ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

PREVALENCE AND FACTORS ASSOCIATED WITH DISRESPECT AND ABUSE DURING CHILDBIRTH AMONG MOTHERS WHO DELIVERED AT PUBLIC HEALTH FACILITIES IN SODO WOREDA, EAST GURAGE ZONE, CENTRAL ETHIOPIA.

BY: MESELE ZEWDIE HAILE

ADVISORS:

ASSEFA SEME (MD, MPH, ASSOCIATE PROFESOR)

A THESIS SUBMITTED TO THE GRADUATE PROGRAM OF ADDIS-ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH IN PARTIAL FULFILLMENT FOR THE DEGREE OF MASTERS OF PUBLIC SPECIALITY IN REPRODUCTIVE FAMILY AND POPULATION HEALTH.

DECEMBER, 2025

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Acronyms and Abbreviations

AAU_____ Addis Ababa University

CI _____Confidence intervals

COHRA_____ Consortium of Reproductive Health Association

D & A _____ Disrespect & Abuse

DHIS2_____ Demographic Health Information System

EDHS_____ Ethiopian Demographic Health Survey

FMOH_____ Federal Ministry of Health

HO_____ Health Officer

HEW_____ Health Extension Worker

PI_____ Principal Investigator

RMC_____ Respectful Maternity Care

SPSS_____ Statistical Package for Social Science

WHO _____World Health Organization

WoHO_____ Woreda Health Office

ZHD_____ Zonal Health Department

Abstract

Background: In low- and middle-income nations like Ethiopia, violence and disrespect during childbirth are serious global health issues. Maternal health outcomes, human rights, and women's willingness to seek facility-based care are all negatively impacted by such abuses, which range from verbal and physical abuse to denial of informed consent. Evidence is scarce despite increased attention, particularly locally.

Objective: To assess the prevalence and factors associated with disrespect and abuse during childbirth among mothers who deliver at public health facilities in Sodo Woreda, East Gurage Zone, Central Ethiopia, 2025.

Method: In 2025, a facility-based mixed-methods study was carried out. 427 postpartum mothers provided quantitative data, and 18 mothers and six providers were interviewed for qualitative data. Five domains were used to measure disrespect and abuse: poor rapport, stigma and discrimination, verbal abuse, physical abuse, and failure to meet professional standards. To account for confounding, all variables with a p-value less than 0.25 in the bi-variable logistic regression analysis were chosen as potential variables for the multivariable logistic regression analysis. When p – value < 0.05 was deemed statistically significant, adjusted odds ratios (AOR) with 95% confidence intervals were presented.

Result: Overall, the prevalence of disrespect and abuse was 42.4%. Physical abuse had been suffered by 18.3% of the mothers, although 64.6% felt that care was provided without their consent, and 67.4% felt that there was poor communication. Only 34.4% of the women felt safe, although 65.6% felt that they were not involved in decision making for their care. There were several variables that were significantly associated with the risk of disrespect and abuse. Women who had a relative with them during childbirth were 34 times more likely than others who did not have anyone with them (AOR = 34.894, 95% CI = 15.208-80.059). However, women who were allowed to deliver in the position of their choice were less likely than others to experience abuse (AOR = 0.062, 95% CI = 0.025-0.152). On the other hand, women who felt supported by healthcare providers were less likely than others to experience disrespect and abuse. Women who felt they received sufficient support were 81% less likely than others to experience disrespect and abuse (AOR = 0.199, 95% CI = 0.085-0.465).

Participants reported that there were inadequacies in privacy provisions when delivering services. Even if the doors and window were closed, this practice did not make them feel safe. A

participant asserted, “During service delivery, there were no adequate measures taken to ensure privacy. Apart from closing the door and window, it did not make me comfortable” (Interview 9, 37 years). “I have not seen a lack of respect or abuse in the service delivery process” (interview 1, 25 years). Another participant asserts, “I have seen a lack of respect or abuse in the service delivery process, which is a result of Ethical issues among professionals.

