinch the woman.

> "*Some women are disobedient and do not listen to the providers. They unnecessarily put their and the baby's life at risk. So, it is acceptable to slap, or pinch disobedient women to discipline them*." (Urban IDI)

Some women empathized with care providers' heavy workload and that some women's behavior makes their work more difficult.

> "*Providers are human beings and deserve respect and it irritates me when some women look down on them or make their job more difficult. Such unsympathetic and inconsiderate women deserve a slap. I wish I could slap them myself*." (Rural IDI)

Disobedient women cause providers to behave badly towards other women

Some participants were also concerned that uncooperative women could test providers' patience, and annoy them by asking too many questions, and this could then negatively impact health care providers approach towards other women.

> "*Sometimes providers could ignore other innocent women in retaliation, only because one rude woman has annoyed them by asking question. I understand providers have feelings too, but they better slap that specific woman [rather] than neglecting others.*" (Urban FGD)

Disobedient women ensure other women receive insufficient care

In addition, participants identified that care providers often need to assist more than one woman at a time and that an uncooperative woman unfairly consumes more time as the providers try to convince her to co-operate, at the expense of having time to provide care for other women.

> "*Some women want special attention and argue with the providers or refuse medically indicated procedure for no reason. Slapping or pinching is necessary for such selfish woman for consuming other women's time.*" (Rural FGD)

A small number of participants discussed that yelling or shouting may be necessary to discipline women labelled as being "disobedient". They expressed a viewpoint that providers have the right to yell or shout at women considered to be acting unreasonably.

> "*Providers must raise their voice on disobedient women to ensure order in the delivery room.*" (Urban IDI)

In summary, women did not consistently hold the same viewpoint across all scenarios, rather they offered different perspectives depending on each scenario. While they generally considered disrespectful and abusive acts during childbirth as unacceptable, some acts presented in the scenarios were accepted by the women to be or deemed necessary, under certain circumstances.

Discussion

This study explored how women perceive acts often considered disrespectful and abusive by international standards (ref white ribbon). Women were provided with scenarios and invited to discuss the circumstances under which the scenarios would be considered acceptable or unacceptable and when and why these circumstances might be acceptable. The results highlight the complexities of women's responses in relation to the types and circumstances of disrespectful and abusive acts that women might consider acceptable, or unacceptable and why. This study offers new insights, as previous studies aimed at improving access to skilled birth care have focused more

on availability of services and less on the perceptions of women as the recipients of care. Arguably, more responsive and culturally acceptable care is possible when women's perspectives and experiences are taken into consideration, potentially leading to an increase in service utilization, and better outcomes.

Women's perspectives regarding disrespectful and abusive acts of maternity care providers in Ethiopia is best understood within the context of violence, limited health care resources and the societal hierarchies that have systematically disempowered women. For some of the women participants, disrespect and abuse is never acceptable in any of the scenarios. Women offering this perception tended to live in more urban areas and had higher levels of education. Sometimes women considered that particular acts may be justified if the intention and purpose was to immediately save the life of the woman and/or her baby, in an emergency situation where there was less time to explain in detail and gain agreement. These perceptions changed depending on the different scenarios; at times women offered a viewpoint that it was acceptable for care providers to provide care in ways classified as disrespectful and abusive by an independent observer, researcher, or advocate due to the care providers knowledge and position of power. At times, participants perceived that it is acceptable for providers to punish women considered "disobedient", further explaining this viewpoint by saying that if women did not 'behave' in a way considered acceptable by the care providers, this could impact negatively on care provided to other women.

Four of the examples of disrespect and abuse presented to participants were categorized as physical abuse; where a woman was pinched or slapped, forcefully held down to the delivery bed, her legs forcefully opened, and disallowance of preferred birthing position as reported by White Ribbon Alliance (7). Women generally found this unacceptable. Studies in Ethiopia are increasingly exploring how physical abuse violates women's basic human rights and autonomy and can traumatize women who are already in a vulnerable position during childbirth and deter them from utilizing skilled care for future childbirth (33).

Slapping or pinching a woman were considered behaviors that could never be justified by most of the participating women. Similar findings have been reported elsewhere in Africa (34). However, some women considered it acceptable if the action was perceived to be needed to save the life of the mother or child. Similar findings were found in a study from Guinea, where women provided justification for pinching or slapping in the belief that providers were using physical force in order to save the woman or baby's life (34, 35). These findings across both studies indicates that some

women perceive there is a medical justification for slapping a woman, and that such behaviors are designed to "assist" the woman in pushing the baby out. Contrarily, some participants in this study considered the act as necessary to discipline “disobedient” women. These participants labeled women who refuse a procedure, annoy providers by asking questions, and make them behave badly towards other women, consume provider’s time to care for others, and make other women feel neglected as “disobedient”. Similarly, in a study from Nigeria, women believed that providers are justified to slap or pinch those “disobedient” women and discipline them (36).

The fact that a number of women in this study considered asking questions as time wasting, refusal of procedure as disobedience, and threatening harmless, indicates how societal hierarchies in Ethiopia have systematically disempowered women so that they feel they need to automatically obey the requests of the healthcare providers, while their own needs and preferences are ignored. Some of the women’s acceptance of disrespectful and abusive treatment by service providers during childbirth may be best understood within the context of violence in Ethiopia. For instance, the 2016 demographic and health survey reported that the majority of women (63%) and men (28%) have attitudes that justify wife beating (37). Similar finding has been reported elsewhere in Africa (34).

Non-dignified care/ verbal abuse including women being shouted at or scolded, insulted, or blamed for negative pregnancy outcomes during facility-based childbirth is one of the most frequent types of disrespect and abuse women experience during childbirth (7, 38). In this study, some women considered these behaviors unacceptable, however, a significant proportion of the participants provided justification for health professionals and considered yelling or shouting at women acceptable to save lives, help prevent complications or to discipline ‘disobedient’ women. Similar findings were reported in a study in Nigeria, Africa (36).

It is widely recognized that women should be given the information and support needed to freely make decisions for themselves and their newborns (39). However, when women give birth in facilities in Ethiopia, informed consent is not always acquired or respected. Often, processes and procedures are not fully explained to women, as evidenced elsewhere (11, 14, 40, 41). Internationally, and within Ethiopian health policy, performing procedures without prior knowledge of women is considered a violation of women’s rights (42). A significant number of women participants in this study however, considered performing procedures without consent as acceptable in an emergency. For these participants providers can rightly perform procedures in emergency situations without seeking consent from the woman. Further, there were other participants who gave their right to decide their care to the health care providers. They expressed a viewpoint that consent is not a

priority, and the provider is professional and knows what works best for them. Thus, they consider it is acceptable if the provider performs a procedure without telling them what is being done and why.

Acts of omission are also forms of disrespect and abuse and failure to recognize, protect, and fulfill a patient's rights is a form of mistreatment (43). No participant considered refusal of care acceptable for any reason and under any circumstance. The majority of participants not only rejected withholding or refusing care but also condemned it. Some participants considered it as an act of evil similar to murder. Abandonment or denial of care is a prevalent form of disrespect and abuse in countries like Ethiopia and inadequate number of healthcare providers is the largest driving cause (44). Ethiopia currently has inadequate skilled maternal health care providers to meet the essential needs of the population. According to the 2020 report of Federal Ministry of Health, the country had only 19,620 Midwives and does not meet the minimum threshold of health professionals to population ratio of 2.3 per 1000 population benchmark set by the WHO, for Sub-Saharan Africa (45).

Overall, this study used more comprehensive scenarios that reflect disrespect and abuse elements that are likely to occur in low-income countries. These build on and extend approaches used in previous studies conducted in Africa, with the aim of providing deeper explanation or enabling different, and at times conflicting, viewpoints to emerge (11, 34, 36). This study has found that normalisation of violence often experienced in private homes and workplaces has crossed over to health care. This has led to the current situation where women seem to accept and justify abusive behaviors of care providers, while ignoring their own needs and preferences.

Conclusion and recommendations

Women's level of acceptance of disrespectful and abusive acts of care providers, varies from woman to woman, and from scenario to scenario, but is overall deeply rooted within the context of violence against women in Ethiopia and the societal hierarchies that have systematically disempowered women. Given the current pervasiveness of disrespect and abuse during childbirth care, policymakers and care providers must take these contextual and societal norms into account and devise a comprehensive intervention involving health care providers and women that addresses these underlying perceptions. Women must be given safe platforms to identify, speak, and examine their care experiences, and discussions with clinicians and legislators must take place to unravel the uncomfortable topic of disrespect and abuse that occurs during childbirth in health care facilities.

Abbreviations

D&A: Disrespect and Abuse

WHO: World Health Organization

Ethical considerations

Ethical approval was obtained from the University of Adelaide human research ethics committee H-2019-153 and Salale University College of health sciences research ethics review committee A/G/H/S/C/768/11. Participants were informed about research objective, what data will be collected, confidentiality of information, and voluntary nature of participation. In addition, they were informed the time the interview and discussion will take and that they reserve a right to withdraw from the study any time and there will be no direct benefit from participation. Also, no information which may identify an individual will be required for the study, and the data will not be used for future research. Data were collected only after informed written consent was obtained. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

Not applicable.

Availability of data and materials

The data that support the findings of this study are available from The University of Adelaide, but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of The University of Adelaide.

Competing interests

The authors declare that they have no competing interests.

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Authors Contributions

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

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Chapter 6: "I would have stayed home if I could manage it alone": A case study of Ethiopian mother abandoned by care providers during facility-based childbirth

This chapter reports on a single interview with a woman, 28-year-old mother of two, that was not recruited directly but referred by women participants to share her story. This case study highlights some of the common disrespectful practices that women face.

The woman was denied care, the provider left her unattended, episiotomy was conducted without her knowledge and consent, she was carried by her arms and legs to the delivery couch and left naked and bleeding on the couch after birth; taking a sick baby home without medical assistance: she was forced to leave the hospital even though her child had breathing difficulties and was not able to suck or breastfeed. This mother lost trust in care providers and went to a facility where a relative works, as she no longer trusted these providers.

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CASE REPORT

"I Would Have Stayed Home if I Could Manage It Alone": A Case Study of Ethiopian Mother Abandoned by Care Providers During Facility-Based Childbirth

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Background: Every woman is entitled to respectful care during pregnancy and childbirth as a basic human right. However, not all women are being treated equally well.

Case Presentation: This case study highlights some of the common disrespectful practices that women face. This is a testimony of a 28-year-old mother of two, narrated in her own words. The data were collected during an in-depth interview in November 2019. The interview was conducted in her house and her name has been changed to protect her identity. The interview was audio-taped using a digital voice recorder, later transcribed, and translated verbatim from the local language – Amharic, to English.

Conclusion: This woman's story highlights the unfortunate reality for some women. Five themes emerged from her narrative: denial of care: the provider left her unattended at a critical moment and denied her the care that she came for; non-consented care: she did not consent to the episiotomy; non-dignified care: she was carried by her arms and legs to the delivery couch, and left naked and bleeding on the couch after birth; taking a sick baby home without medical assistance: she was forced to leave the hospital even though her child had breathing difficulties and was not able to suck or breastfeed; and loss of trust in care providers: for her second birth this woman went to a facility where a relative works, as she no longer trusted these providers.

Keywords: refusal to treat, human rights abuses, respect, birthing centers, Ethiopia

Plain Language Summary

Disrespect and abuse of women during facility-based childbirth includes the way care providers act, behave, or treat childbearing women, these actions contravene the basic human rights of childbearing women. Abandonment is among the seven categories of disrespect and abuse and is characterized by care providers denying care or neglecting a woman during labor, childbirth and/or immediately after birth. The authors sought the opinion of a mother who had experienced abandonment. This information was obtained via a face-to-face interview.

This testimony narrates the woman's story of being a victim of disrespect and abuse in a facility. This abandonment by care providers during childbirth resulted in her child becoming disabled and the woman experiencing significant loss of trust in care providers.

In conclusion, disrespectful care during facility-based childbirth may lead to poor outcomes for both the mother and baby and can deter women from seeking lifesaving professional maternity care for subsequent births.

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Background

Despite progress in reducing maternal mortality, Ethiopia still has one of the highest maternal mortality ratios in the world; this is estimated to be 401 per 100, 000 live births in a recent health survey.[1] As maternal and newborn mortality mostly occur during birth and immediate postpartum period, ensuring access to quality maternity care is a key aspect of reducing avoidable deaths. Quality maternity care requires health facilities to be adequately equipped with compassionate skilled providers, physical resources and medical supplies.[2]

The United Nations established 17 Sustainable Development Goals in 2015. These Sustainable Development Goals are the blueprint to achieve a better and more sustainable future for all. Sustainable Development Goal 3 (SDG 3) outlines "Good Health and Well-being".[3] The first target of Sustainable Development Goal 3 is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.[4] In order to achieve this, Ethiopia needs to reduce its 2.3% annual maternal mortality threefold to 7.5%.[5,6] Accordingly, the government of Ethiopia has focused considerable efforts on education of health care providers, building new and upgraded facilities, and making maternity care services cost free. As a result, primary healthcare coverage has improved.[7] However, despite this progress, significant problems remain. This is reflected by the fact that only 48% of women gave birth in a health facility in 2019.[8]

Improving access to a health care facility is not a sufficient inducement to encourage pregnant women to seek professional maternity care.[9] The perception and experience of women regarding the quality of the service also influences utilization.[10] Improving the quality of care and humanizing maternity care is vital to increase service uptake.[11] Recent studies have suggested that improving both access and quality of care are vital to reduce the maternal mortality ratio.[9]

Quality of care, however, is a complex phenomenon often explained as an interaction between health system structures, interpersonal and technical aspects of care provision, and outcomes of care.[10,12] Respectful care is a universal human right for women and babies and is an important dimension of quality. The World Health Organization (WHO) has issued a statement for stakeholders on prevention and elimination of disrespect and abuse during facility-based childbirth, emphasizing respectful maternity care as core indicator of quality of care.[13] Nonetheless, any attempt to understand quality of care concepts should start with an analysis of "what women need and want".[14]

A global finding from 1.2 million women in 114 countries revealed that women prioritize respectful and dignified care above all else.[15] Respectful care is a fundamental right for every woman and baby.[11] However, many women in Ethiopia are mistreated by their attendants during facility-based childbirth.[16–22] This mistreatment is manifested as any form of uncaring behavior or inhumane treatment,[23] and such encounters can potentially deter women from seeking professional maternity care.[24] As a result, they may opt to birth at home, often relying on traditional birth attendants rather than qualified health professionals. This in turn increases the risk of maternal and neonatal morbidity and mortality.[25]

The White Ribbon Alliance (WRA) has categorised disrespect and abuse during facility-based childbirth in to seven categories; physical abuse, non-consented care, non-confidential care, non-dignified care, discriminatory care, abandonment or denial of care, and detention in facilities.[10] Abandonment or denial of care may have negative health consequences for both a mother and her newborn.[26] This may occur for a variety of reasons including; the facility being closed when it is supposed to operate 24 hours, a facility being open but no staff are available, if healthcare providers did not encourage a woman to call when she needed them, providers making a woman feel alone or unattended, providers not coming quickly when needed, providers denying support during labour, a woman being left unattended during birth of her baby, providers failing to intervene when medically indicated, or providers failing to grant a woman's requests.[27]

The aim of this case report is to record and share one woman's experience of disrespect in a facility that resulted in her child becoming disabled following abandonment by care providers during childbirth.

Case Presentation

This is a testimony of a 28-year-old mother of two, narrated in her own words. The participant is of Gurage ethnicity and has a bachelor's degree. She lives in Fitche town, the capital of north showa zone, about 110kms to the north of Addis Ababa. The data were collected during an in-depth interview in November 2019, in her home. The interview was audio-taped using a digital voice recorder. The woman was invited to share her personal experience during facility-based childbirth. The interview was transcribed and translated verbatim from the local language, Amharic, to English. Both transcript and translated version

of the document were cross-checked with the original interview by an experienced linguist.

This interview was conducted as part of project examining disrespect and abuse of women during facility-based childbirth in Ethiopia. While conducting a focus group and discussing the issue of abandonment or denial of care, I noticed some of the participants gave one another a surprised glance. On further enquiry, they told me that their neighbor is a woman with a traumatic experience of care, and that "her life was never the same since the incident. We can see the sorrow in her eyes you know." Following the focus group, I invited the participants to speak to their neighbor and ask if she would like to share her story with me for our project. I was then invited to talk to her in her house the following day. The respondent was provided with the information sheet and given time and explanation to freely consent (or not) to be involved in the study.

The woman explained that she had visited the hospital to give birth to her first child on Oct 3, 2014 in the afternoon. However, she did not receive the care she had anticipated. Rather, she was abandoned by care providers during labor, and she believes that this lack of appropriate care for the baby led to birth complications and cerebral palsy. She has repeatedly visited different referral hospitals in Addis Ababa to seek better care for her baby. The woman explained that she has significantly lost trust in care providers, and as a result, she visited a different health facility for the birth of her second child, five years later. She has a relative who works in this other facility and could care for her, so that she felt safe.

Abandonment or Denial of Care

Upon our meeting, Aisha (name changed) welcomed me into her house and after taking a deep breath, began narrating her story in a deep sorrowful voice.

> I have fresh memory of it. It was afternoon when I arrived at the hospital, they (care providers) kept me in the waiting room without any checkup till the night shift workers came. The night shift checked me only once as I spent the whole night laboring. Early morning, as I felt the urge to push down the baby, the doctor left me with interns, instructing them to attend me. The baby was coming out, but the doctor did not wait, he abandoned me. I screamed out of helplessness and overwhelming pain, nobody cared. The interns neither helped me nor did they call for help. They denied my very basic right, the care I came for.

Non-Consented Care

> A couple of hours later, the reckless doctor came back very relaxed after I was exhausted by the prolonged labor. I was worn out and could not push anymore; he noticed a problem and rushed to a procedure. He cut my genitalia (episiotomy) without any explanation while I was in the waiting room. He was not careful when he cut my body without my consent. Then, two men hold my legs and other two my arms and took me to the delivery room. They put me on the delivery couch like a trash. What are they going to lose if they give me a tiny respect and took me on stretcher? They did not utter a word all this time, they just did what they think was right and took the baby out. After all who can question them? I gave birth about 24 hours after my admission.

Aisha went silent for a while …

> The baby did not cry at birth and I thought I lost him. The doctor dashed to the bed at the corner. He was pumping something to my baby's mouth and one of the interns was compressing his chest. Seeing my first born like this traumatized me. Still now, thinking of that moment gives me stab on the chest. I laid on that couch naked in humiliating way and bleeding till one of them came remove the placenta and stitch the tear they made down there, as if he was sewing a piece of cloth. The suturing was no more less than a labor, they did not give me any anesthesia. The wound took more than two months to heal. For a couple of weeks sitting was impossible. I turn from one side to the other on bed with so much pain. I was having a smaller number of meals than I should thinking of the misery during defecation. During that period only Allah knows what I went through. I have to ask my mom traditional wound care practices to prevent infection because they neither advised nor gave me antibiotics on my discharge.

Non-Dignified Care

> They transferred me to the postnatal room and kept my child behind. Though I was drained by the prolonged labor I could not rest because of my child's circumstance. None of this could have happened to me if that devil doctor were around. He could have shortened my suffering. I knew my baby was in trouble but nobody, nobody said a word to me, let alone reassuring me. They even yelled at me for crying out loud 'do not make our work difficult already, act like a grown woman.' My husband and family who were waiting outside the ward the whole time heard my cry and interfered. Only then, one of the interns told them

that the baby was suffocated (asphyxiated) and is on oxygen. (being resuscitated)

After a long resuscitation that took more than twenty minutes, my baby cried, and they gave it to me. They did not tell me how to proceed with nursing or any precaution with the illness that my baby had. They just told me I am ready to go off within 3 hours. I wonder how many lives went wrong in their reckless hands. They are accountable for my darkened life. The baby was not breathing well, let alone sucking breast when I left the hospital and they did not care at all, they just wanted me to get out of their sight. The doctor said, 'your child is ok and will start sucking breast any time soon.' He was not sorry that he abandoned me at that critical moment with students who were supposed to work under his supervision and now he rushed me to leave the hospital. I do not know what I did to him to deserve this, he just watched me when I took home a sick baby. I believe someday Allah will punish him the way he deserves. He made me hate all care providers and the entire health care system.

Aisha could not talk any longer and started crying. I gave her time to recover.

Taking Sick Baby Home without Support

After a while Aisha took a breath and continued:

I left the hospital three hours after giving birth as per his (the doctor) decision though the baby was still unable to suck breast. We waited till next morning and even tried canned milk, but he could not take it. We returned to the hospital after 24 hours when the baby's breathing difficulty got worse. Another team of care providers received us and told us that the baby was not breathing well and should not have left the hospital in the first place. They checked and admitted him (to neonatal intensive care unit) for ten days. They were even planning to refer him to Addis Ababa but later changed their minds and kept him there. Nobody updated me about my child's circumstance. Imagine staying in hospital separated from your sick newborn baby that long, thinking they will hand me over his body sooner or later. As a mother that was the worst time of my life.

We went home after 10 days; my baby was spoon feeding, still unable to suck my breast. They told me that was the maximum they could do. As advised, I tried to breast feed him, but did not succeed. My life changed from that day on, he cries day and night. I have to carry him at all times, I cannot rest during the day or sleep at night. I have visited referral hospitals in Addis Ababa and got nothing except wasting my time and money. Finally, a pediatrician neurologist at Tikur Anbessa specialised referral hospital diagnosed him with cerebral palsy. He told me my boy's brain was irreversibly damaged because of the prolonged labor without intervention or help. He told me the poor prognosis of my child: that he may encounter developmental delay, speech problems, not dressing by himself … soooo many disabilities. He is five years old now and still looks like a newborn, he cannot sit, and feed himself. I have to change his position as he cannot move his head. He takes only milk (bottle feeding) and I have to widen the opening of the bottle because he cannot suck. I have tried to diversify his food, but he cannot take them. As to his friends he was in kindergarten, but he never left the bed by himself. They disabled my child and took away his future.

Aisha is still very angry towards the care providers:

"This problem would not have happened to my baby if that doctor has some humanity in him. I feel bad when I think of hospitals now, I have a negative memory. He considered my cry as a joke and abandoned me. My family believes the baby is disabled because of my abandonment during labor. Nobody anticipated this to happen to my child. Since it was my first pregnancy, I was curious and had full antenatal care follow up. I had paid attention to every detail they (care providers) told me. I was never told that my pregnancy has a problem. My relatives and neighbors were all preparing to celebrate Allah's gift with my family. Now, some people say it was a bad luck, but I will always say he (the doctor) put an end to my child's life before it even started. What is the fate of my child, until when he is going to stay in bed?" She became very emotional and cried but continued to tell her story. "I always live with a grief when I see my child lying in bed unable to talk and feed himself. He follows me with his eyes across the room and this breaks my heart most. My life turned upside down, I cannot sleep at night or leave home during the day." Aisha cried again. "I am hopeless creature. What sin did I do to get such a punishment?"

She wiped her tears and continued after a long sigh,

… First, it is a job they are paid for and above all it is a matter of life and death for us. If they do not like the profession, they should change it, otherwise it is not decent to play with our lives. Why are they in a white coat if they are not keen to help others? I would have stayed home if I could manage it alone; it broke my heart when they abandoned me.

Loss of Trust in Care Providers

> When I gave birth to my second child six months ago, I carefully chose the facility where my relative works and she took good care of me. If not for her, I would have given birth at home. I did not allow any other staff to come near me except for her. How can I trust care providers and give birth in their hands after all that they did to me? Look, I am an educated urban woman and understand well the risks of home birth. Likewise, I had bad experience in hospital; the care providers were very mean to me. Their bad attitude deters women from seeking skilled attendants at birth. How can you go there knowing they will degrade your humanity? They treat you with respect only if they know you. So, it is not wise to visit a random health facility for a childbirth, or else you may regret it. I advise women of my community to visit health facilities where they have a relative or at least a friend.