Conclusion and recommendation

Disrespect and abuse during childbirth remains extremely common in the study area, suggesting deep-seated issues in the quality of care and respect for maternal rights. Respectful Maternity Care needs to be brought into practice at all levels of the health system. This should include introducing standard-of-care training for providers; supportive supervision; and a woman-centered,culturallysensitivefacility.

Keywords: Disrespect and Abuse, Maternity Care, Facility Delivery, Ethiopia.

CHAPTER 1: INTRODUCTION

1.1-Background

Globally, there appear to be disrespectful and undignified practices against women during the process of giving birth in health facilities, which hinder the current and prospective use of health facility deliveries (1). In developing countries, the lack of respect and dignity during childbirth has continued to pose various challenges, as illustrated by maternal mortality and morbidity rates associated with low-quality maternity services (2). A 2019 study conducted among women in the United States established that one in six women reported experiences of mistreatment while giving birth and experiencing labor. Other research has also established that the prevalence of mistreatment among new mothers was comparable, with 77.6% of women reporting experiences of mistreatment (3). However, other research has shown that Dutch women experienced high client satisfaction with perinatal health services and the patient-centeredness of healthcare providers during childbirth. A study conducted by Streamwood in 2011, however, established that 9.1% of Dutch women reported their experience of giving birth as being traumatizing(4). A study among Dutch women who earlier experienced giving birth as traumatizing illustrated that they primarily related their experiences to a lack of control, communication problems, and lack of care and support (5).

Disrespect and misconduct during childbirth are defined as any kind of inhumane treatment or negligent actions that are channeled towards a woman throughout the process of delivery(6). Pregnant women are likely to be exposed to various forms of disrespect and misconduct in the healthcare institutions with regard to physical violence, non-consensual medical procedures, confidentiality breaches, disrespectful treatment, abandoning the patient, discrimination, as well as being denied access to care in the institutions as a result of the ability to pay. Additionally, it poses a great challenge faced by women in labor as well as childbirth, acting as one of the major hurdles in accessing maternal healthcare (7). Although, it has attracted less attention than other hurdles in the aspect of the availability and acceptance of maternal care in labor and childbirth(8) . Several research studies give an indication of the high rates of severe types of disrespect and abuse in developing countries worldwide, with rates recorded at 33.3% in Mexico (9). in contrast to 71.0% in India(10) . In countries with high incomes, disrespect as well as abuse can also occur. However, its types, which come in via unbalanced information, non-informed consent, forced medical practices, as well as disregarding birth plans, in both subtle as well as

unsubtle manners (11, 12). Of the participants labeled as victims of disrespect and abuse (n = 136) in this study, just 22 (16.2%) suffered from disrespect and abuse. On being divided for socio-demographic as well as obstetric aspects of disrespect and abuse, merely the participants' monthly income showed a high level of lesser or greater disrespect as well as abuse (89.5% in payment of less than 713 ETB as opposed to 70.3% in payment of more than 713 ETB) (13).

In 2022, a study conducted in Harar, Ethiopia, showed that 53.0% of mothers experienced disrespect and abuse (11). The study conducted in Ethiopia showed that the percentage of Respectful Maternal Care (RMC) was 22% (4, 14, 15).

Currently, the Ethiopian Federal Minister of Health has established the guidelines for in-service care and is in the process of implementing them. Additionally, the Ethiopian government has made great efforts to improve the number of healthcare facilities and link the communities better to the facilities to promote access and utilization of maternity services. However, recently, it was disclosed that improving access alone is not enough to promote utilization of services since perceived service quality and interaction or care between the provider and the client limit women from accessing delivery services from skilled personnel in the health facilities (16). Consequently, the nature of interactions between clients and providers plays a crucial role in influencing women's experiences and perceptions of maternity care during childbirth; in the long term, positive interactions can lead to a decrease in maternal mortality and morbidity (17). Contrary to the established fact that disrespect and abuse are key determinants in the use and service quality of maternity services, the phenomenon has not been as much in the limelight, as are the challenges in accessing and utilizing maternity services in the Ethiopian setting (18, 19).