Discussion

Every woman has the right to receive respectful care during childbirth. Nevertheless, not all women are being treated in this way. This case report provides insight from a testimony provided by a woman using her own words. She clearly describes what it is like to feel abandoned by health care providers during facility-based childbirth, and the devastating ongoing consequences of this. The main themes that arose through her story were denial of care, non-consented care, non-dignified care, taking sick baby home without support, and loss of trust in care providers.

Interpersonal quality of care and disrespect and abuse during facility-based childbirth has garnered increased attention internationally. Studies from a range of cultural contexts have recently reported on care providers' lack of empathy, rudeness, uninformed decision making and denial of care.[25,28] Such abusive practices violate the basic right of women to be treated with respect and dignity[10] and can significantly impact women's willingness to seek life-saving maternity care.[13,25] This case study clearly outlines that the healthcare providers treated Aisha in a disrespectful way and failed to appropriately assess her, with devastating results. She was abandoned during labor and her baby did not receive appropriate treatment after birth.

Appropriate medical care can shorten labor.[29] Conversely, abandonment of a woman during the second stage of labor may prolong the labor and lead to dangerous health complications. Prolonged labor can cause neonatal cerebral palsy, a neurological condition that damages part of the brain that controls muscles and motor skills.[30,31] Oxygen deprivation during prolonged labor is one of major factors that cause this brain damage. This condition largely affects movement and muscle tone, but can include far-reaching complications, such as speech difficulties.[32] This woman was abandoned during labor and her baby did not receive appropriate treatment after birth.

Every woman is entitled to an explanation of any proposed procedures in a language and at a level of explanation that she can comprehend, so that she can knowingly consent or refuse a procedure.[10] The universal definition of non-consented care includes when a provider does not (a) introduce herself/himself, (b) encourage a woman to ask questions, (c) respond politely, truthfully, and promptly, (d) explain procedures and expectations, (e) give periodic updates on status and progress, (f) allow the woman to move during labor, (g) allow the woman to assume a position of choice, (h) ensure informed consent for procedures. Non-consented care violates women's right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care.[33]

Care providers must ensure client's comfort during procedures. Every woman seeking care is a person of value and has the right to be treated with respect and dignity.[13] A laboring mother should be encouraged to express her views freely, even when they differ from service providers' views.[33] Non-dignified care is characterized by (a) humiliation by shouting, blaming, or degrading, (b) not speaking politely, (c) using abusive language, and (d) making insults or threats. In this case study the woman experienced a myriad of these aspects of non-dignified care, was carried into the labor ward by her arms and legs and was left naked and bleeding for an extended period of time.

Disrespect and abuse in facilities are among the biggest barriers to women seeking maternal health services globally[24] and is perceived differently (or even normalized) depending on the specific setting.[20] Therefore, a human rights approach to maternity care internationally is vital to support efforts to reduce maternal mortality. Incorporating fundamental human rights into legal and medical frameworks and translating them into measurable actions and outcomes is critical.[34] Every laboring woman should feel valued, respected, and appreciated by her attendants.[33]

Conclusion

In this case, the provider left the mother unattended and denied her the care she came for. Abandonment of the mother during labor and lack of appropriate care for the baby led to cerebral palsy and significant loss of trust in care providers. As a result, this woman only feels safe attending a facility where a relative works and can care for her. Disrespectful care during facility-based childbirth deters women from seeking lifesaving professional maternity care for subsequent births.

Abbreviations

WHO, World Health Organization; WRA, White Ribbon Alliance.

Ethics Approval and Consent to Participate

Ethical approval was obtained from the University of Adelaide human research ethics committee H-2019-153 and Salale University College of health sciences research ethics review committee A/G/H/S/C/768/11. The participant was informed about the purpose, benefit, risk, confidentiality of the information and the voluntary nature of participation. Original name of the mother was changed due to the sensitivity of the issue. The interview was conducted in participant's house and she was accompanied by person of her choice. Data were collected only after informed written consent was obtained.

Consent for Publication

Written informed consent was provided by the participant for the case details to be published.

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Author Contributions

All authors made substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; took part in drafting the article or revising it critically for important intellectual content; agreed to submit to the current journal; gave final approval of the version to be published; and agree to be accountable for all aspects of the work.

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The authors declare that they have no conflicts of interest for this work.

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Chapter 7: Care providers' perspectives on disrespect and abuse of women during facility-based childbirth in Ethiopia

This chapter covers care providers' perspectives on disrespect and abuse during facility-based childbirth. The study involved care professionals working in maternity units of health facilities who have direct involvement in care of women during pregnancy and labor. In-depth interviews were used to explore how care providers perceive conducts that could be classified as mistreatment by an independent observer, researcher, or advocate. Inductive thematic analysis was employed to identify the themes.

Like women, care providers did not consistently hold the same viewpoint across all scenarios, rather they offered different perspectives depending on each scenario. Four themes were identified 1) Disrespect and abuse breaches professional standards, 2) Disrespectful and abusive actions are justified at times to save the mother and her baby, 3) Disrespect and abuse is used as a tool to assert power, and 4) Disrespect and abuse arise from health system deficiencies.

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ORIGINAL RESEARCH

Care Providers' Perspectives on Disrespect and Abuse of Women During Facility-Based Childbirth in Ethiopia: A Qualitative Study

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Background: It is increasingly evident that disrespect and abuse of women during facility-based childbirth is a violation of a woman's rights and a deterrent to the use of life-saving maternity care. Understanding care providers' perspectives of disrespect and abuse during facility-based childbirth is an essential element to aid in fully comprehending the problem and its underlying complexities.

Objective: To explore care providers' perspectives of disrespect and abuse during facility-based childbirth.

Methods: This study used a qualitative descriptive design involving fifteen in-depth, semi-structured, interviews conducted between 5 October 2019 and 25 January 2020 in north Showa zone of Oromia region, central Ethiopia. Purposive sampling enabled health care professionals working in maternity units of health facilities who have direct involvement in care of women during pregnancy and labor to be recruited. Thematic analysis using Open Code software was used to explore the perspectives of participants.

Results: Four themes were identified. 1) Disrespect and abuse breaches professional standards, 2) Disrespectful and abusive actions are justified at times to save the mother and her baby, 3) Disrespect and abuse is used as a tool to assert power, and 4) Disrespect and abuse arise from health system deficiencies.

Conclusion: Disrespect and abuse is triggered by underlying beliefs about risk versus care, provider attitudes, stress and burnout, and health service structural issues including a lack of medicines and supplies. A number of strategies could improve the quality of maternity care, including training providers how to manage difficult and complex situations, addressing root causes of disrespect and abuse, and increasing access to resources.

Keywords: health care workers, disrespect, human rights abuses, respect, birthing centers, Ethiopia

Background

Almost half of the pregnancy-related deaths in the world are from Sub-Saharan Africa.[1] Most of these deaths occur during the intrapartum period, highlighting the need to focus on this period of care. It is estimated that approximately four million African women and babies would survive annually if 90% of families receive known interventions.[2] The most effective and cost-efficient strategy for reducing maternal and neonatal mortality in low resource countries is encouraging women to give birth in a health facility with the assistance of a skilled birth attendant.[3]

However, women in developing countries have limited access to obstetric care for several reasons including, but not limited to: gender discrimination, traditional beliefs, financial constraint and lack of accessible and reliable transportation.[4,5] Previous research

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has suggested that the treatment women receive in birthing facilities may be substandard and serve as a deterrent to them attending facility-based childbirth.[6] Poorer quality of care,[7,8] and poor health worker attitudes contribute to a woman choosing to use a traditional provider.[9,10] Studies from southern Ethiopia have concluded that women who chose not to give birth in a health facility cited negative provider attitudes,[11] poor quality maternity services and limited availability of trained staff[12] as the primary reasons. According to the 2019 Ethiopian demographic and health survey,[13] 50% of births are not supervised by a skilled birth attendant and 48% of deliveries occur outside a health care facility in Ethiopia. Consequently, improving maternal and child health remains a challenge for a nation where 401 women died per 100,000 live births in 2017,[14] and 1 in every 30 children die within the first month.[13]

Disrespect and abuse (D&A) of women during facility-based childbirth is a violation of human rights and an indicator of poor quality of care,[15] and has been identified as a key deterrent to facility based childbirth in developing nations.[16] The provider–client relationship and experience of care is of central importance, it impacts on access, compliance, quality, and effectiveness,[17–19] as well as the care seeking practices of women.[20] There is growing realization that any approach to care that ignores the importance of this relationship and the culture of care provision, is fundamentally flawed. This has led to a recent global move towards a more person-centered approach.[21]

Healthcare providers play a central role in improving the quality of maternity care and reducing maternal deaths. Therefore, any research and strategy to address disrespectful and abusive treatment must include the perspectives and experiences of healthcare providers themselves. Previous studies conducted in Ethiopia have primarily focused on reports from women, while few sought insights from practicing providers.[22] A better understanding of both perspectives is essential to accurately understand the problem and underlying complexities and identify the drivers of change to inform improvement interventions. Therefore, this paper aims to explore how providers perceive various actions that could be classified as mistreatment by an independent observer, researcher, or advocate.

Methods

Study Design

Interviews with health professionals were conducted as part of a larger mixed methods study[23] that examined disrespect and abuse of women during facility-based childbirth in Ethiopia from the perspectives of women and health care providers. A qualitative descriptive design was used to understand the perspectives of care providers,[24] and the phenomenon under investigation.[25]

Study Setting

This study was conducted in north Showa zone of Oromia region, central Ethiopia, located 110km to north of the capital Addis Ababa. The total population is approximately 1.5 million and 48% are women.[26] Afan Oromo and Amharic are the main languages spoken. There are three hospitals, 62 health centers and 268 health posts in this zone. Study facilities were chosen based on their number of staff and client volume.

Participants

Midwives, nurses, general practitioners, and obstetricians working at maternity units of selected health facilities with direct involvement in the care of women during pregnancy and labor were enrolled in this study. Healthcare providers who do not work at the maternity ward of the study facilities were ineligible to participate. Participants worked in two hospitals and three health centers with urban and rural areas included. Health posts were not included as they do not provide birthing care.

Recruitment of Study Participants

A project information flyer was posted in maternity units and the project eligibility criteria was presented to staff, following permission from administrators. Interested care providers contacted the investigator, provided informed consent, and participated in semi structured interviews. Purposive sampling was used to enroll participants across a range of health professions and experiences. Information saturation (when ideas started to be repeated and no more new ideas emerged) was used to determine the final number of in-depth interviews (IDIs).

Data Collection Tool and Procedures

The research team used previous systematic review findings to develop a semi-structured interview guide that addressed differing forms of disrespect and abuse that women may experience during childbirth.[27,28] Nine examples were developed and used during the interviews to elicit responses from participants about whether, when, and in what circumstances abuse and neglect occurs and whether each scenario was viewed by the participant as acceptable or unacceptable (Table 1). Fifteen IDIs were conducted from 5 October 2019

Table 1 Sample Disrespect and Abuse Questions

No.	Questions
1.	If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
2.	If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
3.	If a health worker was mean and refused to help a woman during her delivery, would this be acceptable? When would it be acceptable?
4.	If a health worker physically held a woman down during her childbirth, would this be acceptable? When would it be acceptable?
5.	If a health worker threatens a woman by unfavorable procedure l ke CS or referral or bad outcome for her or her baby during her childbirth, would this be acceptable? When would it be acceptable?
6.	If a health worker disallowed a woman to deliver in a position of her choice during her childbirth, would this be acceptable? When would it be acceptable?
7.	If a health worker performs a procedure without getting consent during her childbirth, would this be acceptable? When would it be acceptable?
8.	If a health worker forcefully opens a woman's leg during her childbirth, would this be acceptable? When would it be acceptable?
9.	If a health worker disallowed a woman birth companion during her childbirth, would this be acceptable? When would it be acceptable?

to 25 January 2020. Participants were interviewed in private rooms in health facilities during working hours. Interviews lasted approximately 50 minutes. Care was taken to maintain confidentiality of study participants by de-identifying interview transcripts and maintaining privacy during interviews. Healthcare providers were invited to reflect on the occurrence and "acceptability" of hypothetical mistreatment during childbirth, rather than disclosing personal instances of mistreatment. The interviews were audio (voice) recorded with permission, with field memos also taken.

Data Analysis

A thematic analysis approach as described by Braun and Clarke (2006) was used to identify key themes, richly describe large bodies of qualitative data and highlight similarities and differences in experiences.[29] IDIs were conducted in a local language (Afan Oromo or Amharic) by the primary author, translated and transcribed simultaneously by the primary author and reviewed by another experienced bilingual researcher in Ethiopia. De-identified transcripts were stored on a password protected computer. Open coding was performed line-by-line on the transcripts by the primary author and the co-authors to develop an initial thematic framework. Codes were then analyzed alongside field memos to generate categories. Themes were identified and representative quotes were selected to illustrate the range of voices in each theme.

Reliability testing was conducted in two stages: (1) two researchers jointly coded five transcripts and (2) then independently coded four transcripts and discussed coding decisions until consensus. A subset of the coded transcripts was reviewed by an independent researcher to check reliability of the coding. Open Code software version 4.0.2.3 was used for the data analysis. This paper is reported according to the consolidated criteria for reporting qualitative research (COREQ).[30]

Results

A total of 15 IDIs were conducted and included in this analysis: 11 midwives/nurses, three general practitioners and one obstetrician participated. Table 2 reports sociodemographic characteristics of participants (Table 2).

Views of Acceptability of Disrespect and Abuse During Childbirth

A range of viewpoints emerged from the interviews with care providers. These were arranged in four main themes, each with a number of subthemes. (1) Disrespect and abuse breaches professional standards, (2) Disrespectful and abusive actions are justified at times to save the mother and her baby, (3) Disrespect and abuse is used as a tool to assert power, and (4) Disrespect and abuse arise from health system deficiencies (Figure 1).

Disrespect and Abuse Breaches Professional Standards

Disrespectful and abusive treatment during childbirth in facilities not only violates the rights of women to respectful care, but can also threaten their rights to life, health, and bodily integrity. Participants were very clear that D&A is not acceptable under any circumstance because of three reasons. First, according to participants, D&A

Table 2 Socio Demographic Characteristics of Study Participants

		Obstetrician n=1	General Practitioners n=3	Midwives/ Nurse n=11
Age (years)	<30	0	0	3
	30–39	0	2	6
	40–49	1	1	2
	50+	0	0	0
Marital status	Married	1	3	11
	Single	0	0	0
Gender	Female	0	0	5
	Male	1	3	6
Years of experience	0–4	1	1	4
	5–9	0	2	4
	10–14	0	0	3
	15+	0	0	0
Facility type	Health centre	0	0	7
	Hospital	1	3	4
Facility location	Rural	0	1	5
	Semiurban	0	1	4
	Urban	1	1	2

demonstrates a lack of understanding of the feelings of others when care providers fail to empathize with the woman and her circumstance. Secondly, participants denounced D&A based on ethical principles. According to these participants, D&A breaches professional standards of clinical care. Thirdly, participants suggested D&A contributes to an undesirable delivery outcome by affecting the communication between the provider and the woman. These participants prioritized respectful care as part of professional practice and believed that understanding the woman and treating her with respect contributes to good rapport and a positive birth outcome.

Disrespect and Abuse Fails to Acknowledge Women's Circumstances

Women have a right to expect empathy from their healthcare provider. Only three of the participants, all of whom were doctors, considered the majority of the presented D&A scenarios as unacceptable One participant stressed that providers should approach and treat all laboring women with consideration and empathy.

> I feel providers have to understand the woman if she does not comply with their instructions. Because she is in an immense pain and they do not know what she does. She may not respond to your question or disappoint you with inappropriate response. However, the provider has to be patient. (male doctor, urban hospital)

Care providers will gain a woman's cooperation if they approach her with respect and patiently explain procedures to her. A participant had also similar viewpoints where he explained how providers should approach and treat women:

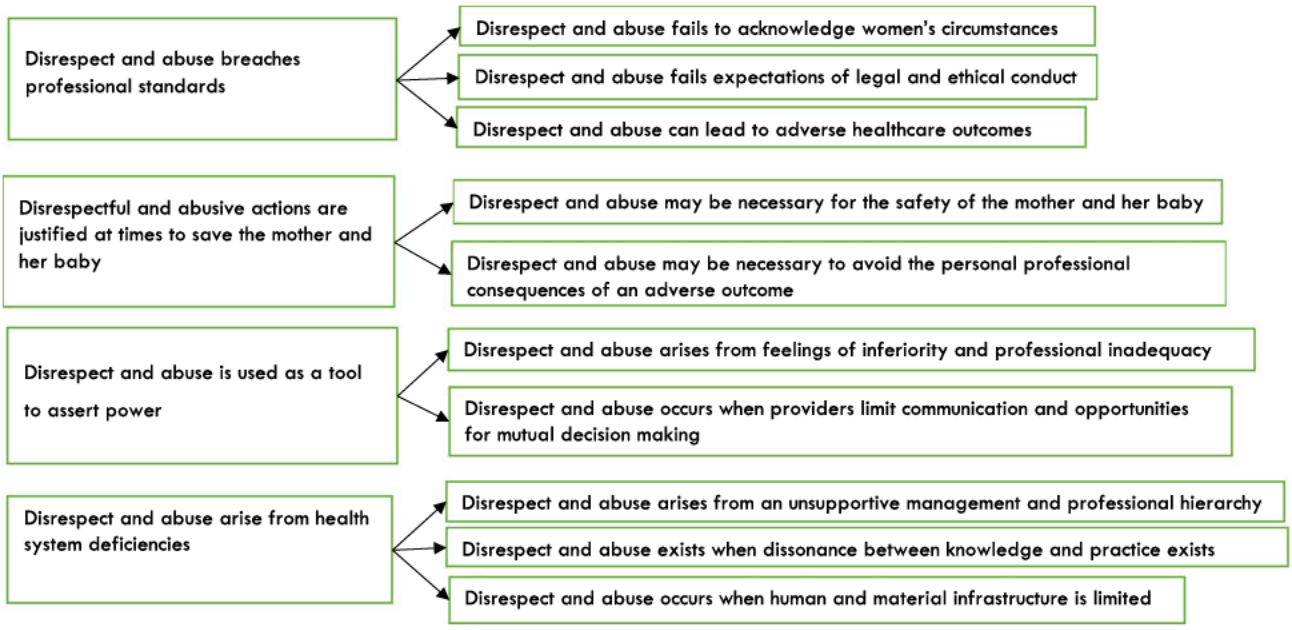

Figure 1 Schematic presentation of the identified themes and subthemes.

> She will cooperate if you explain the importance of the procedure to her baby. However, this depends on our patience and approach. Thus, providers should avoid bossy approach because women will feel looked down on them. It is too much to expect the woman to tolerate bad approach of providers on top of the labor pain. (male doctor, urban hospital)

Labor pain or a lack of knowledge of the physiology of childbirth might influence the woman's interaction with care providers. According to participants, providers have to recognize this and treat women accordingly. These participants believe that any "wrongdoing" of the women could be due to lack of awareness or because of their circumstances and care providers have to understand them. A participant said,

> Who can understand her situation without care providers? Shouting does not help either, you have to be respectful in your approach. Still if the woman does not cooperate, you better inform her families to intervene rather than getting into conflict with her. (male doctor, urban hospital)

Disrespect and Abuse Breach Professional Standards of Legal and Ethical Conduct

There were participants who considered the presented D&A examples unacceptable from legal and ethical point of view. These participants evaluate their actions in relation to the legal consequence they might have. As a result, the majority of participants do not consider pinching or slapping of a mother acceptable. Male providers in particular found it unacceptable to beat a laboring woman. According to these providers, shouting at or beating a woman for any reason is unethical and has legal consequences.

> Why on earth you raise your hand on a woman? It is immoral and unethical to beat any woman let alone a laboring mother who came to seek your help. It can never be acceptable. (male midwife, urban hospital) Another midwife had similar views

> you cannot slap a woman; it is violation of her rights and you will be held accountable. (male midwife, urban hospital)

Most of the respondents strictly practice the traditional lithotomy position and have never assisted a mother in other preferred birthing positions. However, they considered tying a laboring woman to the delivery bed with ropes to control her from leaving the delivery bed inappropriate and illegal. A participant said,

> She is a human being, not animal and never should be tied to the bed. (male midwife, rural health center)

Another midwife said,

> it is a crime to tie a laboring woman to a bed, she is not a threat to anyone's safety. (female midwife, rural health center)

Almost all participants considered performing a procedure without getting consent acceptable for various reasons. However, the only obstetrician in the study said:

> It is not acceptable to perform any procedure without getting a consent. You have to tell her what you are going to do to the level she can comprehend. It is not acceptable to perform a procedure without her knowledge. If she refuses a medically indicated procedure you can involve her family. If she still insists you will make her sign and leave the hospital at her own risk. It is mandatory to take a consent. (Obstetrician, urban hospital)

Participants were asked if it is acceptable for a health worker to refuse to help a woman during her delivery. All participants of the study, except one midwife, did not consider withholding of care acceptable under any circumstance. They preferred transferring the woman to another provider than abandoning her. A participant said:

> Why you withhold the care that she came for? If you cannot continue assisting her because of disagreement, transfer her to another provider. You cannot simply abandon a laboring mother; it is unethical. (male midwife, rural health center)

Another participant stated:

> It is unethical. How would you sleep at night peacefully after abandoning a laboring mother? If you cannot attend her for any reason, you must make sure that another provider oversees her. (female midwife, rural health center)

Disrespect and Abuse Can Lead to Adverse Healthcare Outcomes

Some providers believed that disrespecting or abusing a mother will affect the communication between the provider and the woman and will contribute to an undesirable delivery outcome. According to these participants, if not treated well, the woman may not comply, refuse to undergo procedures, and puts her life in danger.

> Shouting at woman is not acceptable as it damages the relationship and will contribute to bad outcome. (male midwife, rural health center)

Other participant had similar viewpoints,

> if you beat her, she will be angry and uncooperative. (Male midwife, urban health center)

Participants considered disrespect and abuse as unacceptable They believed that D&A breaches professional standards as it fails expectations around legal and ethical conduct, and fails to acknowledge women's circumstance and can lead to adverse outcome.

Disrespectful and Abusive Actions are Justified at Times to Save the Mother and Her Baby

Some participants considered the D&A examples acceptable as they prioritize the medically indicated procedures over patient-centered care. For these participants birthing a live baby to a healthy mother is a top priority. Thus, they are willing to do whatever it takes not to risk the lives of either the baby or the mother.

Disrespect and Abuse May Be Necessary for the Safety of the Mother and Her Baby

Care providers focus on delivering a live baby to a healthy mother and are willing to do whatever it takes. As a result, they considered the disrespect and abuse examples acceptable if the act prevents loss of the mother and her baby.

> My primary aim is to deliver a live baby to a healthy mother. She may be uncomfortable with my approach but, I guarantee her a live baby and that is what matters most for me. I will perform procedure without waiting for her approval as long as it is medically indicated. (Female midwife, urban hospital)

This may be the reason why all participants found it acceptable to threaten a woman with a bad outcome or unfavorable procedure or denial of care, forcefully opening her leg and forcefully holding her down to the delivery bed. They believed that these acts cause no harm to the mother, but rather they make her cooperate and give birth without a problem. According to the participants, any psychological or emotional pain of the mother due to these acts are less emotionally painful than losing a baby.

> Mother should not lose her baby. So, it is ok to frighten her if it contributes to safe delivery. I believe that the major thing here is to get a live baby to a healthy mother, other issues including respect come next. Do you think the mother will be happy because you were respectful even if she loses her baby? No way. So, first thing first. Give priority to delivering a live baby to a healthy mother. Because undesirable outcome either for the mother or the baby is too costly for the family. (female midwife, rural health center)

Threatening a woman with a bad outcome for her or her baby is considered acceptable. According to some participants, it does not cause any physical harm to the woman. A female midwife's view supported this argument:

> Threatening a woman with poor outcome for her or her baby has no harm and will make her cooperative. If you do not have her cooperation, you may lose the baby or even the mother and that will be an absolute failure. (female midwife, rural health center)

The intention determines the acceptability of an action, according to participants. These participants recognized that the actions are not respectful. However, they are ok with them if the intention is to save the life the mother and her baby.