Offering respectful and empathetic maternity services during the process of childbirth encourages the practice of women giving birth at healthcare institutions (13). The extent to which disrespect is involved when offering maternity services during childbirth has become the basic standard when measuring the improvement of the quality of maternity services (18). Therefore, assessing the current prevalence of disrespect and abuse during childbirth is crucial (18, 20). As a result, it is important to evaluate the extent to which disrespect and abuse exist during childbirth, since there has not been adequate research conducted at the institution level in Ethiopia, and there has not been sufficient research conducted concerning the extent to which disrespect and abuse exist during childbirth, together with the influencing

factors. Simply carrying out research at the institution level is not adequate when it comes to assessing the influential factors associated with disrespect and abuse linked to childbirth. Consequently, the aim of this research study sought to evaluate the extent and influencing factors of disrespect and abuse associated with childbirth at the South Sodo Woreda health institutions in the Central Ethiopian region of East Gurage Zone.

1.2. Statement of the problem

Despite the concerted efforts directed at enhancing maternal health outcomes globally, the issue of the standard level of care during delivery still poses a challenge, especially in developing nations such as Ethiopia(21). In rural settings, the issue of respectful maternity care (RMC) among women still forms a pressing concern (22). Although progress has been achieved with regards to enhancing facility delivery rates and the health status of both the mother and the child, the issue of disrespectful, abusive, and/or neglectful care during the time of delivery continues to affect a substantial majority of women (23). These factors have continued to worsen the rates of maternal death and morbidity within the boundaries of Ethiopia (13).

According to the 2019 mini Demographic Health Surveillance report in the Ethiopian state, 50% of the deliveries were attended by skilled birth attendants, with a maternal mortality rate of 412 per 100,000 live births.

From the data presented in the DhIS2 in Sodo Woreda, progressive coverage of skilled births should be delivered annually (107%, 89%, 109%, 102%, and 111% for the year 2019 to 2023). However, maternal deaths are high with unreported data on disrespect and abuse. There remains little exploration into the quality of care offered in terms of RMC even with increased deliveries in many areas like Sodo Woreda. However, few institution-based studies have been undertaken in Ethiopia (13), and little research has also been undertaken on the prevalence and factors that precipitate disrespect and abuse with childbearing. Moreover, merely undertaking research within institutions would not help identify the factors contributing to disrespect and abuse with childbearing. The purpose of undertaking this research was therefore aimed at assessing the level and factors associated with disrespect and abuse with childbearing that occur in public institutions in Sodo Woreda of East Gurage Zone of Central Ethiopia.

1.3- Significance of the study

This research study gives knowledge and provides insight into disrespect and abuse of women in facility-delivered childbirth. This research study aims at emphasizing the need for addressing these problems in the health sector. It will normally provide knowledge on the magnitude of disrespect and abuse, as well as the elements that influence it, to conduct efforts aimed at promoting respectful maternity care, as well as encouraging women to give birth in facilities. In this research study, several aspects of disrespect and abuse of mothers in childbirth will be covered. First, this research study will provide baseline information, since previous research studies on D&A in childbirth in the study area do not exist. There will be a creation of awareness on the experience of D&A in childbirth. This will create awareness among health professionals, stakeholders, as well as the general populace, on the significance of respectful, dignified maternity care.