> Shouting at a woman is somehow a common practice in our ward. It is acceptable if it for her own benefit, like to make her concentrate and push. Otherwise, it is against her right to shout at her for reasons not related to her. (female midwife, rural health center)

Another participant had similar views,

> No one is here to hurt or disrespect a woman intentionally. We do everything for the sake of the mother and her baby. After all we do not know these women personally and our acts shouldn't be taken personal as well. (doctor, urban hospital)

Almost all participants believed that women should not be allowed to leave the bed during the second stage of labor. As a result, they considered forcefully holding her down to the delivery bed acceptable as an act to save her baby.

> The intention is to save her baby, not to limit her right to move around. Because she may suffocate her baby if she sits on it or may lose it to the ground while standing. She may also experience severe genital tear if the baby comes out forcefully. (female midwife, urban hospital)

Another participant justified the act by saying

> You can even do it with help of others. You do this for her own sake, she will kill her baby otherwise. She has waited for nine months to kiss her baby and you should not sit and watch her kill it. (Male midwife, rural health center)

Similarly, even if they know they have to get consent, participants considered doing medically indicated procedures without the women's consent as acceptable to save a life.

> Ethically it is inappropriate to touch a woman without her consent let alone performing a procedure. However, if a woman presents with a second stage of labor you do not have time to explain everything to her, you have to act instantly or else you will lose the baby. (male midwife, urban hospital)

According to participants, saving the woman's life is more important than seeking her consent.

> What will a woman lose if she undergoes a medically indicated procedure without her knowledge? After all she came to us to give birth and we have to make it happen by any means. You may be wasting precious life saving time. (female midwife, rural health center)

Six participants have considered slapping a woman acceptable as a means to encourage her keep pushing.

> If her baby is in distress and she is not pushing enough, you can slap her thigh just to encourage her, or else she will lose her baby in front of your eyes. You do not slap to hurt her, except helping her out. (male midwife, urban hospital)

Similarly, there was a participant who believed that slapping a woman on her thigh is different from slapping her in the face. Thus, it is acceptable to slap women on thigh in order to encourage her or get compliance.

> Slapping on the thigh is not disrespectful like the slap in the face, we do this just to make her focused and get compliance. (female midwife, urban hospital)

Disrespect and Abuse May Be Necessary to Avoid Personal Professional Consequences of an Adverse Outcome

Respondents described a common problem where women in the second stage of labor refuse to push putting themselves and their babies at a higher risk. Participants believed that it is their duty to help women avoid a bad outcome, not only in the best interest of the mother and baby, but also because bad outcomes reflect poorly on them as healthcare professionals. As a result, providers considered the D&A examples acceptable to avoid legal consequences of undesirable delivery outcome.

> If you fail you will be held accountable. So, you have to make sure the woman gets her baby alive at any cost. She will forget all the disrespect and abuse you are talking about after she gave birth. However, is she lose her baby while I am comforting her, rather than urging her to push, I will be blamed. (female midwife, urban hospital)

This may help to explain why some respondents considered their profession as risky.

> Maternal death is politicized, and you will be held accountable if something went wrong in your hand. (female midwife, urban hospital)

One provider considered slapping or pinching a woman acceptable to avoid professional consequences of adverse outcomes.

> I pinch or slap her to deliver a live baby because I will be responsible if she develops complication or lose her baby. (female midwife, urban hospital)

Some providers considered yelling or shouting at the women acceptable to save their career. They thought shouting at a woman cannot cause any harm to the woman, but rather it reminds her of the seriousness of the situation and will make her cooperate and help them escape consequences of undesirable delivery outcome.

> If you do not yell or shout at her, she will ignore your instructions and put you in trouble. If something wrong happens to the mother or her newborn while you are in charge, you will be scrutinized. So, you shout at her to make her onboard [focus and push] and avoid undesirable outcomes. (female midwife, urban hospital)

Forcefully holding down a woman to the delivery bed is considered acceptable by the majority of the participants. These providers feared responsibility of an undesirable delivery outcome and thus they believed that a mother should not be allowed to move out of the delivery bed during the active phase of labor.

> You have to hold her to the bed by any means. She will accuse and put you in big trouble if she loses her baby and nobody will be there in your defense. You have to make sure things end well or else the consequence is not good

> for your career as a midwife. (female midwife, urban hospital)

There were also participants who considered performing a procedure without consent as acceptable to protect their professional career. These participants argued that obtaining consent from the woman consumes time and contributes to the delay of care and potential complications.

> I do not dare to risk a minute explaining procedures to her because she has nothing to lose if the procedure is done for her as long as it is medically indicated. However, if I keep explaining things, I cannot timely do what I am supposed to do, and things may get out of control and that will put me in trouble. (female midwife, urban hospital)

Participants felt that disrespect and abuse may be necessary at times to save the mother and her baby. They perceived that it is necessary to ensure the safety of the mother and her baby and avoid personal professional consequences of an adverse outcome.

Disrespect and Abuse is Used as a Tool to Assert Power

Some participants thought that disrespect and abuse arises from feelings of inferiority and professional inadequacy of care providers. Limited communication and lack of mutual decision-making between providers and women and their families was also mentioned as a reason for disrespect and abuse.

Disrespect and Abuse Arises from Feelings of Inferiority and Professional Inadequacy

Some participants preferred not to attend certain clients due to their personal attributes. They had a perception that urban and educated women are not respectful and thus they use disrespect and abuse as a tool to assert power. These providers had a feeling that educated, rich women look down on them whereas rural women are more submissive and obedient.

> I prefer attending to thousand rural women than a single urban woman. Rural women are obedient whereas the urban woman challenge you on everything you do. You do not repeat instruction for rural women they comply with the first order. What do you feel when some urban women look down on you because of their economic circumstance or educational level? It drives me crazy, and I will retaliate by abandoning her or giving priority for others. (male midwife, urban hospital)

Another participant had similar views,

> Some urban women try to undermine us. They think they are privileged and want us to do what we do not usually do for others. I will degrade her from humanity and teach her obedience and decency. (female midwife, urban health center)

Similarly, another participant said,

> you must be blessed with patience to complete every delivery process with success. From my experience, sometimes you need to be rough for missy kind of mothers. (male midwife, from urban hospital)

Some participants believed that allowing a birth companion will interfere with their "work freedom." This may be because they are not confident that their treatment of the woman is in line with professional standards.

> We do everything in our power to disallow companions. Because we do not want the companion to see how we treat the woman in the delivery room. I am not confident our practice is in line with the national guideline. However, if she is alone, you can do whatever you like in peace. She is in your hand (female midwife, urban hospital)

Providers complained that they lack training and instruments to assist women in positions other than the traditional lithotomy position. However, the only midwife who is assisting women in their preferred birthing position said,

> providers consider only what is comfortable for them. Lithotomy is convenient for the provider to take the baby. Other positions compromise providers comfort as they require them to kneel or squat. Thus, providers use lack of training and material to assist woman in other positions as an excuse.

Another participant's remark supports this argument.

> It is not about the woman; it is comfortable for the provider to assist and receive the baby. You can clearly see and support her perineum to prevent tear. But when you are asked about other positions you complain about lack of instruments and training. (male midwife, rural health center)

One participant totally disagreed with the importance of supporting preferred birthing positions and blamed the respectful care guideline for introducing "uncustomary" practice.

> It is not practiced, and our women do not ask for it either. Lithotomy is the only position they know. I gave birth in lithotomy position. It is the protocol that has a problem, why it requires us to do something that is not customary? I am not doing it. (female midwife, urban hospital)

Disrespect and Abuse Occurs When Providers Limit Communication and Opportunities for Mutual Decision Making

There were participants who believed that a woman has no role in her care and should passively receive care. According to these participants, women know little about the physiology of pregnancy and childbirth and there is no point in discussing it with them or explaining procedures to them as they cannot understand the "complex" care. In addition, interviewed providers indicated that laboring mothers often do not know what is best for them. For these providers, the main criterion to perform a procedure is its indication, not the woman's consent.

> It is acceptable to perform a necessary procedure even if the woman did not consent to it. I do not give her a chance to ask a question or decline the procedure. Because it is me who knows what works for her. (female midwife, urban hospital)

When asked what they would need from a woman and her family to provide supportive care, some participants stressed that they prefer obedient clients and companions that do not ask questions. According to these participants, clients and companions should not be asked for consent as they know little about the procedures and the provider should be the sole decision maker in the care.

> I am the professional and I am the only right person to decide on procedures. What do the woman, or her family know about the care that I ask them for a consent? (female midwife, urban hospital)

Some participants indicated they do not explain procedures to the women as they believe it is unnecessary and out of their remit. According to these participants, the primary aim of the care is to deliver the baby, not to teach the woman about the care she is receiving. As a result, explaining the care to the recipient is not seen as their job.

> I am a midwife not a teacher and thus I am not supposed to explain everything to the women. (female midwife, urban hospital)

A male midwife from same facility shared similar view,

> I am not here to teach women, only to attend. It is too much to ask a midwife to explain procedures to women.

Some even question the importance of obtaining consent.

> Will the woman sit for exam after the procedure? Why would I waste my time and energy explaining everything to her then? (female midwife, urban health center)

Further still, some participants, not only withhold information, but also, prefer not to hear from the woman or her families at all.

> Let alone explaining to her, I do not want to communicate with her or her family. I just want her to deliver and leave. (female midwife, rural health center)

For these participants disrespect and abuse arises from feelings of inferiority and professional inadequacy or when there is limited communication and mutual decision-making between providers and women and their families.

Disrespect and Abuse Arise from Health System Deficiencies

There were participants who thought disrespect and abuse arises from an unsupportive management and professional hierarchy. Others believed that dissonance between knowledge and practice and limited human and material infrastructure exacerbated disrespect and abuse.

Disrespect and Abuse Arises from an Unsupportive Management and Professional Hierarchy

Midwife participants were not happy with their relationship with their supervisors. They perceived that supervisors are not treating midwifery profession with the respect they feel it deserves, and this in turn is making them unkind to their clients.

> The management is not fulfilling what we want to do our work. That is why I feel my profession is neglected. To be respectful, I have to be respected first. (female midwife, urban hospital)

Additionally, mistreatment of the low and middle level providers by higher level providers was mentioned as a reason why providers are not treating women better.

> Higher level providers undermine the middle and lower-level providers, the management favour higher level providers' interest. This disappoints and influences our interaction with women and contribute to their mistreatment. (female midwife, urban hospital)

Midwives felt they spend most of their time with the laboring mother and do the hard work. However, they do not feel valued.

> We are doing the hard job at the frontline, but I do not feel valued as a professional and this has demotivated me (male midwife, urban hospital)

Another participant expressed a similar view,

> Neither we nor the mothers are happy with the care we are providing. The way midwives are treated by the hospital administration determines how midwives treat women. (Male midwife, urban hospital)

As a result, some midwives felt forced to leave the midwifery profession because they are tired of abusing innocent labouring women.

> To speak the truth, it is a novel work. In the contrary though, we are not appreciated for what we are doing in resource limited setup. That is why we beat a laboring woman. I would rather change my profession than abusing a labouring woman who has nothing to do with my problem. (female midwife, urban hospital)

What another female midwife from a rural health center said strengthens this argument.

> Many midwives have joined the new innovative medical education (NEME) program to become a doctor. Because doctors enjoy better salary and working conditions compared to midwives.

Another participant had similar perspectives,

> I have decided to change my profession not because I do not like it but because the administration does not value it. I cannot keep mistreating innocent women to took out my anger on the administration. (male midwife, rural health center)

Disrespect and Abuse Exists When Dissonance Between Knowledge and Practice Exists

Participant midwives complained that they were not practicing what they learned in college as the facilities have restricted their job description to the delivery room. This may help explain the fatigue participants developed on birthing care.

> The hospital has restricted our role only to attending delivery, nothing more. Who has the moral to judge me if I disrespect and abuse women? I am tired of it. (female midwife, urban hospital)

Another midwife from same facility said,

> The hospital has anonymously decided that midwives cannot hold managerial position and have to focus on attending labouring women. We cannot be head of the ward; we cannot work in the gynaecology ward. That is why midwives became hardhearted towards labouring mothers and abuse them. (Male midwife, urban hospital)

Disrespect and Abuse Occurs When Human and Material Infrastructure is Limited

All study facilities have high client volume and a lack of staff and supplies, according to participants. The delivery ward regularly lacks supplies like medication and equipment, sufficient staff proportional to the client volume and enough space. Providers believed that they are not properly treating the women as per the guideline because of this shortage of resources.

> We cannot protect women's privacy due to lack of screen or curtain, and we cannot give them sufficient time due to the workload. Thus, you cannot blame the providers for such breach of privacy and women's feeling of being ignored. (male midwife, urban hospital)

The same participant further blamed the working condition for mistreatment of women.

> Providers do not intentionally disrespect or abuse a woman, but the heavy workload and stressful working environment will change their behavior and the way they interact with women.

Another participant said her workload will not let her assist women in a preferred birthing position.

> Even if I have the training and materials it takes to do so, I am not doing it because I attend more than one woman at a time, and it is not convenient. (female midwife, urban hospital)

Because of the overwhelming workload, some participants consider the regular care they provide as a favour to the women. These participants do not consider birthing care as the right of the women, rather a good will done to the mother at their mercy.

> We are overcrowded, and these made you feel that you are doing favour to the mothers, not doing your job. As a result, health workers attitude towards laboring women is not good. (female midwife, urban hospital)

Providers described that the workload and shortage of resources have made them behave differently. According to these participants, providers are not happy with their working conditions and take out their anger by disrespecting and abusing women.

> I am not happy with the working environment at all. It is stressful to work in a ward that is narrow, understaffed and has a shortage of medical supplies. I yell at women to takeout my anger, I am not happy. (male midwife, urban hospital)

As discussed above, while some providers felt negatively towards birth companions, others believed that birth companions are advocates and a source of strength for the laboring woman. Participants further described the importance of a companion in helping to convince the mother if she refuses a procedure, and this will make providers' job easy.

> Not only will the woman but also providers benefit from presence of a birth companion. If they saw anything unacceptable being done to the mother, companions may defend. So, you will be mindful of your words and acts. This will make the relationship smooth and the work fruitful.

However, women are being denied having a companion in the study facilities due to "space constraints". A participant said,

> It is the woman's right to have a birth companion. But we are not allowing them as the delivery room is too narrow. (female midwife, rural health center)

Discussion

This study explored healthcare providers' perceptions of disrespect and abuse during childbirth. Participants perceived variously that disrespect and abuse breaches professional standards, may be necessary at times to save the mother and her baby, may be used as a tool to ascertain power, and occurs due to health system deficiencies. The drivers of disrespect and abuse included stress and burnout, poor facility infrastructure including lack of medicines and supplies, and provider perceptions of women as being difficult. More than one of the above drivers were often at any given time.

However, unlike a previous study from South Africa where midwives reportedly used disrespect and abuse as a way to establish and maintain social distance between themselves and their clients,[31] the primary motivator for the majority of our participants appears to be the desire to see a positive birth outcome and to avoid being blamed for a negative outcome. Midwives reported a strong sense of accountability and responsibility for positive delivery outcomes, and they explained that they would do "whatever it takes" to deliver a live baby to a healthy mother. According to these participants, disrespect and abuse tends to occur in situations where the mother is not behaving in a way that the provider perceives as beneficial to the mother or baby. They reported that in such cases, yelling, pinching, or slapping, carrying out procedures without consent, threatening the mother to comply, forcefully opening her legs, or holding her down to the delivery bed are considered acceptable Following this perception, disrespect and abuse is intertwined with a sense of professional responsibility for ensuring a physically safe birth for the laboring women in their charge. These findings are similar to a study from Ghana where midwives reported feeling a strong sense of responsibility for the delivery outcomes and as a result, yell at, and hit women to encourage them to deliver a live baby to a healthy mother.[32]

Adding to this complexity, some midwives described ways in which they felt urban women undermined them. This particularly occurred when female providers believed that women doubted their professional competence. Female providers have low status within the health service in Ethiopia, and arguably in society more generally. The system is not sensitive to gender equality and females are not fairly represented in tertiary education and the health work force. Some participants suggested that the best way to assert power or obtain compliance from a laboring

woman is to yell at or abandon or even slap her. Studies from different contexts have also reported similar findings.[28,31,33]

Respectful care that prioritizes women's dignity and liberty, and improved communication between the woman, her family, and the providers can be promoted with proper managerial support. Midwives expect their supervisors to fairly distribute incentives and responsibilities to all professional disciplines and avail resources to provide supportive care. However, the majority of the participating midwives reported administrative bias as a source of discouragement that is preventing them from properly fulfilling their responsibilities. They perceived that administrators did not treat them as well as physicians. Professional hierarchy is rarely seen as supportive by healthcare providers but when present, good leadership changes the experience of both women and care providers.[34] Absence of good leadership affects the quality of care rendered and may manifest through disrespect and abuse of laboring women. Previous research has identified that anxiety in providers is associated in particular with conflicts at work between staff and supervisors.[35] This could help explain why more midwives, who reported bias, than doctors have considered the disrespect and abuse examples acceptable A study from Nigeria similarly revealed that midwives found mistreatment to be acceptable practice, compared to doctors.[36] In this study, participant doctors did not report unfair treatment by facility administration and workload. This is likely related to the fact that they do not attend normal deliveries and are called to the ward only for cesarean section or to handle complications, an experience reported elsewhere in the literature.[37]

Women have the right to assume any position comfortable to them while giving birth in the facility and restraining a woman from choosing a birthing position of her choice is violation of her right.[38] Thus, alternative locations to the general labor and delivery floor have to be provided for those women accustomed to squatting. Unfortunately, only a single provider reported assisting mothers in their preferred birthing position. Believing they are acting to save the infant, other midwives not only deny this right but also consider it acceptable to forcefully hold down women to the delivery bed. Confinement of women to bed during labor and delivery has also been acknowledged as a common and normal practice elsewhere[39] because most providers consider what is comfortable for them, not the woman. The providers participating in this study also reported that they limit birthing position to lithotomy for their own comfort and use lack of training and instrument as an excuse not to assist women in other positions.

Women have the right to be treated with respect and consideration. Thus, care providers must acknowledge that every woman is a person of value and is worthy of respect. Words and non-verbal communication of providers must honor the dignity of each woman. However, participants did not seem to appreciate the psychological trauma of non-dignified care where they threaten women with a poor outcome or unfavorable medical procedures in order to get compliance. Worse still these providers believe that threatening has no harm to the mother. A South African study also revealed that providers believe that threatening and raising their voice are sometimes the only things that work.[34]

Birthing care has to be participatory. The woman and her family should actively engage in the care and be part of decision making. It is important for midwives to collaborate with women in labor by inviting them to participate and be responsible for their care during childbirth.[40] However, women were not given the opportunity to clarify doubts or ask questions. Doctors and midwives did not provide important information on reasons for, or outcomes of physical examinations, progress of labor and the health of the baby, because providers believed women do not understand explanations and are unable to participate in decision-making. Thus, providers want women just to follow their instructions. In addition, they discouraged birth companions, thus not allowing for other people to advocate on behalf of the labouring woman. Studies from varying contexts have reported likewise.[41–45]

It is too simplistic to attribute poor quality of care, including lack of respectful care, solely to the healthcare providers. However, the social, economic and health system barriers healthcare providers experience in their daily working lives can be significant. The task of practicing midwifery in low-income countries appears to be more difficult than ever, particularly in settings where resources for maternal health care services are limited.[46] Understaffing and overcrowding on the labor ward can create a stressful work environment.[47] The participants of the current study have blamed mistreatment during childbirth on a disempowering health system where providers are overworked, and facilities are understaffed and overcrowded. Multinational research has indicated that disrespect and abuse is often a greater problem in developing

countries where inadequate numbers of care providers serve a large number of clients.[48] Likewise, studies from varying contexts have identified health systems constraints, staff shortages and lack of resources, as drivers for disrespect and abuse.[34,49] These conditions contribute to healthcare providers' feelings of impulsivity, lower tolerance for aberration, and exhaustion, and can contribute to transference of aggression to the woman.[33]

Limitations and Strengths of the Study

This study was carried out in five health facilities among self-selected participants in the North Showa zone. Therefore, this may not reflect the perceptions of care providers in other parts of Ethiopia. However, participants with diverse age, education and years of experience were involved in the study which contributes to the diversity of perspectives included.

Conclusion and Recommendation

In addition to poor provider attitudes, our findings suggest that health system constraints and working under high levels of stress has influenced participants' relationship with women. Strengthening the health systems to address the system-level stressors would enhance provider-client relationship and improve quality of maternity care. Furthermore, in-service provider training that focuses on women's perspectives, rights and cultural roles in society is necessary to change attitudes. Supportive supervision and mentoring could also help to empower providers to manage difficult situations and develop positive coping mechanisms for stress. Policies and procedures that describe the responsibilities of healthcare providers in the respectful maternal care process should be developed and reinforced through education and audit processes. Respectful care should be a central pillar of entry-level nursing, midwifery and medical curricula.

Abbreviations

D&A, Disrespect and Abuse.

Data Sharing Statement

The data that support the findings of this study are available from The University of Adelaide, but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of The University of Adelaide.

Ethical Considerations

Ethical approval was obtained from the University of Adelaide human research ethics committee H-2019-153 and Salale University College of health sciences research ethics review committee A/G/H/S/C/768/11. Salale University gave the clearance as the study was conducted in its catchment area. Letter of confirmation was received from the included health facilities that the facilities will not take disciplinary actions on care provider participants based on finding of the study. Participants were informed about research objective, what data will be collected, confidentiality of information, and voluntary nature of participation. In addition, they were informed the time the interview will take and that they reserve a right to withdraw from the study any time and there will be no direct benefit from participation. Also, no information which may identify an individual will be required for the study, and the data will not be used for future research. Data were collected only after informed written consent was obtained. The participants' informed consent included publication of anonymized responses, and that this study was conducted in accordance with the Declaration of Helsinki.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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The authors declare that they have no competing interests in this work.

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Chapter 8: Discussion and conclusion

In this chapter the findings of the mixed-methods studies are brought together and discussed. This project investigated women's experiences of disrespect and abuse during facility-based childbirth and explored how women and care providers perceive healthcare professionals' conduct that could be classified as disrespect and abuse by an independent observer, researcher or advocate. The project involved four studies. The first study was a community-based cross-sectional survey conducted with women who had given birth at a public health facility to quantify the frequency and categories of disrespect and abuse and identify factors associated with disrespect and abuse. The second study used qualitative in-depth interviews and focus group discussions to discuss scenarios. The study participants were women who had given birth at public health facilities within the previous twelve months. The third study was an in-depth case study in which a 28-year-old mother of two children narrated her personal experience during a facility-based childbirth in her own words. This was conducted alongside the second study. The fourth study used qualitative in-depth interviews and scenarios to collect data from midwives, nurses, general practitioners, and obstetricians working at maternity units of selected health facilities with direct involvement in the care of women during pregnancy and labour. This study aimed to explore care providers' perspectives on disrespect and abuse of women during facility-based childbirth.

The findings from the survey of women (study 1) suggest that mistreatment of women during labour and childbirth in Ethiopia is common. All women reported at least one form of disrespect or abuse during childbirth, with physical abuse the most prevalent (100% of women participants). Non-consented care was the second most common category of disrespect and abuse reported by 423 (97.2%) women participants.

The extent and triggers of abuse identified in this project are largely congruent with those from recent international studies on disrespect and abuse of women during facility-based childbirth(104, 119, 128, 141), indicating that disrespect and abuse is a global problem. However, this project found differences in the motivation or underlying reasons why healthcare professionals provide care that can be perceived to be disrespectful and abusive. Unlike a previous study from South Africa, where care providers reportedly used mistreatment as a way to establish and maintain social distance between themselves and their clients (129), the primary motivator for the majority of our care provider participants (study 4) appears to be the desire to see a positive birth outcome and to avoid being blamed for a negative outcome. Both

women and care providers in this project reported in interviews and focus groups (studies 2 and 4) that disrespect and abuse is likely to happen in circumstances where the provider believes the mother is not acting in a way that is helpful to the mother or baby. Furthermore, in such cases, some women and some care providers believe that yelling at, slapping or hitting a woman in labour is justified.

In addition, healthcare providers expressed a strong sense of responsibility for positive birth outcomes. They explained that they would do "whatever it takes" to deliver a live baby to a healthy mother. The fear of losing the mother or the baby makes providers nervous, a factor that has been found to further suppress compassion and empathy in other studies (154, 156). Healthcare providers' fears are very real in countries with high rates of maternal and infant morbidity and mortality. Abusive care being employed in an effort to save the mother and her baby has been described in other local and international studies (140, 144, 148, 172). Thus, abuse in these contexts can be conceptualised as a complex response by providers attempting to save women's and babies' lives while also overcoming a sense of powerlessness and reduced empathy.

The findings from discussions with women using possible disrespect and abuse scenarios (study 2) indicate that some women participants also perceive that there is a medical justification for care that could be interpreted as disrespecting and abusing a woman, and that such behaviours are used to "assist" the woman to push the baby out and ensure safe delivery of a live baby. Some women participants in study 2 also considered disrespect and abuse as necessary to discipline women whom they themselves labelled "disobedient" women. These are women who refuse a procedure, annoy providers by asking questions, consume "too much" of the health provider's time, and potentially make care providers so frustrated that they then behave badly towards other women. In situations where healthcare providers are already stretched to meet the needs of large numbers of women, these women are seen to monopolise and frustrate the care providers, which then impacts on the level of care other women receive. Similar findings were found in a study from Nigeria, where women believed that providers are justified in slapping or pinching "disobedient" women to discipline them (140).

A number of other studies have also emphasised the role of power imbalances, institutional and health system factors, and broader gender and social norms that facilitate the mistreatment of women (129, 140, 144, 203). Women in this study also appeared to normalise disrespect and abuse as part of receiving health care. They are placed in a position where they are encouraged

to attend health facilities for maternity care in Ethiopia for increased clinical safety but may endure disrespectful and abusive care during their birth when doing so.

8.1 Women's positioning in Ethiopian society and health care

It is concerning that both women and healthcare providers commonly stated that a woman's "uncooperativeness" and "disobedience" during childbirth was the reason why she experienced disrespect and abuse. The fact that a large number of women in this study considered asking questions as wasting time, refusal of a procedure as disobedience, and scolding by health professionals as harmless indicates how deeply societal hierarchies in Ethiopia have systematically disempowered women so that women feel, and healthcare providers perceive, that women need to automatically obey the requests of the healthcare providers, while their own needs and preferences are subjugated. This situation parallels that described in intimate partner violence literature, demonstrating how structural gender inequality is exacerbated by social pressures. Traditional and customary practices that give women lower status disempower women and are a basis for gender inequality (204). Social influences include a sense of shame and difficulty condemning violent crimes against women, a lack of resources to address the causes and effects of violence, and a lack of legislation prohibiting violence (204, 205). The responses women give to questions regarding acceptability of intimate partner violence in other studies are similar to responses women gave to the questions asked in this project about disrespect and abuse in healthcare settings.

Women's acceptance of disrespectful and abusive treatment by service providers during childbirth may be best understood within the wider context of violence in Ethiopia. For example, the 2016 Ethiopian demographic and health survey reported that the majority of women (63%) and men (28%) have attitudes that justify wife beating (51), which is similar to findings reported in Guinea, Africa (148). Justifications given and acceptability for some acts of abuse during delivery (e.g. verbal and physical abuse) and intimate partner violence are clearly similar: both are impacted by societal norms and pressures that normalise women being punished for being "difficult" or "disobedient".

In health care, the term "difficult" is often used to characterise individuals who are interpersonally or medically challenging (206, 207). Khalil studied South African nurses' attitudes towards "difficult" and "good" patients, and found the most "undesirable behaviour" that led providers to label a woman as "difficult or bad" was that they were uncooperative (208).

Patients who agree with providers and allow them be in charge are frequently preferred, and submission is typically rewarded as "good" patient behaviour (209). Labelling women who do not follow instructions, such as pushing when instructed not to, calls into question the provider's assumption that they should be in charge and that women should obey. When healthcare workers refer to women as "difficult", it suggests that they see them as "the problem".

However, deeper analysis of providers' descriptions of birthing situations that led to abuse identified more complex situations, which involved a combination of patient and provider characteristics and the environment (207). For example, women of low economic status reported more disrespect and abuse in this project, indicating another prevailing social attitude towards women in society that can impact the way they are perceived and treated in health care. Differential treatment by social status has also been found in research in the United States (210), Ghana (211) and Kenya (212). Women from lower socioeconomic classes have also been reported to be more likely to be undermined (213). Implicit bias, unintended unfavourable or positive assessment of one group in comparison to another, likely plays a role in these disparities. Signals such as a person's dialect or attire trigger a rapid and unconscious negative response (214, 215), reflecting deeper and unaddressed cultural norms and behaviours (216, 217). In addition, there are no redress procedures in Ethiopia and other low-resource countries for women to protest about mistreatment, and they are frequently denied a labour companion who could act as an advocate and give emotional support.

In a country and society such as Ethiopia, normative gender-based violence, disregard for the poor, and discriminatory treatment based on socioeconomic standing continues to play out in healthcare settings (211, 217). Most healthcare providers are positioned higher within social hierarchies than the women attending for health care. Interventions that enable care providers to be more conscious of their prejudices and their consequences and provide them with the means to address these partialities are needed to help reduce mistreatment of the underprivileged. Individual and professional recognition and acknowledgement of implicit prejudice is the first step toward reducing it (214). Furthermore, institutional policies are required to guarantee that individual prejudices do not impact patient treatment.

Another theme that emerged in study 4 is that when care providers meet a woman whom they perceive is challenging their status, they are more inclined to express authority in ways that are disrespectful and abusive, resulting in disrespectful treatment of women from wider

socioeconomic backgrounds. Some midwives stated that they felt urban women of higher socioeconomic status were undermining them and questioning their professional competence. Some healthcare providers suggested that yelling at or slapping these labouring women was the best method to demonstrate dominance or to get her to comply.

While prior research has revealed that Ethiopian women generally accept care from male midwives (145), an unexpected finding within the survey was that women who were attended by female providers were more likely to report disrespect and abuse. Similarly, the qualitative findings from both women's and care providers' interviews indicated that male providers are well accepted and preferred, and perceived to be more caring. This finding conflicts with research performed elsewhere, where female caregivers were assumed to treat women better (218). Given the Ethiopian gender norm and the prevalent gender-based violence, it was surprising to find in this study that male midwives were often perceived by women attending birthing services as more compassionate and less abusive than female midwives. On further investigation, similar findings were observed in research from Mozambique where women attended by female care providers reported higher rates of disrespect and abuse (219). What is unknown is whether women have different expectations of male and female healthcare providers, or whether female healthcare providers are in fact more abusive.

A deeper analysis of how women healthcare providers are perceived and positioned has identified that care providers in this project ascribed disrespect and abuse to the societal norms that depict women as weaker than men, more susceptible to influence and incapable of making decisions. Such cultural beliefs appear to weaken women by instilling biased assumptions about how women should be treated and behave, which is reflected in maternity care settings. In Ethiopia, female healthcare practitioners are positioned poorly within the healthcare system and, perhaps, in society as a whole. Gender equality is not achieved in education or health care; women are underrepresented in tertiary education and the healthcare workforce. Furthermore, research has revealed that when people are anxious deep-seated prejudices are more likely to surface (215). As a result, the high stress of maternity care in low-resource settings for female healthcare providers may intensify their unconscious bias and prejudices.

Hegemonic power dynamics in maternity wards further devalue birthing women, resulting in the normalisation and acceptability of healthcare workers' use of abusive techniques to assert power and penalise disobedience (220). Despite the fact that midwives form the backbone of maternity services in developing countries, they frequently work in disempowering

circumstances where their efforts are not sufficiently recognised and they are unsupported and disrespected by their supervisors (221). Midwives are mostly women who work in their local communities, where they experience many of the same issues as women attending for care, such as poor social standing, disrespect and gender inequity. Moreover, the healthcare system, particularly in public institutions, may be a debilitating atmosphere characterised by poor wages, understaffing and physical resource limits. Working under such circumstances is disempowering for healthcare workers, and there are few options for reducing stress and increasing motivation.

Given that both men and women caregivers in resource-constrained settings are constantly subjected to stressors such as increased workload, poor working conditions, limited supplies and equipment, and low compensation, as identified in a systematic mapping of barriers in low- and middle-income countries from the provider perspective, the impact of the environment in difficult birthing situations is particularly important (217, 222). Burnout develops as a result of prolonged exposure to these stresses without proper redress mechanisms, manifesting as overwhelming tiredness, cynicism, diminished empathy, numbness and reactivity, preventing caregivers from adequately responding to their patients (223-225). Moreover, traumatic experiences such as losing a baby and stillbirths are common in low-income countries such as Ethiopia (226). Traumatic events cause persistent high arousal and excessive responses in every circumstance that is even loosely related to the preceding trauma, according to trauma theory (224). As a result of the dread of losing the newborn, providers' responses in stressful situations may be exaggerated, leading to increased levels of mistreatment. This was also indicated in a systematic mapping of barriers in low- and middle-income countries from the provider perspective (217) and a study from Kenya that explored providers' perspectives on respectful maternity care (227).

In low-resource countries, the labour and delivery ward is a hotbed for difficult and complex circumstances: it has women attending for delivery who may be deemed difficult because their needs are not being addressed, and demotivated and stressed healthcare providers working under challenging conditions, influenced by societal and rigid expectations of how a woman in labour should behave. Providers prefer clarity, order and control and feel frustrated and tense when this is disrupted and they feel out of control (207). Ndwiga et al. from Kenya found that these complexities result in negative emotions and responses such as rage, impatience, fear, hatred and hopelessness (227). It is unlikely that unfavourable events can be totally avoided in the unique, dynamic and complex context of birthing. However, responses such as frustration

can be reduced by assisting caregivers in anticipating problems, preparing for them, and ensuring that they have the resources to deliver effective care (228).

The findings of this project need to be understood in the context of a healthcare system that is seeking to expand and improve access to maternity care, but is also experiencing significant staffing, facility and resource limitations. According to the interviews with care providers (study 4), mistreatment mostly happens when overworked caregivers encounter "non-compliant" women, overcrowding and a heavy workload, further increasing providers' frustration and decreasing their ability to provide care. Any training programs focusing on patient disrespect and abuse must be supplemented by strategies that address health system and structural concerns regarding the burden on providers. The feasibility and effectiveness of both training and addressing workload concerns requires further operational and evaluation research.

Unlike studies undertaken in neighbouring nations, no substantial reports of inappropriate demands for payment from care providers or detention for non-payment were reported in this project. This reflects similar findings of other studies in Ethiopia (30, 43, 109, 110, 119, 229, 230) and is possibly due to maternity services being free of charge in Ethiopia. When compared to other sub-Saharan African research (194), reports of neglect and denial of care were rarely found in this project. When such mistreatment was recorded, it was connected to specific personal attributes rather than racial prejudice or monetary concerns.

8.2 Significance of the thesis

This research was the first to triangulate mixed-methods quantitative and qualitative data from both women and healthcare providers to explore perspectives on and determine the prevalence of disrespect and abuse during facility-based childbirth Ethiopia. The findings of this project contribute significantly to the rapidly emerging literature on the mistreatment of women. Specifically, this project provides an understanding of women's experiences, analyses one woman's experience in depth, and explores more broadly healthcare providers' and women's perspectives on disrespect and abuse, and the perceived factors that contribute to it. Furthermore, this project was conducted in North Showa zone of Oromia region where no previous research has been undertaken on this topic. The findings of this research can help inform future research and be used as baseline data for further interventional studies which aim to improve maternity care.

This project privileges women's voice in maternity care and has created an evidence base to inform future education/training and policy. More specifically, the findings are important for the North Showa zone health office, Oromia regional health bureau and the federal health ministry policy makers, as they indicate a change is required to improve care providers' working conditions in order to improve women's experiences in the delivery room.

8.3 Strengths and limitations of the study

8.3.1 Strengths

A mixed-methods design was used which enabled the researcher to comprehensively investigate women's experiences and explore their and care providers' perspectives. Study 1 employed a validated instrument which has adequate validity and reliability measurement scores. This ensured that the quantitative findings are comparable to those in other countries using the same survey.

Another strength is that the project was conducted by an Ethiopian health professional who understands the health system and society.

8.3.2 Limitations

There are four areas of limitations in this project.

First, the involvement of women and care providers in this project was entirely voluntary. As a result, experiences and viewpoints of people who chose not to participate were not recorded, and so their perspectives may not have been included.

Second, studies 1 and 2 included only women who had given birth at a health facility. This possibly excluded women who might have chosen not to attend the health facility due to previous experiences of disrespect and abuse.

Third, the studies relied on self-reported experience, which is prone to recall bias and social desirability bias, in which participants might report a socially acceptable response.

Last, study 4 was carried out in five health facilities among self-selected participants in the North Showa zone, and therefore may not reflect the perceptions of care providers in other parts of Ethiopia. A national-level epidemiological investigation is indicated to enable a comprehensive understanding of the situation in Ethiopia.

Furthermore, this project was conducted in only one developing nation, and therefore may not be generalisable to other settings.

8.4 Implications for policy and practice

The findings of this study have implications for policy, healthcare practice and future research.

8.4.1 Implications for policy

This project calls for policy initiatives from a public health perspective to prevent and decrease levels of disrespect and abuse during facility-based childbirth. As a result of the increasing need for client-centred care, Ethiopia has incorporated compassionate and respectful maternity care in its latest health sector strategic plan (87). However, evidence regarding how the practices have been carried out, and their effectiveness, is unknown. This highlights the urgent need for public health stakeholders at all levels of government to take immediate action to address this issue by ensuring that respectful maternity care is included into everyday healthcare practice and to include monitoring and evaluation to track progress.

Women's acceptance of disrespectful and abusive acts by care providers is deeply embedded within the context of violence against women in Ethiopia and the societal hierarchies that have systematically disempowered women. Thus, policy makers and care providers must take these contextual and societal norms into account and devise a comprehensive intervention involving healthcare providers and birthing women that addresses these underlying perceptions. Women must be given safe platforms to identify, speak about and examine their care experiences, and discussions with clinicians and legislators must take place to unravel the uncomfortable topic of disrespect and abuse that occurs during childbirth in healthcare facilities. Furthermore, radio broadcasts and prenatal clinics should also provide women with awareness and information about respectful maternity care (231-233).

8.4.2 Implications for healthcare practice

Developing providers' interpersonal skills and changing their attitudes will involve time, motivation, practice and reinforcement. Internationally, respectful care is perceived to be a cornerstone of nursing, midwifery and medical school curricula. This project has identified the need for both pre-service and in-service training that seeks to identify, prevent and address disrespect and abuse. To shift views of healthcare providers, in-service provider training that

emphasises women's perspectives, rights and cultural roles in society is required. Training can assist caregivers to understand factors that lead to challenging circumstances and develop alternative ways of coping with those situations to further reduce disrespect and abuse. Training should also attempt to assist providers in recognising and controlling their prejudices. Such training should go beyond academic sessions and include more practical strategies that enable providers to embed and practise interpersonal skills in their constrained working environments while also critically reflecting on their values and experiences.

Furthermore, the role of management and supervision should also be considered: supportive supervision and mentorship has been found to help to empower providers in managing challenging situations and developing healthy methods of coping with stress. Providers should be both motivated and held accountable for delivering respectful and dignified care. Education and audit processes should be used to build and reinforce policies and procedures that clarify healthcare professionals' duties in the respectful maternal care process.

Findings in this project suggest that various economic and infrastructural constraints impacting health facilities play a significant role in women's mistreatment. Health facilities are underfunded, and they are significantly impacted by staff shortages, lack of supplies and medicines, and poor facility infrastructure. Strengthening health systems to address system-level stressors would improve provider–client relationships and the quality of maternity care. Healthcare facilities' physical structures need to be enhanced, and medical supplies and equipment made available to meet women's maternity care needs. It is feasible that, if midwives are given more resources to deal with difficult situations, they will not resort to mistreatment to get the desired results. Interventions that help providers cope with traumatic and other stressful circumstances while also addressing the stressors are essential.

Mistreatment of women should also be evaluated in the context of lack of respect and power relations amongst various hierarchies of providers to build a culture of respect inside facilities (216). Inter-professional rivalry plays a role in women's mistreatment, according to evidence from health professionals in this project. Birthing women are removed from the centre of the maternity care process due to conflicts between healthcare workers and the urge to demonstrate professional superiority. Methods and a system that encourage and focus on cooperation among a multidisciplinary team of care providers, such as midwives, nurses and doctors, are required.

As well as the benefits for healthcare practitioners and women, the community could also benefit from respectful care awareness initiatives. The study's findings about underlying

gender-related conceptions and societal attitudes highlight the need for interventions at a larger socio-political and communal level. Community involvement could include a range of activities such as information sharing, consultation, collaboration and collective decision-making. The benefit of including the community in the ownership and sustainability of effective interventions is clearly identified by Rifkin (234).

8.5 Directions for future research

This project has identified several areas for future research. The women participants in this study gave birth at public health facilities. Future study could investigate the experiences of women who have used private health facilities or given birth at home to see if there are any disparities in their experiences.

In addition, many women in interviews expressed sadness, dissatisfaction or distress, indicating the emotional impact of disrespect and abuse. This research included one detailed case study; however, this field of inquiry is yet to be fully explored. Future research could investigate further the negative impact of disrespect and abuse on women's health, particularly from the perspective of those who have experienced abusive treatment in health institutions. Research could also investigate the negative effects of disrespect and abuse on babies, women's partners and other family members.

The findings from the qualitative research methodology used in this project may not be generalisable to other settings (186). Therefore, large-scale studies with a representative sample size are needed to determine if the perspectives of providers and women on disrespect and abuse expressed in this project can be generalised to the region and throughout Ethiopia as well as to similar countries. Furthermore, research involving providers in multiple settings may reveal dynamics that differ by setting. Comparison of newly educated midwives and those who have been in the field for a longer time may also reveal substantial differences and disparities. Furthermore, the provider and patient perspectives were not brought together for joint qualitative analysis in this study. Rather the two qualitative and one quantitative study were brought together and triangulated for the discussion chapter. Future studies could triangulate the views of care providers and women. Moreover, future studies could include the perspectives of health facility administrators/ managers as they may be most able to address barriers/facilitators to implementing respectful care practices. The potential for interventions to generate lasting improvements in labour and delivery experiences is perhaps the most

intriguing area for further investigation. Moving beyond presenting well-documented problems, intervention research and evaluation of effectiveness is a crucial next step.

Future study on respectful maternity care in Ethiopia could also explore more fully gender dynamics, particularly the links between perceived provider authority and gender. For instance, it would be interesting to examine if women view male midwives as having more legitimacy and authority than female midwives, and if female midwives have a stronger desire to assert power in ways that manifest and are interpreted as disrespectful and abusive.

8.6 Conclusion

In general, the level of disrespect and abuse reported by women participants in the North Showa zone of Ethiopia is high. The drivers and enablers include both structural and interpersonal factors. In addition to providers' own attitudes and practices, the findings of this study suggest that health system constraints and working under high levels of stress has influenced providers' relationships with women. Women's level of acceptance of disrespectful and abusive acts from care providers varies from woman to woman, and from scenario to scenario, but is overall deeply rooted within the context of violence against women in Ethiopia and the societal hierarchies that have systematically disempowered women.

Given the current pervasiveness of disrespect and abuse during childbirth care, policy makers and care providers must take these contextual and societal norms into account and devise a comprehensive intervention involving healthcare providers and women that addresses these underlying perceptions. Women must be given safe platforms to identify, speak about and examine their care experiences, and discussions with clinicians and legislators must take place to unravel the uncomfortable topic of disrespect and abuse that occurs during childbirth in healthcare facilities.

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Appendixes

Appendix A1: participant information sheet for women participants English version

Project Title: Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study

Human research ethics committee approval number: H-2019-153

Principal investigator: Dr Janet Kelly

Student researcher: Mr Yohannes Adinew

Student's degree: PhD in Nursing

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

This research project is about how women are treated during facility-based childbirth in Ethiopia. This research will explore women's expectations and understanding of their rights, the prevalence of disrespect and abuse of women, and care providers' perspectives of disrespect and abuse during childbirth in Ethiopia. The study will identify the perspectives of both women and care providers regarding the treatment of women during childbirth in Ethiopia, and it will help to inform policy makers to promote respectful maternity care.

Who is undertaking the project?

This project is being undertaken by Mr. Yohannes Mehretie, Dr Janet Kelly, Dr Amy Marshall and Assoc. Prof. Helen Hall. This research will form the basis of Mr. Yohannes Mehretie's PhD in Nursing, at the University of Adelaide, in South Australia, Australia

under the supervision of Dr Janet Kelly, Dr Amy Marshall and Assoc. Prof. Helen Hall. This PhD study is being funded by an Australian Research training Scholarship.

Why am I being invited to participate?

You are being invited because you gave birth in health facility in the last twelve months, and we want to know your experience of the maternity care you received.

What am I being invited to do?

You are invited to participate in either a survey, an in-depth interview or group discussion with other women. You can choose which of these activities to participate in. Each activity involves answering a range of questions about your obstetric history, knowledge of respectful maternity care, experience of disrespect and abuse, and future intent to use maternity care. Each activity will be conducted face to face. The in-depth interview and group discussions will be audiotaped with your consent. The survey and interview will be held at your home or any other place of your choice whereas the group discussion will be held at community gathering points.

How much time will my involvement in the project take?

The survey and in-depth interview will take approximately 30 minutes each and the group discussion will take approximately 60 minutes. You will participate in this study only once.

Are there any risks associated with participating in this project?

There is a possibility of emotional distress as you describe past experience during the interview process. To reduce the possibility of distress, you have the right to be accompanied by the person of your choice during the interview. The presence of a family member or carer will also provide the opportunity for significant emotional support. The interview will be conducted at a time and location convenient to you to protect your privacy. You have the right to withdraw during interview at any time or within four weeks after completion of the interview without penalty.

What are the potential benefits of the research project?

By participating in this study, you will not get immediate benefit, as there will be no reimbursement for participation, but the outcomes of this study may be useful to the wider community as it may contribute to quality and safety in maternity care by providing policy makers further evidence to guide policies, inform curriculum and professional development courses.

Can I withdraw from the project?

Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time. This will not affect your current or future care.

What will happen to my information?

Privacy and Confidentiality: Data will be collected identifiably, but then de-identified via the use of unique codes. No information that could identify you will be recorded and the information you provide us will be confidential. The questionnaire will be coded, and no references will be made in oral or written reports that could link you to the research.

Storage: The completed questionnaire will be stored in a locked box, and all electronic copies of the data including audio recordings of interview will be stored in secure Adelaide University servers for five years after the last publication. Only the investigators named above will have access to the recorded data.

Publishing: The findings of the study will be reported only for the whole study population and will not report any data at an individual level. The findings of the research will be reported in a PhD thesis, published in peer-reviewed journal, and will be communicated trough academic conference, local radio station and presented to Oromia regional health bureau and administrators of all health facilities in the zone.

Sharing: You will have access to your interview transcript, and the data will be used for future related research undertaken by any researchers. The data will be shared with researchers of The University of Adelaide and future use of the data will be guided by the University regulation. Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?

If you have any questions or enquiries at any time about the study or the procedures, please contact and communicate with the investigators through phone or email address below.

Name	Telephone	Email
Dr. Janet Kelly	+61 8 83130964	janet.kelly@adelaide.edu.au
Mr. Yohannes Mehretie	+61 4 69366152	yohannes.adinew@adelaide.edu.au
Dr. Amy Marshall	+61 8 83136288	amy.marshall@adelaide.edu.au
Assoc. Prof. Helen Hall	+61 3 99044120	helen.hall@monash.edu.au

What if I have a complaint or any concerns?