CHAPTER 2: LITERATURE REVIEW

2.1. Factors affecting disrespect and abuse

Disrespect and abuse (DA) in the health care environment has lately come into the spotlight as one of the crucial issues that affects the dignity, safety, and general well-being of the patient. Recognition of the pros and cons that lead to the occurrence of DA is fundamental for the formulation of intervention strategies. Educational Status of Women with no formal education is more prone to D&A (24). One of the major factors that contributes to D&A is the status of the woman being married. In a research by Abia State, Nigeria, women who are married are more prone to D&A during childbirth (25). Economic status is a fundamental determinant of the potential for occurrence of D&A. Women who earn low amounts each month are twice as liable to experience D&A compared to women who earn much higher amounts each month (25). Residency** plays a crucial role in the D&A of the woman. Women who originate from rural setups are more exposed to D&A due to the lack of access to convenient health care facilities and services for everyone in the society at all costs (24). Proximity to medical facilities is another significant aspect that determines the occurrence of D&A of the patient. Women who are more than 30 minutes away from the health facilities are more liable compared to closer women (25). Cultures play a significant determinant in the aspect of health care, particularly health care delivery, which affects the health care professionalism of the providers of the services in health care. Cultural aspects, particularly within society, exhibit health care disregard due to the aspect of gender inequality that tends to demean the health care well-being of the woman (26). Bohren, in her research in 2019, established that the aspect of health care authority, which is fundamental within the society, tends to create health care superiority of the health care authorities over the women who are at the verge of health care services, thus health care abuse, neglect, or disregard by the facilities due to the geographical superiority of the facility (27). Health care provider professionalism** is a significant determinant of health care services. Such providers are liable for the aspect of health care disregard of the patient due to the lack of professionalism in health care services, such as training offered on health care respectful conduct, which might, in the process of delivery, lead to health care abuse of the woman by the health care providers.

Mhlanga, in her research, established that health care providers who were ill-trained on health care respectful conduct were more prone than others who received the training, which might lead to health care disregard for the woman. Additionally, the need for continuous training among professionals cannot be overemphasized if the culture of respect is to be promoted. Systemic problems associated with healthcare institutions play a critical role in the widespread nature of DA. If the healthcare institutions are overcrowded, understaffed, and the number of patients per provider is high, a provider may become stressed, thus increasing the chances of them disrespecting others (28). A study conducted by Sultana (2020) found that issues associated with the failure of the system, like the lack of infrastructure, play a critical role in increasing the chances of the occurrences of DA. The characteristics of the patients, like socio-economic status, education level, and ethnicity, play a critical role in determining the rates of DA (29). Marginalized communities tend to be faced with the highest rates of disrespect because of the issues associated with the systemic inequality present within the healthcare institutions. A study conducted by Pereira (2021) found that low-income women reported higher rates of disrespect compared to those in higher income when the childbirth process occurred. Moreover, patients within the healthcare institutions may lack adequate health literacy. As a result, they may not be aware of the rights accorded to them. Consequently, they may be faced with the highest rates of disrespect because the provider may not understand what they are saying (30). Communication between the provider and the patients plays a critical role in healthcare institutions. A lack of effective communication may lead to problems because the provider may not understand the patients. As a result, the provider may be faced with the highest rates of disrespect because the patients may perceive them as if they are not interested (31). A study conducted by Rogers (2021) found that patients faced with challenges associated with communicating within the healthcare institution were faced with the highest rates of feeling neglected and disrespected by the healthcare provider. Improved provider communication skills play a critical role in the process of reducing the rates of disrespect among patients.

2.2. Prevalence of disrespect and abuse

In one study that explored the amount of disrespect and abuse, findings showed that 91.7% of mothers who participated in the study suffered disrespect and abuse during childbirth (32). From another study, it was revealed that 46.9% of mothers suffered disrespect and abuse in healthcare