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2019-153). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:

Australia
Phone: +61 8 8313 6028

Email: hrec@adelaide.edu.au

Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If you wish to contact local independent person for complaint, please contact
Salale University, College of Health sciences, Dean Office on:
Telephone: +25111 -160-93-52
Fax: +251 1160 9320
Post: 245, Fitche, Ethiopia
Email: mengstutesema@gmail.com.

If I want to participate, what do I do?
If you want to participate, please choose if you would like to participate in the survey, an in-depth interview, or a group discussion. I will read the consent form for you, and you will sign it to show your voluntary participation. Then, we will arrange a time and location convenient to you for you to participate in the study.

If I want to participate, what do I do?
You have one week to consider your participation. I will contact you after a week and if you decide to participate you will sign the consent form and we will arrange appointment and you will participate in either the survey or interview or group discussion as per your choice.

Yours sincerely,

Dr. Janet Kelly

Mr. Yohannes Mehretie

Dr. Amy Marshall

Assoc. Prof. Helen Hall

Appendix A2: Participant information sheet for women participants Amharic version

የፕሮጀክት ርዕስ፡ በኢትዮጵያ ጤና ተቋም ዉስጥ እናቶች በሚወልዱበት ወቅት የሚደረግረግላቸዉ እንክብካቤ፡ ቅይጥ ዘዴ ጥናት

የሰዉ ምርምር ስነምግባር ኮሚቴ ፍቃድ ቁጥር: H-2019-153

ዋና ተመራማር፤ ጃኔት ኬሊ

የጥናቱ ተማሪ፤ ዮሐንስ ምህረቴ አድነዉ

የተማሪ ድግሪ፤ ፒ. ኤች. ዲ በነርስንግ

ውድ ተሳታፊ፣

ከዚህ በታች በተገለፀው የምርምር ፕሮጀክት ላይ እንዲሳተፉ ተጋብዘዋል።

ፕሮጀክቱ ስለ ምንድን ነው?

ይህ የምርምር ፕሮጀክት በኢትዮጵያ ጤና ተቋማት ዉስጥ በወሊድ ወቅት ሴቶች እንዴት እንደሚስተናገዱ የሚያሳይ ነው። ይህ ጥናት ሴቶች ስለመብታቸው የሚጠብቁትን እና ግንዛቤን፣ የሴቶችን ክብር ማጣት እና መጎሳቆል እና ተንከባካቢዎች በኢትዮጵያ በወሊድ ጊዜ የሚደርስባቸውን ንቀት እና እንግልት አመለካከቶችን ይዳስሳል። ጥናቱ በኢትዮጵያ በወሊድ ወቅት የሴቶችን አያያዝ አስመልክቶ የሴቶች እና ተንከባካቢዎች ያላቸውን አመለካከት በመለየት ለፖሊሲ አውጪዎች ክብር የተላበሰ የወሊድ አገልግሎትን ለማስተዋወቅ ይረዳል።

ፕሮጀክቱን የሚያካሂደው ማነው?

ይህ ፕሮጀክት የሚካሄደው በ ተባባሪ ፕሮፌሰር ጃኔት ኬሊ፣ ዮሐንስ ምህረቴ አድነዉ፣ ዶ/ር ኤሚ ማርሻል፣ ተባባሪ ፕሮፌሰር ሄለን ሀል ነዉ፡፡ ጥናቱ አቶ ዮሐንስ ምህረቴ በአዴላይድ ዩኒቨርስቲ ፒ.ኤች.ዲ ድግሪያቸዉን ለማጠናቀቅ ከተባባሪ ፕሮፌሰር ጃኔት ኬሊ፣ ዶ/ር ኤሚ ማርሻል እና ተባባሪ ፕሮፌሰር ሄለን ሀል ጋር የምሰሩት ነዉ። ይህ የዶክትሬት ጥናት በአውስትራሊያ የምርምር ስልጠና ስኮላርሺፕ እየተደገፈ ነው።

ለምን እንድሳተፍ እየተጋበዝኩ ነው?

እርስዎ የተጋበዙት ባለፉት አስራ ሁለት ወራት ውስጥ በጤና ተቋም ስለወለዱ ነው እና ስለተቀበሉት የእናቶች እንክብካቤ ያለዎትን ልምድ ማወቅ እንፈልጋለን።

ምን እንድሰራ እየተጋበዝኩ ነው?

በዳሰሳ ጥናት፣ ጥልቅ ቃለ-መጠይቅ ወይም ከሌሎች ሴቶች ጋር በቡድን ውይይት ላይ እንድትሳተፉ ተጋብዘዋል። ከእነዚህ ተግባራት ውስጥ የትኛውን እንደሚሳተፉ መምረጥ ይችላሉ ። እያንዳንዱ እንቅስቃሴ ስለ የወሊድ ታሪክዎ ፣ የተከበረ የወሊድ እንክብካቤ እውቀት ፣ አክብሮት የጎደለው እና የመጎሳቆል ልምድ እና የወደፊት የወሊድ እንክብካቤን በተመለከተ የተለያዩ ጥያቄዎችን መመለስን ያካትታል ። እያንዳንዱ እንቅስቃሴ ፊት ለፊት ይከናወናል፡፡ ጥልቅ ቃለ-መጠይቁ እና የቡድን ውይይቶቹ በእርስዎ ፍቃድ በድምጽ ይቀረጻሉ። የዳሰሳ ጥናቱ እና ቃለ መጠይቁ በቤትዎ ወይም በመረጡት ሌላ ቦታ የሚደረጉ ሲሆን የቡድን ውይይቱ የሚካሄደው በማህበረሰብ መሰብሰቢያ ቦታዎች ነው።

በጥናቱ መሳተፍ ምንህል ግዜ ወስዳል?

የጥናቱ ተሳትፎ ፍትለፍት ቀለመጠየቅ ማድረግ ነዉ። ቀለመጠየቁ በግምት 30 ደቂቃ ይወስዳል፤ መጠየቁን አንዴ ብቻ ትጠየቃለህ። ለተሳተፎ የምሰጥ/የምከፈል ምንም የለም።

በዚህ ፕሮጀክት ውስጥ ከመሳተፍ ጋር የተያያዙ አደጋዎች አሉ?

በቃለ መጠይቁ ሂደት ውስጥ ያለፈውን ልምድ ሲገልጹ የስሜት ጭንቀት ሊኖር ይችላል. የጭንቀት እድልን ለመቀነስ በቃለ መጠይቁ ወቅት ከመረጡት ሰው ጋር አብሮ የመሄድ መብት አለዎት. የቤተሰብ አባል ወይም ተንከባካቢ መኖሩ ጉልህ የሆነ ስሜታዊ ድጋፍ ለማግኘት እድል ይሰጣል። ቃለ መጠይቁ የሚካሄደው የእርስዎን ግላዊነት ለመጠበቅ

በሚመችዎ ጊዜ እና ቦታ ነው። በቃለ መጠይቁ ወቅት በማንኛውም ጊዜ ወይም በአራት ሳምንታት ውስጥ ያለ ቅጣት ቃለ መጠይቁን ከጨረሱ በኋላ የመተው መብት አልዎት።

የጥናት ፕሮጀክቱ ሊሆኑ የሚችሉ ጥቅሞች ምንድ ናቸው?

በዚህ ጥናት ውስጥ በመሳተፍ ወዲያውኑ ጥቅም አያገኙም, ምክንያቱም ለተሳትፎ የሚከፈል ክፍያ አይኖርም, ነገር ግን የዚህ ጥናት ውጤት ለሰፊው ማህበረሰብ ጠቃሚ ሊሆን ይችላል, ምክንያቱም ፖሊሲ አውጪዎችን በማቅረብ በወሊድ እንክብካቤ ጥራት እና ደህንነት ላይ አስተዋፅኦ ይኖረዋል. ፖሊሲዎችን ለመምራት, ሥርዓተ-ትምህርት እና የሙያ ማሻሻያ ኮርሶችን ለማሳወቅ ተጨማሪ ማስረጃዎች.

ከፕሮጀክቱ መውጣት እችላለሁ?

በዚህ ፕሮጀክት ውስጥ መሳተፍ ሙሉ በሙሉ በፈቃደኝነት ነው. ለመሳተፍ ከተስማሙ በማንኛውም ጊዜ ከጥናቱ መውጣት ይችላሉ። ይህ የአሁኑን እና የወደፊት እንክብካቤዎን አይጎዳውም.

የእኔ መረጃ ምን ይሆናል?

ግላዊነት እና ሚስጥራዊነት፡ ውሂብ በሚለይ መልኩ ይሰበሰባል፣ ነገር ግን ልዩ የሆኑ ኮዶችን በመጠቀም ከመለየት ይሰረዛል። እርስዎን የሚለይ ምንም አይነት መረጃ አይመዘገብም እና ያቀረቡት መረጃ ሚስጥራዊ ይሆናል። መጠይቁ ኮድ ይደረጋል፣ እና እርስዎን ከጥናቱ ጋር ሊያገናኝዎት የሚችል የቃል ወይም የጽሁፍ ዘገባዎች ማጣቀሻዎች አይደረጉም።

ማከማቻ፡ የተጠናቀቀው መጠይቅ በተቆለፈ ሣጥን ውስጥ ይከማቻል፣ እና ሁሉም ኤሌክትሮኒክ ቅጂዎች የቃለ መጠይቁ የድምጽ ቅጂዎችን ጨምሮ ደህንነቱ በተጠበቀ የአዴሌድ ዩኒቨርሲቲ አገልጋዮች ውስጥ ከመጨረሻው ህትመት በኋላ ለአምስት ዓመታት ይቀመጣሉ። ከላይ የተጠቀሱት መርማሪዎች ብቻ የተቀዳውን መረጃ ማግኘት ይችላሉ።

ማተም፡ የጥናቱ ግኝቶች ለጠቅላላው የጥናት ህዝብ ብቻ ሪፖርት ይደረጋል እና በግለሰብ ደረጃ ምንም አይነት መረጃ አይዘግብም. የጥናቶቹ ግኝቶች በፒኤችዲ ተሲስ፣ በአቻ ግምገማ ጆርናል ላይ የሚታተሙ ሲሆን በአካዳሚክ ኮንፈረንስ፣ በአገር ውስጥ ሬዲዮ ጣቢያ ተላልፈው ለኦሮሚያ ክልል ጤና ቢሮ እና ለዞኑ የሁሉም ጤና ተቋማት አስተዳዳሪዎች ይቀርባል።

ማጋራት፡ የቃለመጠይቁን ግልባጭ ማግኘት ትችላላችሁ፣ እና ውሂቡ ወደፊት በማናቸውም ተመራማሪዎች ለሚደረጉ ተዛማጅ ምርምሮች ጥቅም ላይ ይውላል። መረጃው ከአድላይድ ዩኒቨርሲቲ ተመራማሪዎች ጋር ይጋራል እና ለወደፊቱ የመረጃ አጠቃቀም በዩኒቨርሲቲው ደንብ ይመራል. የእርስዎ መረጃ በዚህ የተሳታፊ መረጃ ወረቀት ላይ በተገለጸው መሰረት ብቻ ጥቅም ላይ ይውላል እና በህግ ካልተጠየቀ በስተቀር ይፋ የሚሆነው በተሰጠው ፈቃድ መሰረት ብቻ ነው።

ስለ ፕሮጀክቱ ጥያቄዎች ካሉኝ ማንን አነጋግራለሁ?

ስለ ጥናቱ ወይም አካሄዶቹ በማንኛውም ጊዜ ማንኛውም አይነት ጥያቄ ወይም ጥያቄ ካሎት፣ እባክዎን ከዚህ በታች ባለው ስልክ ወይም ኢሜል መርማሪዎችን ያነጋግሩ እና ያነጋግሩ።

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ቅሬታ ወይም ስጋት ቢኖረኝስ?

ጥናቱ በአደሌድ ዩኒቨርሲቲ (የማጽደቂያ ቁጥር H-2019-153) በሰዎች ምርምር ሥነ-ምግባር ኮሚቴ ጸድቋል። ይህ የምርምር ፕሮጀክት የሚካሄደው በ 2007 (እ.ኤ.አ. የተሻሻለው 2018) በኤንኤችኤምአርሲ ብሔራዊ የሥነ ምግባር መግለጫ መሠረት ነው። በፕሮጀክቱ ውስጥ ካለው ተሳትፎዎ ተግባራዊ ገጽታዎች ጋር የተያያዙ ጥያቄዎች ወይም ችግሮች ካሉዎት፣ ወይም ስለ ፕሮጀክቱ ስጋት ወይም ቅሬታ ለማንሳት ከፈለጉ፣ ዋናውን መርማሪ ማማከር አለብዎት። ከገለልተኛ ሰው ጋር ስለ ስጋቶች ወይም ቅሬታዎች፣ የዩኒቨርሲቲው የሰው ልጅ ተሳታፊዎችን በሚያሳትፍ የምርምር ፖሊሲ ወይም እንደ ተሳታፊ ያለዎትን መብቶች በተመለከተ፣ እባክዎን የሰብአዊ ጥናትና ምርምር ስነ-ምግባር ኮሚቴን ሴክሬታሪያትን ያነጋግሩ።

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ማንኛውም ቅሬታ ወይም ስጋት በምስጢር ይታከማል እና ሙሉ በሙሉ ይመረመራል። ውጤቱን ይነግርዎታል።

ለቅሬታ የአካባቢውን ገለልተኛ ሰው ማነጋገር ከፈለጉ እባክዎን ያነጋግሩ

የሰላሌ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ ዲን ጽ/ቤት በ፡

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መሳተፍ ከፈለግኩ ምን አደርጋለሁ?

መሳተፍ ከፈለጉ፣ እባክዎን በዳሰሳ ጥናቱ፣ በጥልቀት ቃለ መጠይቅ ወይም በቡድን ውይይት መሳተፍ ከፈለጉ ይምረጡ። የስምምነት ቅጹን አነብልዎታለሁ፣ እና እርስዎ በፈቃደኝነት ተሳትፎዎን ለማሳየት ይፈርሙበታል። ከዚያም በጥናቱ ላይ ለመሳተፍ አመቺ ጊዜ እና ቦታ እናዘጋጅልዎታለን።

መሳተፍ ከፈለግኩ ምን አደርጋለሁ?

ተሳትፎዎን ለማጤን አንድ ሳምንት አለዎት። ከሳምንት በኋላ አነጋግርዎታለሁ እና ለመሳተፍ ከወሰኑ የፍቃድ ቅጹን ይፈርማሉ እና ቀጠሮ እናዘጋጃለን እና እርስዎ በመረጡት የዳሰሳ ጥናት ወይም ቃለ መጠይቅ ወይም የቡድን ውይይት ውስጥ ይሳተፋሉ።

ከአክብሮት ጋር,
ተ/ፕሮፌሰር ጃኔት ኬሊ
አቶ ዮሐንስ ምህረቴ
ዶክተር ኤሚ ማርሻል
ተ/ፕሮፌሰር ሄለን ሀል

Appendix B1: Survey questionnaire; English version

Part 1: Sociodemographic questions		
1	How old are you?	_____ Years
2	Residence	☐ Urban ☐ Rural
3	What is your current marital status?	☐ Never married/single ☐ Currently married ☐ Divorced ☐ Widowed ☐ Other _____ ☐ Unknown
4	What is your highest level of formal education?	☐ No education ☐ Pre-primary education ☐ Primary education ☐ Secondary education ☐ Post-secondary/tertiary education ☐ Other ☐ Vocational training ☐ Unknown ☐ If other, specify: _____
5	Work	☐ Unemployed ☐ Governmental employee ☐ Private employee ☐ Farmer ☐ Others, specify_____
6	Monthly household income?	☐ _____
7	Spouse occupation	☐ Governmental employee ☐ Private employee ☐ Farmer

		☐ Unemployed ☐ Others, specify_____
Part 2: Obstetric history		
1	Approximately how many minutes' walking is your house from the hospital where you gave birth?	_____ Minutes
2	How many times have you given birth to a live baby (that lived or died)?	_____
3	How many of your children were born at health facility? (Including most recent childbirth	_____
4	Have you visited any facility/ facilities during your recent pregnancy for antenatal check-up?	☐ Yes ☐ No
5	Was it same facility where you delivered your baby?	☐ Yes ☐ No
6	Type of health facility visited for birth	☐ Health center ☐ Hospital
7	For your most recent childbirth, by what method did you give birth?	☐ Vaginal delivery ☐ Caesarean section ☐ Don't know
8	At your most recent childbirth, did you have one baby or two babies (twins)?	☐ One baby (single birth) ☐ Two babies (twin)
9	Which health worker looked after you most of the time during your recent childbirth in hospital?	☐ No attendant ☐ Obstetrician ☐ General Doctor ☐ Midwife ☐ Nurse ☐ Nursing Student ☐ Midwifery Student ☐ Other

		☐ Unknown/Not Sure ☐ If other, specify: _____
10	What was sex of the care provider	☐ Male ☐ Female ☐ I don't remember

Part 3: Disrespect and Abuse

Some women tell us when they give birth they are mistreated or treated with disrespect while in the hospital. We would like to know how common this problem is, so we would like to ask you your own experiences with childbirth. There are no right or wrong answers to these questions. It is only important to us that we understand your experiences. Nothing you tell us 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 upsetting or stressful. As I said before, you can skip any question you are not comfortable answering, and you can stop the interview at any point.

Physical Abuse

At any time during your time in the hospital, did any of the following events occur?

1. You were pinched/kicked/slapped by a health worker or other staff?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
2. You were hit with an instrument by a health worker or other staff?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
3. You were gagged (eg: something put across or in your mouth to prevent you from speaking or making noise) by a health worker or other staff?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
4. You were physically tied/ held down forcefully to the bed by a health worker or other staff?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know

5. You had forceful downward pressure placed on your abdomen before the baby came out (fundal pressure)?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
6. Were you permitted to deliver in your preferred birthing position?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown

7. During your time in the hospital, were you denied pain relief for any reason?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
8. Were you told that you could walk or move around during labour?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown

9. Did you have easy access to water or other oral fluids?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
10. Were you allowed to eat?
    - ☐ No
    - ☐ Yes
    - ☐ Refuse
    - ☐ Don't know/Unknown

Non-dignified care

During your time in the hospital, did any of the following events occur?

1. Were you shouted or screamed at by a health worker or other staff?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
2. Were you insulted or scolded or mocked by a health worker or other staff?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
3. Did the health worker or other staff member made negative comments about your/ your baby's physical appearance (such as your weight, private parts, cleanliness or other parts of your body)?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
4. Did the health worker or other staff member made negative comments to you regarding your sexual activity?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know

5. Did the health worker or other staff threaten you with a physical violence or medical procedure (such as episiotomy or caesarean section)?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
6. Did the health worker or other staff threatened you that if you did not comply, you or your baby would have poor outcome?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
7. Did the health worker or other staff threatened you to withhold care from you or your baby?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
8. Did the health worker or other staff blamed you for something that happened to you or your baby during your time in hospital?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
9. Did the health worker or other staff hissed at you during your time in hospital?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know

Discriminatory care

During the time in hospital, did any of the following events occur?

1. A health worker or staff made negative comments to you regarding your ethnicity or religion:
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
2. A health worker or staff made negative comments to you regarding your age:
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
3. A health worker or staff made negative comments to you regarding whether you were married or not:
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
4. A health worker or staff made negative comments to you regarding your level of education or literacy:
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
5. A health worker or staff made negative comments to you regarding your economic circumstances:
   - ☐ No
   - ☐ Yes

☐ Refuse ☐ Don't know

6. A health worker or staff made negative comments to you regarding your HIV status:
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know
7. During your time in hospital, did you get a language interpreter?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown

Non-consented care

1. Have you received vaginal examination?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know
2. Did the health worker explain to you why a vaginal examination was needed?
   ☐ No ☐ Refuse ☐ Don't know
   ☐ Yes
3. Did the health worker ask you permission before performing vaginal examination?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know
4. Did the health worker protect your privacy while performing vaginal examination?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know
5. Did you receive episiotomy?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
6. If yes, did you agree to the procedure?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
7. Was postpartum IUD Insertion or tubal ligation / sterilization received?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
8. If yes, did you agree to the procedure?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
9. Was induction or augmentation of labor received?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
10. If yes, did you agree to the procedure?
    ☐ No ☐ Refuse
    ☐ Yes ☐ Don't know/Unknown

Non-confidential care

1. Did a staff member discuss your private information about your health in a way that others could hear?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know
2. Were curtains, partitions, or other measures used to provide privacy for you from other patients, patients' family members, or health workers/staff not involved in providing you care?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
3. Did you have a bed to yourself during labour?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
4. Did you have a bed to yourself during childbirth?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
5. At any time, did you have to share a bed with another woman or women?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
6. Were vaginal examinations conducted privately (in a way that other people could not see)?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know

Abandonment or denial of care

1. Was any health worker present when the baby came out?
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown

   Do you agree with the following statements?
2. During my time in hospital for childbirth I felt ignored by the health workers or staff:
   - ☐ No
   - ☐ Yes
   - ☐ Refuse
   - ☐ Don't know/Unknown
3. During my time in hospital for childbirth I had to wait for long periods of time before I was attended by health workers:
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly disagree
   - ☐ Unknown
4. During my time in hospital for childbirth I felt emotionally supported by the health workers or staff:
   - ☐ No
   - ☐ Yes

☐ Refuse ☐ Don't know/Unknown

5. During my time in hospital for childbirth, the health workers or staff listened to my concerns:
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
6. During my time in hospital for childbirth, the health workers or staff responded to my questions or concerns:
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
7. During your time in hospital, were you allowed to have a birth companion present? For example, this includes your husband, a friend, sister, mother-in-law, etc.?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown

Detention in facility

1. Were you or your baby or your companion detained in the hospital due to inability to pay hospital bills?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
2. After the birth, were you instructed to clean up your own blood, urine, feces or amniotic fluid?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown
3. Did staff suggest or ask you (or your family or friends) for a bribe, informal payment or gift?
   ☐ No ☐ Refuse
   ☐ Yes ☐ Don't know/Unknown

Appendix B2: Survey questionnaire; Amharic version

ክፍል 1፡ ሶሺዮዲሞግራፊ ጉዳዮች		
1	እድሜዎ ስንት ነው?	_____ ዓመት
2	መኖሪያ	☐ ከተማ ☐ ገጠር
3	የጋብቻ ሁኔታ ምንድነዉ?	1=ያላገባ/ች 2=ያገባ/ች 3=የተለያዩ 4=የተፋቱ ☐ 5=የሞቼችበት/የሞቼባት
4	ያጠናቀቀዉ ከፍተኛ የትምህርት ደረጃ ምንድነዉ?	1=መደበኛ ትምህረት ያልተከታተለ 2=ከአንደኛ ደረጃ በታች 3=አንደኛ ደረጃ ያጠናቀቀ/ች 4=ሁለተኛ ደረጃ ያጠናቀቀ/ች 5=ኮሌጅ/ዩኒቨርስቲ ያጠናቀቀ/ች 6=ድህረ ምረቃ ትምህረት ያጠናቀቀ/ች 7=መመለስ አልፈልግም 8=አላዉቅም ☐ 9=ሌላ መልስ -------
5	ሥራ	☐ ሥራ አጥ ☐ የመንግስት ሰራተኛ ☐ የግል ሰራተኛ ☐ እርሻ ☐ ሌሎች፣ ይግለጹ_____
6	ወርሃዊ የቤተሰብ ገቢ?	☐ _____
7	የትዳር ጓደኛ ሥራ	☐ የመንግስት ሰራተኛ ☐ የግል ሰራተኛ ☐ እርሻ ☐ ሥራ አጥ ☐ ሌሎችን ይግለጹ _____
ክፍል 2፡ የወሊድ እና ማህፀን ህክምና ታሪክ		

1	ቤትሽ ከወለድሽበት ሆስፒታል በስንት ደቂቃ የእግር መንገድ ነው?	_____ ደቂቃ
2	ስንት ጊዜ ሕፃን ወለድሽ (የኖረ ወይም የሞተ)?	_____
3	ስንት ልጆችዎ በጤና ተቋም ተወለዱ? (የመጨረሻ ልጅ ጨምሮ	_____
4	በቅርብ እርግዝናዎ ወቅት ለቅድመ ወሊድ ምርመራ ማንኛውንም ተቋም/ፋሲሊቲ ጎብኝተዋል?	□ አዎ □ የለም
5	ልጅዎን የወለዱበት ተመሳሳይ ተቋም ነበር?	□ አዎ □ የለም
6	ለመውለድ የተጎበኘው የጤና ተቋም ዓይነት	□ ጤና ጣቢያ □ ሆስፒታል
7	በቅርብ ጊዜ ለመውለድዎ, በየትኛው ዘዴ ነው የወለዱት?	☐ የሴት ብልት መውለድ ☐ ቀዶ ህክምና ☐ አላውቅም
8	በቅርብ ጊዜ በምትወልድበት ጊዜ አንድ ልጅ ወይም ሁለት ሕፃናት (መንትዮች) ነበራችሁ?	☐ አንድ ሕፃን ☐ ሁለት ሕፃናት (መንትዮች)
9	በሆስፒታል ውስጥ በቅርብ ጊዜ በወሊድ ጊዜዎ ብዙ ጊዜ የሚንከባከበዎት የትኛው የጤና ሰራተኛ ነው?	☐ ረዳት የለም። ☐ የማህፀን ሐኪም ☐ አጠቃላይ ዶክተር ☐ አዋላጅ ☐ ነርስ ☐ የነርሲንግ ተማሪ ☐ አዋላጅ ተማሪ ☐ ሌላ ☐ ያልታወቀ/እርግጠኛ ያልሆነ ☐ ሌላ ከሆነ፡ ይግለጹ፡- _____
10	የእንክብካቤ ሰጪው ጾታ ምን ነበር	☐ ወንድ ☐ ሴት ☐ አላስታውስም።

ክፍል 3: አክብሮት ማጣት እና ጥቃት

አንዳንድ ሴቶች ሲወልዱ በደል እንደተፈፀመባቸው ወይም በሆስፒታል ውስጥ እያሉ በአክብሮት መታከም እንዳለባቸው ይነግሩናል። ይህ ችግር ምን ያህል የተለመደ እንደሆነ ለማወቅ እንፈልጋለን፣ ስለዚህ ከወሊድ ጋር በተያያዘ የራስዎን ተሞክሮ ልንጠይቅዎ እንፈልጋለን። ለእነዚህ ጥያቄዎች ትክክለኛ ወይም የተሳሳቱ መልሶች የሉም። የእርስዎን ተሞክሮዎች መረዳታችን ለእኛ ብቻ አስፈላጊ ነው። ምንም የሚነግሩን ነገር ከእርስዎ ስም፣ ከልጆችዎ ስም ወይም ከእርስዎ ወይም ከቤተሰብዎ አባላት የጤና አገልግሎት የማግኘት ችሎታ ጋር አይገናኝም። ከእነዚህ ጥያቄዎች መካከል አንዳንዶቹ የሚያናድዱ ወይም የሚያስጨንቁ ሊሆኑ ይችላሉ። ቀደም ብዬ እንዳልኩት፣ መልስ ለመስጠት ያልተመቸዎትን ማንኛውንም ጥያቄ መዝለል ይችላሉ፣ እና በማንኛውም ጊዜ ቃለ-መጠይቁን ማቆም ይችላሉ።

አካላዊ ጥቃት

በሆስፒታል ቆይታዎ በማንኛውም ጊዜ፣ ከሚከተሉት ከስተቶች ውስጥ የትኛውም ተከስቷል?

11. በጤና ሰራተኛ ወይም በሌላ ሰራተኛ ቆንጥጦ/ተረገጠ/ በጥፊ ተመታ?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም
12. በጤና ሰራተኛ ወይም በሌላ ሰራተኛ በመሳሪያ ተመታህ?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም
13. በጤና ሰራተኛ ወይም በሌላ ሰራተኛ ተጭኖብዎታል (ለምሳሌ፡- እርስዎን ከመናገር ወይም ከመጮህ የሚከለክል ነገር በአፍዎ ወይም በአፍዎ ውስጥ የተተከለ ነገር) በጤና ሰራተኛ ወይም በሌላ ሰራተኛ?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም
14. በጤና ሰራተኛ ወይም በሌላ ሰራተኛ በአካል ታስረው ወደ አልጋው በኃይል ተይዘዋል?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም
15. ህጻኑ ከመውጣቱ በፊት (የፈንድ ግፊት) በሆድዎ ላይ ኃይለኛ ወደታች ግፊት ተደረገ?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም
16. በምትመርጥበት የወሊድ ቦታ እንድትወልድ ተፈቅዶልሃል?
    - ☐የለም
    - ☐እምቢ
    - ☐አዎ
    - ☐አላውቅም

17. በሆስፒታል ቆይታዎ በማንኛውም ምክንያት የህመም ማስታገሻ ተከልክሏል?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም
18. በወሊድ ጊዜ በእግር መሄድ ወይም መንቀሳቀስ እንደሚችሉ ተነግሮዎታል?
    - ☐የለም
    - ☐እምቢ
    - ☐አዎ
    - ☐አላውቅም

19. ውሃ ወይም ሌላ የአፍ ውስጥ ፈሳሾች በቀላሉ ማግኘት ችለዋል?
    - ☐ የለም
    - ☐ እምቢ
    - ☐ አዎ
    - ☐ አላውቅም

20. እንድትበይ ተፈቅዶልሻል?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

ክብር የሌለው እንክብካቤ

በሆስፒታል ውስጥ በነበሩበት ጊዜ ከሚከተሉት ክስተቶች ውስጥ የትኛውም ተከስቷል?

1. በጤና ሰራተኛ ወይም በሌላ ሰራተኛ ተጮህብሽ ነበር?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

2. በጤና ሰራተኛ ወይም በሌሎች ሰራተኞች ተሳድበዋል ወይም ተነቅፈዋል ወይም ተሳለቁበት?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

3. የጤና ባለሙያው ወይም ሌላ ሰራተኛ ስለ ልጅዎ/የልጅዎ አካላዊ ገፅታ (እንደ ክብደትዎ፣ የግል ክፍሎቻችሁ፣ ንፅህናዎ ወይም ሌሎች የሰውነትዎ ክፍሎች ያሉ) አሉታዊ አስተያየቶችን ሰጥተዋል?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

4. የጤና ሰራተኛው ወይም ሌላ ሰራተኛ ስለ ወሲባዊ እንቅስቃሴዎ አሉታዊ አስተያየት ሰጥተውዎታል?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

5. የጤና ሰራተኛው ወይም ሌሎች ሰራተኞች በአካላዊ ጥቃት ወይም በህክምና ሂደት (እንደ ኤፒሲዮቶሚ ወይም ቄሳሪያን ክፍል) አስፈራርተውብዎታል?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

6. የጤና ሰራተኛው ወይም ሌላ ሰራተኛ ካላዘዙት እርስዎ ወይም ልጅዎ መጥፎ ውጤት እንደሚኖርዎት አስፈራርተውዎት ነበር?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

7. የጤና ሰራተኛው ወይም ሌሎች ሰራተኞች ለእርስዎ ወይም ለልጅዎ እንክብካቤን እንደሚከለክሉ አስፈራርተውብዎታል?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

8. በሆስፒታል ውስጥ በነበሩበት ወቅት በአንተ ወይም በልጅህ ላይ ለደረሰው ነገር የጤና ባለሙያው ወይም ሌሎች ሰራተኞች ወቀሱህ?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

9. በሆስፒታል ቆይታዎ የጤና ሰራተኛው ወይም ሌሎች ሰራተኞች ያፍጨብዎታል?

☐ የለም ☐ እምቢ

☐ አዎ ☐ አላውቅም

ኢድሎአዊ እንክብካቤ

በሆስፒታል ውስጥ በነበረበት ጊዜ, ከሚከተሉት ክስተቶች ውስጥ የትኛውም ተከስቷል?

1. አንድ የጤና ሰራተኛ ወይም ሰራተኛ ብሄርዎን ወይም ሀይማኖትን በተመለከተ አሉታዊ አስተያየቶችን ሰጥተዋል፡-
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
2. የጤና ሰራተኛ ወይም ሰራተኛ እድሜዎን በተመለከተ አሉታዊ አስተያየቶችን ሰጥተዋል፡-
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
3. አንድ የጤና ሰራተኛ ወይም ሰራተኛ ባለትዳር መሆንዎን ወይም አለመሆኑን በተመለከተ አሉታዊ አስተያየቶችን ሰጥተውዎታል፡-
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
4. የጤና ሰራተኛዎ ወይም ሰራተኛዎ የእርስዎን የትምህርት ደረጃ ወይም ማንበብና መፃፍ በተመለከተ አሉታዊ አስተያየቶችን ሰጥተዋል።
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
5. አንድ የጤና ሰራተኛ ወይም ሰራተኛ በኢኮኖሚ ሁኔታዎ ላይ አሉታዊ አስተያየቶችን ሰጥተዋል።
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
6. የጤና ሰራተኛ ወይም ሰራተኛ የኤችአይቪ ሁኔታዎን በተመለከተ አሉታዊ አስተያየቶችን ሰጥተዋል፡-
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
7. በሆስፒታል ቆይታዎ የቋንቋ አስተርጓሚ አግኝተዋል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም

ያልተፈቀደ እንክብካቤ

1. የሴት ብልት ምርመራ ተደርጎሎታል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
2. የጤና ባለሙያው የሴት ብልት ምርመራ ለምን እንደሚያስፈልግ ገልጾልዎታል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
3. የጤና ባለሙያው የሴት ብልት ምርመራ ከማድረግዎ በፊት ፍቃድ ጠይቆዎታል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
4. የሴት ብልት ምርመራ በሚያደርጉበት ወቅት የጤና ባለሙያው የእርስዎን ግላዊነት ጠብቋል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም

5. ስቲች ተስርቶሎታል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
6. አዎ ከሆነ፣ በሂደቱ ተስማምተሃል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
7. ድኅረ ወሊድ IUD ማስገባት ወይም ቱቦል ligation / ማምከን ተቀብሏል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
8. አዎ ከሆነ፣ በሂደቱ ተስማምተሃል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
9. የጉልበት ሥራን ማነሳሳት ወይም መጨመር ተቀብሏል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
10. አዎ ከሆነ፣ በሂደቱ ተስማምተሃል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም

ሚስጥራዊ ያልሆነ እንክብካቤ

1. አንድ የሰራተኛ አባል ስለ ጤናዎ የግል መረጃዎን ሌሎች ሊሰሙት በሚችሉት መልኩ ተወያይተዋል?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
2. ከሌሎች ታካሚዎች፣ የታካሚዎች ቤተሰብ አባላት ወይም የጤና ሰራተኞች/ሰራተኞች ለእርስዎ ግላዊነትን ለመስጠት መጋረጃዎች፣ ክፍልፋዮች ወይም ሌሎች እርምጃዎች ለእርስዎ እንክብካቤ ለመስጠት አልተሳተፉም?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
3. በምጥ ጊዜ ለራስሽ አልጋ ነበረሽ?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
4. በወሊድ ጊዜ ለራስሽ አልጋ ነበረሽ?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
5. በማንኛውም ጊዜ፣ ከሌላ ሴት ወይም ሴት ጋር አልጋ መጋራት ነበረብህ?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም
6. የሴት ብልት ምርመራዎች በግል (ሌሎች ሰዎች ማየት በማይችሉበት መንገድ) ይደረጉ ነበር?
   - ☐ የለም
   - ☐ እምቢ
   - ☐ አዎ
   - ☐ አላውቅም

እንክብካቤን መተው ወይም መከልከል

1. ሕፃኑ ሲወጣ የጤና ሠራተኛ ይኖር ነበር?
   - ☐ የለም
   - ☐ አዎ

☐ እምቢ ☐ አላውቅም

በሚከተሉት መግለጫዎች ይስማማሉ?

2. በወሊድ ምክንያት ሆስፒታል በነበርኩበት ጊዜ በጤና ሰራተኞች ወይም በሰራተኞች ችላ እንደተባሉ ተሰማኝ፡-
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም
3. በወሊድ ምክንያት ሆስፒታል በነበርኩበት ጊዜ የጤና ባለሙያዎች ከመገኘቴ በፊት ለረጅም ጊዜ መጠበቅ ነበረብኝ፡-
   ☐ በጣም እስማማለሁ። ☐ አልስማማም።
   ☐ እስማማለሁ። ☐ በጣም አልስማማም።
   ☐ ገለልተኛ ☐ የማይታወቅ
4. ለመውለድ ሆስፒታል በነበርኩበት ጊዜ በጤና ሰራተኞች ወይም በሰራተኞች ስሜታዊ ድጋፍ ተሰማኝ፡-
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም
5. ለመውለድ ሆስፒታል በነበርኩበት ጊዜ፣ የጤና ባለሙያዎች ወይም ሰራተኞች ጭንቀቴን አዳምጠዋል፡-
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም
6. ለመውለድ ሆስፒታል በነበርኩበት ጊዜ፣ የጤና ባለሙያዎች ወይም ሰራተኞች ለጥያቄዎቼ ተገቢውን መልስ ሰተዉኛል፡፡
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም
7. በሆስፒታል ውስጥ በነበሩበት ጊዜ, የወሊድ ጓደኛ እንዲኖርዎት ተፈቅዶልዎታል? ለምሳሌ ይህ ባልህን፣ ጓደኛህን፣ እህትህን፣ አማችህን ወዘተ ያጠቃልላል?
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም

በተቋሙ ውስጥ ማሰር

1. እርስዎ ወይም ልጅዎ ወይም ጓደኛዎ የሆስፒታል ሂሳቦችን መክፈል ባለመቻልዎ በሆስፒታል ውስጥ ታስረው ነበር?
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም
2. ከተወለዱ በኋላ የእራስዎን ደም, ሽንት, ሰገራ ወይም የአሞኒቲክ ፈሳሾችን እንዲያጸዱ ታዝዘዋል?
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም
3. ሰራተኞች እርስዎ (ወይም ቤተሰብዎ ወይም ጓደኞችዎ) ጉቦ፣ መደበኛ ያልሆነ ክፍያ ወይም ስጦታ እንዲሰጡዎት ጠቁመዋል ወይም ጠይቀዋል?
   ☐ የለም ☐ እምቢ
   ☐ አዎ ☐ አላውቅም

Appendix C1: Poster for qualitative study

THE UNIVERSITY of ADELAIDE

CALL FOR PARTICIPANTS

TITLE: RESPECTFUL CARE DURING FACILITY BASED CHILDBIRTH IN ETHIOPIA: MIXED METHOD STUDY

HREC approval number: ____

Purpose: to explore the perspectives of women and care providers on how women are treated during facility based childbirth

Who is eligible to participate: Women who gave birth in health facility within the last 12 months

Participation is voluntary

What am I invited to do: Either of **A 30 minutes survey**
A 30 minutes in-depth interview
A 60 minutes group discussion

Nature of the questions involved: your views and experiences on how you were received and treated while giving birth in the facility

Investigators:

Dr. Janet Kelly

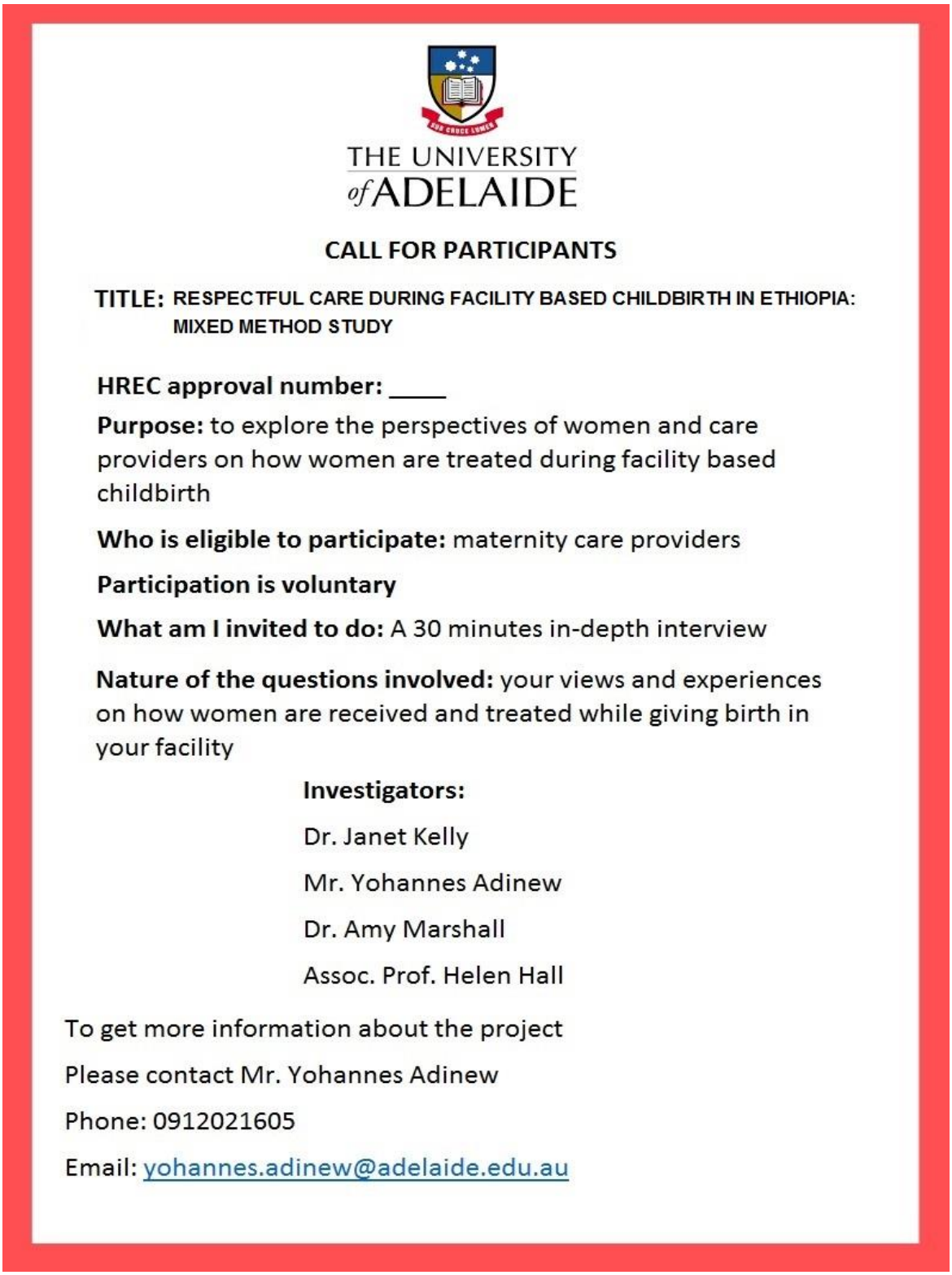
Mr. Yohannes Adinew

Dr. Amy Marshall

Assoc. Prof. Helen Hall

To get more information about the project
Please contact Mr. Yohannes Adinew
Phone: 0912021605
Email: yohannes.adinew@adelaide.edu.au

Appendix C2: Poster for qualitative study



THE UNIVERSITY of ADELAIDE

CALL FOR PARTICIPANTS

TITLE: RESPECTFUL CARE DURING FACILITY BASED CHILDBIRTH IN ETHIOPIA: MIXED METHOD STUDY

HREC approval number: ____

Purpose: to explore the perspectives of women and care providers on how women are treated during facility based childbirth

Who is eligible to participate: maternity care providers

Participation is voluntary

What am I invited to do: A 30 minutes in-depth interview

Nature of the questions involved: your views and experiences on how women are received and treated while giving birth in your facility

Investigators:

Dr. Janet Kelly

Mr. Yohannes Adinew

Dr. Amy Marshall

Assoc. Prof. Helen Hall

To get more information about the project

Please contact Mr. Yohannes Adinew

Phone: 0912021605

Email: yohannes.adinew@adelaide.edu.au

Appendix D1: Participant information sheet for care providers

Project title: Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study

Human research ethics committee approval number: h-2018-***

Principal investigator: Dr Janet Kelly

Student researcher: Mr Yohannes Adinew

Student's degree: PhD in Nursing

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

This research project is about how women are treated during facility-based childbirth in Ethiopia. This research will explore women's expectations and understanding of their rights, the prevalence of disrespect and abuse of women, and care providers' perspectives of disrespect and abuse during childbirth in Ethiopia. The study will identify the perspectives of both women and care providers regarding the treatment of women during childbirth in Ethiopia, and it will help to inform policy makers to promote respectful maternity care.

Who is undertaking the project?

This project is being undertaken by Mr. Yohannes Mehretie, Dr Janet Kelly, Dr Amy Marshall and Assoc. Prof. Helen Hall. This research will form the basis of Mr. Yohannes Mehretie's PhD in Nursing, at the University of Adelaide, in South Australia, Australia under the supervision of Dr Janet Kelly, Dr Amy Marshall and Assoc. Prof. Helen Hall. This PhD study is being funded by an Australian Research training Scholarship.

Why am I being invited to participate?

You are being invited because you work as a maternity care provider in health facilities found in study setting and have direct involvement in the care for women during pregnancy and labour. And we want to know how you perceive the way women are being treated in maternity units during childbirth.

What am I being invited to do?

You are invited to participate in an in-depth interview. The interview involves answering a range of questions about your perceptions and experiences of how women are received and

treated during childbirth. The interview will be conducted face to face and will be audiotaped with your consent. The interview will be held at your facility or any other place of your choice.

How much time will my involvement in the project take?

The in-depth interview will take approximately 30 minutes. You will be interviewed only once for the study.

Are there any risks associated with participating in this project?

There is a possibility of emotional distress as you describe past experience during the interview process. To reduce the possibility of distress, you have the right to be accompanied by the person of your choice during the interview. The presence of a family member or carer will provide the opportunity for significant emotional support. In addition, the interview will be conducted at a time and location convenient to you to protect your privacy. Your participation in the study will not affect your employment as your hospital has provided a letter that it will not take disciplinary or legal action based on findings. You have the right to withdraw during interview at any time without penalty.

What are the potential benefits of the research project?

By participating in this study, you will not get immediate benefit, as there will be no reimbursement for participation, but the outcomes of this study may be useful to the wider community as it may contribute to quality and safety in maternity care by providing policy makers further evidence to guide policies, inform curriculum and professional development courses.

Can I withdraw from the project?

Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time during the interview or within four weeks after completion of the interview. This will not affect your current or future career.

What will happen to my information?

Privacy and Confidentiality: Data will be collected identifiably, but then de-identified via the use of unique codes. No information that could identify you will be recorded and the information you provide us will be confidential. The questionnaire will be coded and no references will be made in oral or written reports that could link you to the research.

Storage: The completed questionnaire will be stored in a locked box, and all electronic copies of the data including audio recordings of interview will be stored in secure Adelaide University

servers for five years after the last publication. Only the investigators named above will have access to the recorded data.

Publishing: The findings of the study will be reported only for the whole study population and will not report any data at an individual level. The findings of the research will be reported in a PhD thesis, published in peer-reviewed journal, and will be communicated trough academic conference, local radio station and presented to Oromia regional health bureau and administrators of all health facilities in the zone.

Sharing: You will have access to your interview transcript, and the data will be used for future related research undertaken by any researchers. The data will be shared with researchers of The University of Adelaide and future use of the data will be guided by the University regulation. Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?

If you have any questions or enquiries at any time about the study or the procedures, please contact and communicate with the investigators through phone or email address below.

Name	Telephone	Email
Dr. Janet Kelly	+61 8 8313**0964**	janet.kelly@adelaide.edu.au
Mr. Yohannes Mehretie	+61 4 69366152	yohannes.adinew@adelaide.edu.au
Dr. Amy Marshall	+61 8 83136288	amy.marshall@adelaide.edu.au
Assoc. Prof. Helen Hall	+61 3 99044120	helen.hall@monash.edu.au

What if I have a complaint or any concerns?

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2019-153). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on: Australia

Phone: +61 8 8313 6028

Email: hrec@adelaide.edu.au

Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If you wish to contact local independent person for complaint, please contact

Salale University, College of Health sciences, Dean Office on:

Telephone: +25111 -160-93-52

Fax: +251 1160 9320

Post: 245, Fitche, Ethiopia

Email: mengstutesema@gmail.com

If I want to participate, what do I do?

If you want to participate, I will give you the consent form and you will sign it to show your voluntary participation. Then, we will arrange a time and location convenient to you for you to participate in the study.

If I want to participate, what do I do?

You have one week to consider your participation. If you decide to participate, contact me. Then you will sign the consent form and we will arrange appointment and you will participate in an in-depth interview.

Yours sincerely,

Dr. Janet Kelly

Mr. Yohannes Mehretie

Dr. Amy Marshall

Assoc. Prof. Helen Hall

Appendix D2: Participant information sheet for care providers Amharic version

የፕሮጀክት ርዕስ፡ በኢትዮጵያ ጤና ተቋም ዉስጥ እናቶች በሚወልዱበት ወቅት የሚደረግረግላቸዉ እንክብካቤ፡ ቅይጥ ዘዴ ጥናት

የሰዉ ምርምር ስነምግባር ኮሚቴ ፍቃድ ቁጥር: H-2019-153

ዋና ተመራማር፤ ጃኔት ኬሊ

የጥናቱ ተማሪ፤ ዮሐንስ ምህረቴ አድነዉ

የተማሪ ድግሪ፤ ፒ. ኤች. ዲ በነርስንግ

ውድ ተሳታፊ፣

ከዚህ በታች በተገለፀው የምርምር ፕሮጀክት ላይ እንዲሳተፉ ተጋብዘዋል።

ፕሮጀክቱ ስለ ምንድን ነው?

ይህ የምርምር ፕሮጀክት በኢትዮጵያ ጤና ተቋማት ዉስጥ በወሊድ ወቅት ሴቶች እንዴት እንደሚስተናገዱ የሚያሳይ ነው። ይህ ጥናት ሴቶች ስለመብታቸው የሚጠብቁትን እና ግንዛቤን፣ የሴቶችን ክብር ማጣት እና መጎሳቆል እና ተንከባካቢዎች በኢትዮጵያ በወሊድ ጊዜ የሚደርስባቸውን ንቀት እና እንግልት አመለካከቶችን ይዳስሳል። ጥናቱ በኢትዮጵያ በወሊድ ወቅት የሴቶችን አያያዝ አስመልክቶ የሴቶች እና ተንከባካቢዎች ያላቸውን አመለካከት በመለየት ለፖሊሲ አውጪዎች ክብር የተላበሰ የወሊድ አገልግሎትን ለማስተዋወቅ ይረዳል።

ፕሮጀክቱን የሚያካሂደው ማነው?

ይህ ፕሮጀክት የሚካሄደው በ ተባባሪ ፕሮፌሰር ጃኔት ኬሊ፣ ዮሐንስ ምህረቴ አድነዉ፣ ዶ/ር ኤሚ ማርሻል፣ ተባባሪ ፕሮፌሰር ሄለን ሀል ነዉ።፡ ጥናቱ አቶ ዮሐንስ ምህረቴ በአዴላይድ ዩኒቨርስቲ ፒ.ኤች.ዲ ድግሪያቸዉን ለማጠናቀቅ ከተባባሪ ፕሮፌሰር ጃኔት ኬሊ፣ ዶ/ር ኤሚ ማርሻል እና ተባባሪ ፕሮፌሰር ሄለን ሀል ጋር የምሰሩት ነዉ። ይህ የዶክትሬት ጥናት በአውስትራሊያ የምርምር ስልጠና ስኮላርሺፕ እየተደገፈ ነው።

ለምን እንድሳተፍ እየተጋበዝኩ ነው?

እርስዎ የተጋበዙት በጥናት ላይ ባሉ የጤና ተቋማት ውስጥ የእናቶች ክብካቤ አቅራቢ በመሆን ስለምትሰሩ እና በእርግዝና እና ምጥ ጊዜ ለሴቶች እንክብካቤ ላይ ቀጥተኛ ተሳትፎ ስላላችሁ ነው። እና በወሊድ ጊዜ ሴቶች በወሊድ ክፍል ውስጥ እንዴት እንደሚስተናገዱ እንዴት እንደሚረዱ ማወቅ እንፈልጋለን.

ምን እንድሰራ እየተጋበዝኩ ነው?

በጥልቀት ቃለ መጠይቅ ላይ እንድትሳተፉ ተጋብዘዋል። ቃለ-መጠይቁ ሴቶች በወሊድ ወቅት እንዴት እንደሚቀበሉ እና እንዴት እንደሚስተናገዱ የእርስዎን ግንዛቤ እና ልምድ በተመለከተ የተለያዩ ጥያቄዎችን መመለስን ያካትታል። ቃለ ምልልሱ ፊት ለፊት የሚካሄድ ሲሆን በእርስዎ ፍቃድ በድምጽ ይቀረጻል። ቃለ-መጠይቁ በእርስዎ ተቋም ወይም በመረጡት ሌላ ቦታ ይካሄዳል።

በፕሮጀክቱ ውስጥ የእኔ ተሳትፎ ምን ያህል ጊዜ ይወስዳል?

ጥልቅ ቃለ መጠይቁ በግምት 30 ደቂቃ ይወስዳል። ለጥናቱ አንድ ጊዜ ብቻ ቃለ መጠይቅ ይደረግልዎታል.

በዚህ ፕሮጀክት ውስጥ ከመሳተፍ ጋር የተያያዙ አደጋዎች አሉ?

በቃለ መጠይቁ ሂደት ውስጥ ያለፈውን ልምድ ሲገልጹ የስሜት ጭንቀት ሊኖር ይችላል. የጭንቀት እድልን ለመቀነስ በቃለ መጠይቁ ወቅት ከመረጡት ሰው ጋር አብሮ የመሄድ መብት አለዎት. የቤተሰብ አባል ወይም ተንከባካቢ መኖሩ ጉልህ የሆነ ስሜታዊ ድጋፍ ለማግኘት እድል ይሰጣል። በተጨማሪም ቃለ መጠይቁ የሚካሄደው ግላዊነትዎን ለመጠበቅ በሚመችዎ ጊዜ እና ቦታ ነው። በጥናቱ ውስጥ ያለዎት ተሳትፎ በስራዎ ላይ ምንም ተጽእኖ አይኖረውም ምክንያቱም ሆስፒታሎችዎ በግኝቶች ላይ ተመሥርተው የዲሲፕሊን ወይም ህጋዊ እርምጃ እንደማይወስድ ደብዳቤ ስላቀረበ ነው። በቃለ መጠይቁ ወቅት በማንኛውም ጊዜ ያለ ቅጣት የመተው መብት አልዎት።

የጥናት ፕሮጀክቱ ሊሆኑ የሚችሉ ጥቅሞች ምንድ ናቸው?

በዚህ ጥናት ውስጥ በመሳተፍ ወዲያውኑ ጥቅም አያገኙም, ምክንያቱም ለተሳትፎ የሚከፈል ክፍያ አይኖርም, ነገር ግን የዚህ ጥናት ውጤት ለሰፊው ማህበረሰብ ጠቃሚ ሊሆን ይችላል, ምክንያቱም ፖሊሲ አውጪዎችን በማቅረብ በወሊድ እንክብካቤ ጥራት እና ደህንነት ላይ አስተዋፅኦ ይኖረዋል. ፖሊሲዎችን ለመምራት, ሥርዓተ-ትምህርት እና የሙያ ማሻሻያ ኮርሶችን ለማሳወቅ ተጨማሪ ማስረጃዎች.

የጥናት ፕሮጀክቱ ሊሆኑ የሚችሉ ጥቅሞች ምንድ ናቸው?

በዚህ ጥናት ውስጥ በመሳተፍ ወዲያውኑ ጥቅም አያገኙም, ምክንያቱም ለተሳትፎ የሚከፈል ክፍያ አይኖርም, ነገር ግን የዚህ ጥናት ውጤት ለሰፊው ማህበረሰብ ጠቃሚ ሊሆን ይችላል, ምክንያቱም ፖሊሲ አውጪዎችን በማቅረብ በወሊድ እንክብካቤ ጥራት እና ደህንነት ላይ አስተዋፅኦ ይኖረዋል. ፖሊሲዎችን ለመምራት, ሥርዓተ-ትምህርት እና የሙያ ማሻሻያ ኮርሶችን ለማሳወቅ ተጨማሪ ማስረጃዎች.

ከፕሮጀክቱ መውጣት እችላለሁ?

በዚህ ፕሮጀክት ውስጥ መሳተፍ ሙሉ በሙሉ በፈቃደኝነት ነው. ለመሳተፍ ከተስማሙ በማንኛውም ጊዜ ከጥናቱ መውጣት ይችላሉ። ይህ የአሁኑን እና የወደፊት እንክብካቤዎን አይነዳውም.

የእኔ መረጃ ምን ይሆናል?

ግላዊነት እና ሚስጥራዊነት፡ ውሂብ በሚለይ መልኩ ይሰበሰባል፣ ነገር ግን ልዩ የሆኑ ኮዶችን በመጠቀም ከመለየት ይሰረዛል። እርስዎን የሚለይ ምንም አይነት መረጃ አይመዘገብም እና ያቀረቡት መረጃ ሚስጥራዊ ይሆናል። መጠይቁ ኮድ ይደረጋል፣ እና እርስዎን ከጥናቱ ጋር ሊያገናኝዎት የሚችል የቃል ወይም የጽሁፍ ዘገባዎች ማጣቀሻዎች አይደረጉም።

ማከማቻ፡ የተጠናቀቀው መጠይቅ በተቆለፈ ሣጥን ውስጥ ይከማቻል፣ እና ሁሉም ኤሌክትሮኒክ ቅጂዎች የቃለ መጠይቁ የድምጽ ቅጂዎችን ጨምሮ ደህንነቱ በተጠበቀ የአዴሌድ ዩኒቨርሲቲ አገልጋዮች ውስጥ ከመጨረሻው ህትመት በኋላ ለአምስት ዓመታት ይቀመጣሉ። ከላይ የተጠቀሱት መርማሪዎች ብቻ የተቀዳውን መረጃ ማግኘት ይችላሉ።

ማተም፡ የጥናቱ ግኝቶች ለጠቅላላው የጥናት ህዝብ ብቻ ሪፖርት ይደረጋል እና በግለሰብ ደረጃ ምንም አይነት መረጃ አይዘግብም. የጥናቶቹ ግኝቶች በፒኤችዲ ተሲስ፣ በአቻ ግምገማ ጆርናል ላይ የሚታተሙ ሲሆን በአካዳሚክ ኮንፈረንስ፣

በአገር ውስጥ ሬዲዮ ጣቢያ ተላልፈው ለኦሮሚያ ክልል ጤና ቢሮ እና ለዞኑ የሁሉም ጤና ተቋማት አስተዳዳሪዎች ይቀርባል።

ማጋራት፡ የቃለመጠይቁን ግልባጭ ማግኘት ትችላላችሁ፣ እና ውሂቡ ወደፊት በማናቸውም ተመራማሪዎች ለሚደረጉ ተዛማጅ ምርምሮች ጥቅም ላይ ይውላል። መረጃው ከአድላይድ ዩኒቨርሲቲ ተመራማሪዎች ጋር ይጋራል እና ለወደፊቱ የመረጃ አጠቃቀም በዩኒቨርሲቲው ደንብ ይመራል. የእርስዎ መረጃ በዚህ የተሳታፊ መረጃ ወረቀት ላይ በተገለጸው መሰረት ብቻ ጥቅም ላይ ይውላል እና በህግ ካልተጠየቀ በስተቀር ይፋ የሚሆነው በተሰጠው ፈቃድ መሰረት ብቻ ነው።

ስለ ፕሮጀክቱ ጥያቄዎች ካሉኝ ማንን አነጋግራለሁ?

ስለ ጥናቱ ወይም አካሄዶቹ በማንኛውም ጊዜ ማንኛውም አይነት ጥያቄ ወይም ጥያቄ ካሎት፣ እባክዎን ከዚህ በታች ባለው ስልክ ወይም ኢሜል መርማሪዎችን ያነጋግሩ እና ያነጋግሩ።

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ቅሬታ ወይም ስጋት ቢኖረኝስ?

ጥናቱ በአደሌድ ዩኒቨርሲቲ (የማጽደቂያ ቁጥር H-2019-153) በሰዎች ምርምር ሥነ-ምግባር ኮሚቴ ጸድቋል። ይህ የምርምር ፕሮጀክት የሚካሄደው በ 2007 (እ.ኤ.አ. የተሻሻለው 2018) በኤንኤችኤምአርሲ ብሔራዊ የሥነ ምግባር መግለጫ መሠረት ነው። በፕሮጀክቱ ውስጥ ካለው ተሳትፎዎ ተግባራዊ ገጽታዎች ጋር የተያያዙ ጥያቄዎች ወይም ችግሮች ካሉዎት፣ ወይም ስለ ፕሮጀክቱ ስጋት ወይም ቅሬታ ለማንሳት ከፈለጉ፣ ዋናውን መርማሪ ማማከር አለብዎት። ከገለልተኛ ሰው ጋር ስለ ስጋቶች ወይም ቅሬታዎች፣ የዩኒቨርሲቲው የሰው ልጅ ተሳታፊዎችን በሚያሳትፍ የምርምር ፖሊሲ ወይም እንደ ተሳታፊ ያለዎትን መብቶች በተመለከተ፣ እባክዎን የሰብአዊ ጥናትና ምርምር ስነ-ምግባር ኮሚቴን ሴክሬታሪያትን ያነጋግሩ።

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ማንኛውም ቅሬታ ወይም ስጋት በምስጢር ይታከማል እና ሙሉ በሙሉ ይመረመራል። ውጤቱን ይነግርዎታል።

ለቅሬታ የአካባቢውን ገለልተኛ ሰው ማነጋገር ከፈለጉ እባክዎን ያነጋግሩ

የሰላሌ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ ዲን ጽ/ቤት በ፡

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መሳተፍ ከፈለግኩ ምን አደርጋለሁ?

መሳተፍ ከፈለጉ፣ እባክዎን በዳሰሳ ጥናቱ፣ በጥልቀት ቃለ መጠይቅ ወይም በቡድን ውይይት መሳተፍ ከፈለጉ ይምረጡ። የስምምነት ቅጹን አነብልዎታለሁ፣ እና እርስዎ በፈቃደኝነት ተሳትፎዎን ለማሳየት ይፈርሙበታል። ከዚያም በጥናቱ ላይ ለመሳተፍ አመቺ ጊዜ እና ቦታ እናዘጋጅልዎታለን።

መሳተፍ ከፈለግኩ ምን አደርጋለሁ?

ተሳትፎዎን ለማጤን አንድ ሳምንት አለዎት። ከሳምንት በኋላ አነጋግርዎታለሁ እና ለመሳተፍ ከወሰኑ የፍቃድ ቅጹን ይፈርማሉ እና ቀጠሮ እናዘጋጃለን እና እርስዎ በመረጡት የዳሰሳ ጥናት ወይም ቃለ መጠይቅ ወይም የቡድን ውይይት ውስጥ ይሳተፋሉ።

ከአክብሮት ጋር,

ተ/ፕሮፌሰር ጃኔት ኬሊ

አቶ ዮሐንስ ምህረቴ

ዶክተር ኤሚ ማርሻል

ተ/ፕሮፌሰር ሄለን ሀል

Appendix E1: Focus group guide; English version

Part 1: Sociodemographic questions		
1	How old are you?	_____ Years
2	Residence	☐ Urban ☐ Rural
3	What is your current marital status?	☐ Never married/single ☐ Currently married ☐ Divorced ☐ Widowed ☐ Other _____ ☐ Unknown
4	What is your highest level of formal education?	☐ No education ☐ Pre-primary education ☐ Primary education ☐ Secondary education ☐ Post-secondary/tertiary education ☐ Other ☐ Vocational training ☐ Unknown ☐ If other, specify: _____
5	Work	☐ Unemployed ☐ Governmental employee ☐ Private employee ☐ Farmer ☐ Others, specify_____
6	Monthly household income?	☐ _____
7	Spouse occupation	☐ Governmental employee ☐ Private employee ☐ Farmer ☐ Unemployed ☐ Others, specify_____

	Scenarios
1.	If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
2.	If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
3.	If a health worker was mean and refused to help a woman during her delivery, would this be acceptable? When would it be acceptable?
4.	If a health worker physically held a woman down during her childbirth, would this be acceptable? When would it be acceptable?
5.	If a health worker threatens a woman by unfavorable procedure like CS or referral or bad outcome for her or her baby during her childbirth, would this be acceptable? When would it be acceptable?
6.	If a health worker disallowed a woman to deliver in a position of her choice during her childbirth, would this be acceptable? When would it be acceptable?
7.	If a health worker performs a procedure without getting consent during her childbirth, would this be acceptable? When would it be acceptable?
8.	If a health worker forcefully opens a woman's leg during her childbirth, would this be acceptable? When would it be acceptable?
9.	If a health worker disallowed a woman birth companion during her childbirth, would this be acceptable? When would it be acceptable?

Appendix E2: Focus group guide; Amharic version

Part 1: የማህበራዊ ሁኔታ		
1	እድሜዎ ስንት ነው?	_____ ዓመት
2	መኖሪያ	☐ ከተማ ☐ ገጠር
3	የጋብቻ ሁኔታ ምንድነዉ?	1=ያላገባ/ች 2=ያገባ/ች 3=የተለያዩ 4=የተፋቱ 5=የሞቴችበት/የሞቴባት
4	ያጠናቀቀዉ ከፍተኛ የትምህርት ደረጃ ምንድነዉ?	1=መደበኛ ትምህረት ያልተከታተለ 2=ከአንደኛ ደረጃ በታች 3=አንደኛ ደረጃ ያጠናቀቀ/ች 4=ሁለተኛ ደረጃ ያጠናቀቀ/ች 5=ኮሌጅ/ዩኒቨርስቲ ያጠናቀቀ/ች 6=ድህረ ምረቃ ትምህረት ያጠናቀቀ/ች 7=መመለስ አልፈልግም 8=አላዉቅም 9=ሌላ መልስ -------
5	ሥራ	☐ ሥራ አጥ ☐ የመንግስት ሰራተኛ ☐ የግል ሰራተኛ ☐ እርሻ ☐ ሌሎች፣ ይግለጹ_____
6	ወርሃዊ የቤተሰብ ገቢ?	☐ _____
7	የትዳር ጓደኛ ሥራ	☐ የመንግስት ሰራተኛ ☐ የግል ሰራተኛ ☐ እርሻ ☐ ሥራ አጥ ☐ ሌሎችን ይግለጹ _____
	ሁኔታዎች	
10	አንዲት ሴት በምጥዋ ወቅት በጤና ባለሙያ በጥፊ ብትመታ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?	

11	አንዲት ሴት በምጥዋ ወቅት በጤና ባለሙያ ቢጮህ ወይም ቢጮህ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
12	አንድ የጤና ሰራተኛ ሴትን በወሊድ ወቅት ለመርዳት ጨካኝ እና ሴትን ለመርዳት ፈቃደኛ ካልሆነ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
13	አንድ ዋና ባለሙያ አንዲት ሴት በምጥዋ ወቅት ቢያንጎብብ ይህ ተቀባይነት ምልክት? መቼ ነው ተቀባይነት ያለው?
14	አንድ የጤና ሰራተኛ ሴትን እንደ ሲኤስ ወይም ሪፈራል ወይም በወሊድ ወቅት በእሷ ወይም በልጅዋ ላይ መጥፎ ውጤት በማድረግ ሴትን የሚያስፈራራት ከሆነ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
15	አንድ የጤና ባለሙያ አንዲት ሴት በሥራዋ ወቅት በፈለገችው ቦታ እንድትወልድ ቢከለክላት ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
16	አንዲት የጤና ሰራተኛ በምጥዋ ወቅት ፈቃድ ሳታገኝ የአሰራር ሂደቱን ብታከናውን ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
17	አንድ የጤና ባለሙያ የሴትን እግር በጉልበት በጉልበት ከከፈተ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
18	አንድ የጤና ሰራተኛ ሴት በምትወልድበት ጊዜ የትውልድ ጓደኛዋን ከከለከለ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?

Appendix F1: Interview guide; English version

Part 1: Sociodemographic questions		
1	How old are you?	_____ Years
	Sex	☐ Female ☐ Male
2	Residence	☐ Urban ☐ Rural
3	What is your current marital status?	☐ Never married/single ☐ Currently married ☐ Divorced ☐ Widowed ☐ Other _____ ☐ Unknown
4	What is your highest level of formal education?	☐ Diploma ☐ BSc ☐ Medical degree ☐ Specialization (MD+) ☐ If other, specify: _____
5	Profession	☐ Midwife ☐ Nurse ☐ Medical doctor (GP) ☐ Obstetrics and gynaecologist ☐ Others, specify_____
6	Years of experience	☐ Less than a year ☐ 1-5 years ☐ More than 5 years
7	Where do you currently work?	☐ Health center ☐ Hospital
	Scenarios	
1.	If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable? When would it be acceptable?	

2.	If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable? When would it be acceptable?
3.	If a health worker was mean and refused to help a woman during her delivery, would this be acceptable? When would it be acceptable?
4.	If a health worker physically held a woman down during her childbirth, would this be acceptable? When would it be acceptable?
5.	If a health worker threatens a woman by unfavorable procedure like CS or referral or bad outcome for her or her baby during her childbirth, would this be acceptable? When would it be acceptable?
6.	If a health worker disallowed a woman to deliver in a position of her choice during her childbirth, would this be acceptable? When would it be acceptable?
7.	If a health worker performs a procedure without getting consent during her childbirth, would this be acceptable? When would it be acceptable?
8.	If a health worker forcefully opens a woman's leg during her childbirth, would this be acceptable? When would it be acceptable?
9.	If a health worker disallowed a woman birth companion during her childbirth, would this be acceptable? When would it be acceptable?

Appendix F2: Interview guide; Amharic version

Part 1: የማህበራዊ ሁኔታ		
1	እድሜዎ ስንት ነው?	_____ **ዓመት**
2	*መኖሪያ*	☐ ከተማ ☐ ገጠር
3	የጋብቻ ሁኔታ ምንድነዉ?	1=ያላገባ/ች 2=ያገባ/ች 3=የተለያዩ 4=የተፋቱ 5=የሞቴችበት/የሞቴባት
4	ያጠናቀቀዉ ከፍተኛ የትምህርት ደረጃ ምንድነዉ?	1=መደበኛ ትምህረት ያልተከታተለ 2=ከአንደኛ ደረጃ በታች 3=አንደኛ ደረጃ ያጠናቀቀ/ች 4=ሁለተኛ ደረጃ ያጠናቀቀ/ች 5=ኮሌጅ/ዩኒቨርስቲ ያጠናቀቀ/ች 6=ድህረ ምረቃ ትምህረት ያጠናቀቀ/ች 7=መመለስ አልፈልግም 8=አላዉቅም 9=ሌላ መልስ -------
5	*ሥራ*	☐ ሥራ አጥ ☐ የመንግስት ሰራተኛ ☐ የግል ሰራተኛ ☐ እርሻ ☐ ሌሎች፣ ይግለጹ_____
6	ወርሃዊ የቤተሰብ ገቢ?	☐ _____
7	የትዳር ጓደኛ ሥራ	☐ የመንግስት ሰራተኛ ☐ የግል ሰራተኛ ☐ እርሻ ☐ ሥራ አጥ ☐ ሌሎችን ይግለጹ _____
	ሁኔታዎች	
19	አንዲት ሴት በምጥዋ ወቅት በጤና ባለሙያ በጥፊ ብትመታ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?	

20	አንዲት ሴት በምጥዋ ወቅት በጤና ባለሙያ ቢጮህ ወይም ቢጮህ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
21	አንድ የጤና ሰራተኛ ሴትን በወሊድ ወቅት ለመርዳት ጨካኝ እና ሴትን ለመርዳት ፈቃደኛ ካልሆነ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
22	አንድ ዋና ባለሙያ አንዲት ሴት በምጥዋ ወቅት ቢያንጎብብ ይህ ተቀባይነት ምልክት? መቼ ነው ተቀባይነት ያለው?
23	አንድ የጤና ሰራተኛ ሴትን እንደ ሲኤስ ወይም ሪፈራል ወይም በወሊድ ወቅት በእሷ ወይም በልጅዋ ላይ መጥፎ ውጤት በማድረግ ሴትን የሚያስፈራራት ከሆነ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
24	አንድ የጤና ባለሙያ አንዲት ሴት በሥራዋ ወቅት በፈለገችው ቦታ እንድትወልድ ቢከለክላት ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
25	አንዲት የጤና ሰራተኛ በምጥዋ ወቅት ፈቃድ ሳታገኝ የአሰራር ሂደቱን ብታከናውን ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
26	አንድ የጤና ባለሙያ የሴትን እግር በጉልበት በጉልበት ከከፈተ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?
27	አንድ የጤና ሰራተኛ ሴት በምትወልድበት ጊዜ የትውልድ ጓደኛዋን ከከለከለ ይህ ተቀባይነት ይኖረዋል? መቼ ነው ተቀባይነት ያለው?

Appendix G1: Evidence of permission from Salale University.jpg

ሰላሌ ዩኒቨርሲቲ
ጤና ሳይንስ ኮሌጅ

Salale University
Health Sciences College

Ref. No: ሳ/ጤ/ዲ/ኮ/768/11
Date: 19/7/2011

To: **University of Adelaide, Human Research Ethics Committee**

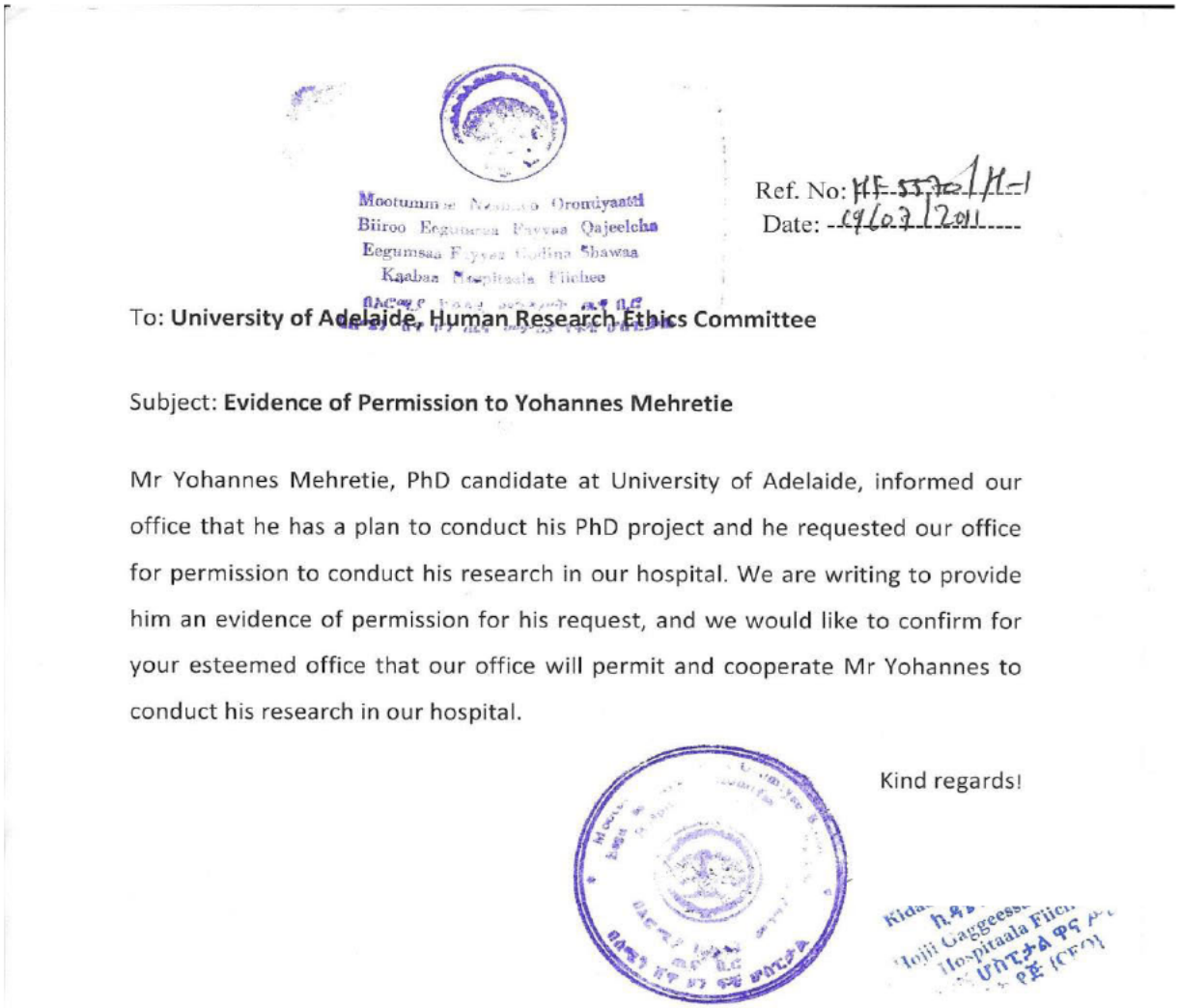
Subject: **Evidence of Permission to Yohannes Mehretie**

Mr Yohannes Mehretie, PhD candidate at University of Adelaide, is staff member of Salale University, College of Health Sciences. He has recently contacted our office if he can get an ethical clearance for his PhD project planned to be conducted in health facilities found in our University's catchment area. We are writing to provide him an evidence of permission for his request, and we would like to confirm for your esteemed office that our office will cooperate and grant Mr Yohannes an ethical clearance which will enable him conduct his project.

egards!

Men
na Milk
ሚልክ
Health Science College
Dean
ና ሳይንስ ኮሌጅ ዲን

Appendix G2: Evidence of permission from Fitche Hospital.jpg



Mootummaa Naannoo Oromiyaatii
Biiroo Eegumsaa Fayyaa Qajeelcha
Eegumsaa Fayyaa Godina Shawaa
Kaabaa Hospitaala Fitchee

Ref. No: HF-552/11-1
Date: 19/07/2011

To: **University of Adelaide, Human Research Ethics Committee**

Subject: **Evidence of Permission to Yohannes Mehretie**

Mr Yohannes Mehretie, PhD candidate at University of Adelaide, informed our office that he has a plan to conduct his PhD project and he requested our office for permission to conduct his research in our hospital. We are writing to provide him an evidence of permission for his request, and we would like to confirm for your esteemed office that our office will permit and cooperate Mr Yohannes to conduct his research in our hospital.

Kind regards!

Hospitaala Fitche

Appendix H1: Consent form for women participants for Survey

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study
Ethics approval number:	**H-2019-153**

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project is to improve the quality of health/medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I agree to participate in the activities as outlined in the participant information sheet.
6. I understand that I am free to withdraw from the project at any time during the survey or within the first four weeks after completion of the survey and that this will not affect medical advice in the management of my health, now or in the future.
7. I have been informed that the information gained in the project may be reported in a PhD thesis, published in peer-reviewed journal, and will be communicated trough academic conference, local radio station and presented to Oromia regional health bureau and administrators of all health facilities in the zone.
8. I have been informed that in the published materials I will not be identified, and my personal results will not be divulged.
9. I agree to my information being used for related future research undertaken by any researcher(s).

Participant to complete:

Name: _____ Signature: _____ Date:_____

Researcher/Witness to complete:

I have described the nature of the research to_____ *(print name of participant)* and in my opinion, she/he understood the explanation.

Signature: _____ Position: _____ Date: _____

Appendix H2: Consent form for women participants for Survey Amharic version

1. **የተያያዘውን የመረጃ ወረቀት አንብቤ በሚከተለው የምርምር ፕሮጀክት ለመሳተፍ ተስማምቻለሁ፡-**

የፕሮጀክት ርዕስ፡	በኢትዮጵያ ጤና ተቋም ዉስጥ እናቶች በሚወልዱበት ወቅት የሚደረግረግላቸዉ እንክብካቤ፡ ቅይጥ ዘዴ ጥናት
የሰዉ ምርምር ስነምግባር ኮማቴ	H-2019-153

2. ጥናቱ እንደምንዳኝ ተነቦልኛል፣ ጥናቱ ልአመጣ የምችሉ ጉዳቶች በረዳት ተመራማርዉ በቂ በሆነ ሁኔታ ተገልጾልኛል። ስለምርምሩ ጥያቄ ና ስለ ተሳትፎዬ ለመጠየቅ እድል ተሰቶኛል። ስምምነቴ በነጻነት የተሰጠ ነዉ።

3. ስለምርምሩ ስገለጽልኝ ቤተሰቦቼ ወይም ጓደኞቼ ከእሌ ጋር እንድሆኑ ተፈቅዶልኛል።

4. ምርምሩ የጤና አገልግሎት ለማሻሻል የምረዳ ብሆንም፤ ተሳትፎዬ ምንም አይነት ጥቅም እንደማይአስገኝልኝ ተነግሮኛል።

5. በመረጃ ቅጽ ላይ በተገለጸ መሰረት ለመሳተፍ ፍቃደኛ ነኝ።

6. በዉይይት ግዜ ድምሴ እንድቀዳ ፍቃደኛ ነኝ አዎ አይደለም

7. ተሳትፎዬ ማንነት የማይገልጽ መሆኑ ተረድቶለሁ፤ ከምረምሩ የመረጃ መሰበሰብየ ቅጽ እስክገባ ድረስ ተሳትፎዬን ለማቋረጥ እችለለሁ፤ ተሳትፎዬን ማቋረጤ አሁንም ሆነ ወደፍት የምአገኘዉን የጤና አገልግሎት አይጎዳም።

8. የጥናቱ ግኝት በ ፒ.ኤች. ዲ ጽሁፍ ዉስጥ እንደምጻፈ፣ የምርምረ ጽሁፍ በምአሳትሙ ጆርናል ላይ እንደምታተም፤ በኮንፍራንስ ላይ እንደምቀርብ ተነግሮኛል።

9. ጽሁፉ ስታተም ማንኛዉም እኔነቴን የምገልጽ መረጃ አይኖርም/አብሮ አይታተምም።

10. መረጃዬ ለዝህ ጥናት ብቻ የምዉል ስሆን፤ በህግ ከተፈለገ በስተቀር ለማንም አሰልፎ አይሰጥም።

11. ኤሄን የስምምነት ቅጽና የተሳታፊ መረጃ ቅጽ ግልባጩን መያዝ እንደምኖረብኝ ተረድቶአለሁ።

ተሳታፊ የምሞላ:

ስም_____ፊርማ_____ ቀን_____
ተመራማሪ/ መረጃ

ሰብሳቢ የምሞላ:
የምረምሩ ሁኔታ ለ (ስም)_____ገልጨለሁ፤ በእኔ እይታ ገለጻዉን ተረድቷል።
ፍርማ : _____ስራ ድርሻ : _____ ቀን :_____

Appendix H3: Consent Form for women participants for In-depth interview

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study
Ethics approval number:	**H-2019-153**

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project is to improve the quality of health/medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I agree to participate in the activities as outlined in the participant information sheet.
6. I understand that I am free to withdraw from the project at any time during the survey or within the first four weeks after completion of the survey and that this will not affect medical advice in the management of my health, now or in the future.
7. I have been informed that the information gained in the project may be reported in a PhD thesis, published in peer-reviewed journal, and will be communicated trough academic conference, local radio station and presented to Oromia regional health bureau and administrators of all health facilities in the zone.
8. I have been informed that in the published materials I will not be identified, and my personal results will not be divulged.
9. I agree to my information being used for related future research undertaken by any researcher(s).

Participant to complete:

Name: _____ Signature: _____ Date:_____

Researcher/Witness to complete:

I have described the nature of the research to _____ *(print name of participant)* and in my opinion she/he understood the explanation.

Signature: _____ Position: _____ Date: _____

Appendix H4: Consent Form for women participants for In-depth interview Amharic Version

1. የተያያዘውን የመረጃ ወረቀት አንብቤ በሚከተለው የምርምር ፕሮጀክት ለመሳተፍ ተስማምቻለሁ፡-

የፕሮጀክት ርዕስ፡	በኢትዮጵያ ጤና ተቋም ዉስጥ እናቶች በሚወልዱበት ወቅት የሚደረግረግላቸዉ እንክብካቤ፡ ቅይጥ ዘዴ ጥናት
የሰዉ ምርምር ስነምግባር ኮማቴ	H-2019-153

2. ጥናቱ እንደምንዳኝ ተነቦልኛል፣ ጥናቱ ልአመጣ የምችሉ ጉዳቶች በረዳት ተመራማርዉ በቂ በሆነ ሁኔታ ተገልጾልኛል። ስለምርምሩ ጥያቄ ና ስለ ተሳትፎዬ ለመጠየቅ እድል ተሰቶኛል። ስምምነቴ በነጻነት የተሰጠ ነዉ።

3. ስለምርምሩ ስገለጽልኝ ቤተሰቦቼ ወይም ጉደኞቼ ከእሌ ጋር እንድሆኑ ተፈቅዶልኛል።

4. ምርምሩ የጤና አገልግሎት ለማሻሻል የምረዳ ብሆንም፤ ተሳትፎዬ ምንም አይነት ጥቅም እንደማይአስገኝልኝ ተነግሮኛል።

5. በመረጃ ቅጽ ላይ በተገለጸ መሰረት ለመሳተፍ ፍቃደኛ ነኝ።

6. በዉይይት ግዜ ድምሴ እንድቀዳ ፍቃደኛ ነኝ አዎ አይደለም

7. ተሳትፎዬ ማንነት የማይገልጽ መሆኑ ተረድቸለሁ፤ ከምረምሩ የመረጃ መሰበሰብየ ቅጽ እስክገባ ድረስ ተሳትፎዬን ለማቋረጥ እችለለሁ፤ ተሳትፎዬን ማቋረጤ አሁንም ሆነ ወደፍት የምአገኘዉን የጤና አገልግሎት አይጎዳም።

8. የጥናቱ ግኝት በ ፒ.ኤች. ዲ ጽሁፍ ዉስጥ እንደምጸፈ፣ የምርምረ ጽሁፍ በምአሳትሙ ጆርናል ላይ እንደምታተም፤ በኮንፍራንስ ላይ እንደምቀርብ ተነግሮኛል።

9. ጽሁፉ ስታተም ማንኛዉም እኔነቴን የምገልጽ መረጃ አይኖርም/አብሮ አይታተምም።

10. መረጃዬ ለዝህ ጥናት ብቻ የምዉል ስሆን፤ በህግ ከተፈለገ በስተቀር ለማንም አሰልፎ ኣይሰጥም።

11. ኤሄን የስምምነት ቅጽና የተሳታፊ መረጃ ቅጽ ግልባጩን መያዝ እንደምኖረብኝ ተረድቸአለሁ።

ተሳታፊ የምሞላ:
ስም_____ፊርማ_____ ቀን_____
ተመራማሪ/ መረጃ

ሰብሳቢ የምሞላ:
የምረምሩ ሁኔታ ለ (ስም)_____ገልጨለሁ፤ በእኔ እይታ ገለጻዉን ተረድቷል።
ፍርማ : _____ስራ ድርሻ : _____ ቀን :_____

Appendix H5: Consent Form for women participants for focus groups

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study
Ethics approval number:	**H-2019-153**

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project is to improve the quality of health/medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I agree to participate in the activities as outlined in the participant information sheet.

6. I understand that I am free to withdraw from the project at any time during the survey or within the first four weeks after completion of the survey and that this will not affect medical advice in the management of my health, now or in the future.
7. I have been informed that the information gained in the project may be reported in a PhD thesis, published in peer-reviewed journal, and will be communicated trough academic conference, local radio station and presented to Oromia regional health bureau and administrators of all health facilities in the zone.
8. I have been informed that in the published materials I will not be identified and my personal results will not be divulged.
9. I agree to my information being used for related future research undertaken by any researcher(s).

Participant to complete:

Name: _____ Signature:_____ Date: _____

Researcher/Witness to complete:

I have described the nature of the research to _____ *(print name of participant)* and in my opinion, she/he understood the explanation.

Signature: _____ Position:_____ Date: _____

Appendix H6: Consent Form for women participants for focus groups Amharic version

ı. የተያያዘውን የመረጃ ወረቀት አንብቤ በሚከተለው የምርምር ፕሮጀክት ለመሳተፍ ተስማምቻለሁ፡-

የፕሮጀክት ርዕስ፡	በኢትዮጵያ ጤና ተቋም ዉስጥ እናቶች በሚወልዱበት ወቅት የሚደረግረግላቸዉ እንክብካቤ፡ ቅይጥ ዘዴ ጥናት
የሰዉ ምርምር ስነምግባር ኮማቴ	H-2019-153

2. ጥናቱ እንደምንዳኝ ተነቦልኛል፣ ጥናቱ ልአመጣ የምችሉ ጉዳቶች በረዳት ተመራማርዉ በቂ በሆነ ሁኔታ ተገልጾልኛል። ስለምርምሩ ጥያቄ ና ስለ ተሳትፎዬ ለመጠየቅ እድል ተሰቶኛል። ስምምነቴ በነጻነት የተሰጠ ነዉ።

3. ስለምርምሩ ስገለጽልኝ ቤተሰቦቼ ወይም ጉደኞቼ ከእሌ ጋር እንድሆኑ ተፈቅዶልኛል።

4. ምርምሩ የጤና አገልግሎት ለማሻሻል የምረዳ ብሆንም፤ ተሳትፎዬ ምንም አይነት ጥቅም እንደማይአሰገኝልኝ ተነግሮኛል።

5. በመረጃ ቅጽ ላይ በተገለጸ መሰረት ለመሳተፍ ፍቃደኛ ነኝ።

6. በዉይይት ግዜ ድምሴ እንድቀዳ ፍቃደኛ ነኝ አዎ አይደለም

7. ተሳትፎዬ ማንነት የማይገልጽ መሆኑ ተረድቶለሁ፤ ከምረምሩ የመረጃ መሰበሰብየ ቅጽ እስክገባ ድረስ ተሳትፎዬን ለማቋረጥ እችለለሁ፤ ተሳትፎዬን ማቋረጤ አሁንም ሆነ ወደፍት የምአገኘዉን የጤና አገልግሎት አይጎዳም።

8. የጥናቱ ግኝት በ ፒ.ኤች. ዲ ጽሁፍ ዉስጥ እንደምጸፈ፣ የምርምረ ጽሁፍ በምአሳትሙ ጆርናል ላይ እንደምታተም፤ በኮንፍራንስ ላይ እንደምቀርብ ተነግሮኛል።

9. ጽሁፉ ስታተም ማንኛዉም እኔነቴን የምገልጽ መረጃ አይኖርም/አብሮ አይታተምም።

10. መረጃዬ ለዝህ ጥናት ብቻ የምዉል ስሆን፤ በህግ ከተፈለገ በስተቀር ለማንም አሰልፎ አይሰጥም።

11. ኤሄን የስምምነት ቅጽና የተሳታፊ መረጃ ቅጽ ግልባጩን መያዝ እንደምኖረብኝ ተረድቶአለሁ።

ተሳታፊ የምሞላ:

ስም_____ፊርማ_____ ቀን_____

ተመራማሪ/ መረጃ

ሰብሳቢ የምሞላ:

የምረምሩ ሁኔታ ለ (ስም)_____ገልጨለሁ፤ በእኔ እይታ ገለጻዉን ተረድቷል።

ፍርማ : _____ስራ ድርሻ : _____ ቀን :_____

Appendix H7: Consent Form for care providers for Interview

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Disrespect and Abuse During Facility-Based Childbirth in Ethiopia: A Mixed-Methods Study
Ethics approval number:	**H-2019-153**

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project is to improve the quality of health/medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I agree to participate in the activities as outlined in the participant information sheet.
6. I understand that I am free to withdraw from the project at any time during the survey or within the first four weeks after completion of the survey.
7. I have been informed that the information gained in the project may be reported in a PhD thesis, published in peer-reviewed journal, and will be communicated trough academic conference, local radio station and presented to Oromia regional health bureau and administrators of all health facilities in the zone.
8. I have been informed that in the published materials I will not be identified, and my personal results will not be divulged.
9. I agree to my information being used for related future research undertaken by any researcher(s).

Participant to complete:

Name: _____ Signature: _____ Date:_____

Researcher/Witness to complete:

I have described the nature of the research to _____ *(print name of participant)* and in my opinion, she/he understood the explanation.

Signature: _____ Position: _____ Date:_____

Appendix H8: Consent Form for care providers for Interview

1. የተያያዘውን የመረጃ ወረቀት አንብቤ በሚከተለው የምርምር ፕሮጀክት ለመሳተፍ ተስማምቻለሁ፡-

የፕሮጀክት ርዕስ፡	በኢትዮጵያ ጤና ተቋም ዉስጥ እናቶች በሚወልዱበት ወቅት የሚደረግረግላቸዉ እንክብካቤ፡ ቅይጥ ዘዴ ጥናት
የሰዉ ምርምር ስነምግባር ኮማቴ	H-2019-153

2. ፕሮጀክቱ በእኔ ላይ ተጽዕኖ እስከሚያደርስ ድረስ እና ሊከሰቱ የሚችሉ አደጋዎች እና ሽክሞች በተመራማሪው እርካታ ሙሉ በሙሉ ተብራርተዋል. ስለ ፕሮጀክቱ እና ስለ ተሳትፎዬ ያለኝን ማንኛውንም ጥያቄ ለመጠየቅ እድሉን አግኝቻለሁ። የእኔ ፈቃድ በነጻ ይሰጣል።

3. ፕሮጀክቱ ሲገለፅልኝ የቤተሰቤ አባል ወይም ጓደኛ እንድገኝ እድል ተሰጥቶኛል።

4. የምርምር ፕሮጀክቱ ዓላማ የጤና/የህክምና አገልግሎትን ጥራት ማሻሻል እንደሆነ ቢገባኝም የእኔ ተሳትፎ ምንም ጥቅም ላይኖረው እንደሚችልም ተብራርቷል።

5. በተሳታፊ የመረጃ ወረቀት ላይ በተገለፀው መሰረት በእንቅስቃሴዎቹ ለመሳተፍ ተስማምቻለሁ።

6. በጥናቱ ወቅት ወይም ጥናቱ ከተጠናቀቀ በኋላ ባሉት አራት ሳምንታት ውስጥ በማንኛውም ጊዜ ከፕሮጀክቱ የመውጣት ነፃነት እንዳለኝ ተረድቻለሁ።

7. በፕሮጀክቱ የተገኘው መረጃ በፒኤችዲ ተሲስ፣ በአቻ ግምገማ ጆርናል ላይ ታትሞ በአካዳሚክ ኮንፈረንስ፣ በአገር ውስጥ ሬዲዮ ጣቢያ ተላልፎ ለኦሮሚያ ክልል ጤና ቢሮ እና የሁሉም አስተዳዳሪዎች እንደሚቀርብ ተነግሮኛል። በዞኑ ውስጥ ያሉ የጤና ተቋማት.

8. በታተሙ ጽሑፎች ውስጥ ማንነቴ እንደማልታወቅ እና የግል ውጤቶቼ እንደማይገለጡ ተነግሮኛል.

9. መረጃዬ በማንኛውም ተመራማሪ(ዎች) ለሚደረጉ ተዛማጅ የወደፊት ጥናቶች ጥቅም ላይ እንዲውል ተስማምቻለሁ።

ስም_____ፊርማ_____ ቀን_____

ተመራማሪ/ መረጃ

ሰብሳቢ የምሞላ:

የምረምሩ ሁኔታ ለ (ስም)_____ገልጨለሁ፤ በእኔ እይታ ገለጻዉን ተረድቷል።

ፍርማ : _____ስራ ድርሻ : _____ ቀን :_____