settings (22, 33). In another study conducted in Tanzania, disrespect and abuse in childbirth had a prevalence rate, which stood recorded at 19.5% in exit interviews and 28.2% in follow-through interviews (34). In another study in Tanzania, it was revealed that 15.0% of mothers suffered disrespect and abuse during childbirth in healthcare facilities (35). In one study in Southeastern Nigeria with a cross-sectional study model, an astonishing rate of 98.0% of mothers suffered disrespect and abuse in childbirth (11). In another study conducted in Kenya, it was revealed that 20.0% of mothers giving childbirth suffered disrespect and abuse In another study in Bahir Dar Town, overall disrespect and abuse in childbirth in healthcare facilities was recorded at 67.1% (36). The main prevalent disrespect and abuse included culturally inconspicuous care (75.2%), failing to encourage the client to question care (75.9%), failing to introduce staff (80.0%), failing to take care to obtain consent (63.8%), and failing to utilize screens to conceal care recipients (81.7%) (14, 33). The main factors that reduce the chances of respect and abuse being found included unmarried status, multiple pregnancies, and attendance to care administered by females (22). In contrast, achieving secondary schooling raised the chances of respect and abuse during childbirth being found. Women cared for by females had greater chances of experiencing disrespect and abuse than those cared for by men (23). Chances of respect and abuse being found are lower among those earning lower income, those staying in healthcare facilities following childbirth, those staying in public hospitals in healthcare settings, and fewer visits to healthcare settings for antenatal care (22, 37). Several sources pointed out some gaps such as. Limited Quantitative Data. There is some qualitative summary presentation of respect and abuse in childbirth in healthcare settings; yet, much quantitative evidence does not exist in respect to respect and abuse in childbirth in settings that lack adequate resources and funds (22, 38). More in-depth research could be done through techniques such as in-depth interviews or focus group discussions, which might provide more in-depth information on the issues surrounding the experience of women who experience disrespect and abuse during childbirth (33). The primary research, however, primarily analyzes data quantitatively. More in-depth analysis might be done through techniques such as interviews with women who have had the experience of disrespectful care, which might better provide information on the factors surrounding the issue and the effects of the experience (33, 38). Although the issue states that the factors which contribute to the experience of women during facility-based childbirth are complex and might be interpreted based on the situation, there is a lack of discussion on the several different factors which

contribute individually and collectively on the experience of the issue (11, 33). There is also a gap in the analysis of the comprehensive approaches that are effectively utilized on the issue in the health care systems (23).The research is, however, specifically outlined for a particular geographical setting in Southwest Ethiopia. More generalized research might be done on a comparison of the several different areas or nations, which might provide more information on the prevalence of the experience of the issue and the effectiveness of the approaches which are used on alleviating the problems of the issue regarding the facilities and health care systems on the nations (22). Although the issue identifies the primary effects of the experience on the facilities, more analysis might be done on the comprehensive effects of the experience on the health outcomes of the mother, the perception of the health care systems on the women, and the several different health approaches on the health care systems of the nations on the health status of the women on the experience of the nations on the support of health care systems of the health facilities on the nations on the experience of the issue on the health status of the nations on the experience of the issue on the health facilities on the nations on the experience of the issue on the health status of the issue on the health facilities on the nations on the experience of the issue on the issue (11, 22). The analysis, however, specifically identifies the several different factors on the city of Hawassa on the Southern parts of Ethiopia. Using findings from healthcare professionals, policymakers, and communities might offer a broader understanding of the problem (23). The study specifically analyzes Hawassa City in Southern Ethiopia. This narrow scope might not represent the conditions in rural settings or other parts of Ethiopia, where healthcare facilities and practices might differ (33). The study recognizes factors linked to disrespect and abuse; there could be further elements that were not included in the analysis. Variables such as cultural norms, healthcare providers' attitudes, or institutional policies might significantly influence the situation (23). The research primarily centers on the experiences of women who have given birth in health facilities. Incorporating insights from healthcare providers, policymakers, and community members could present a more comprehensive understanding of the issue(11, 23). Although the study offers strategies for solving the problem of disrespect and abuse, the study does not go in-depth into the effectiveness of the strategies or the challenges that might be involved in their implementation (23, 38). The study from 2018 may not offer an understanding of recent developments in the healthcare systems, policies, or practices. The study could offer a new understanding of the problem's relationship with

disrespect and abusive practices during childbirth. The study focuses primarily on the role of women. Using findings from healthcare professionals might offer a broader understanding of the factors that lead to disrespect and abusive practices during childbirth (11, 14, 33). Although the study indicates the factors that lead to disrespect during childbirth, there is a lack of information on the potential strategies or solutions that can be used to address the problem. Suggestions for changing healthcare policies or providing training for healthcare professionals might be beneficial for the applicability of the study (23).

The study remains highly relevant from a number of key angles. The study demonstrates the struggles women face in institutional childbirth in resource-limited settings and the need for respectful and dignified treatment in maternal healthcare services (22). The research emphasizes the critical issue of the disrespectful and abusive behavior of healthcare providers, which can act as a deterrent to women seeking professional help during childbirth, thereby having a subsequent effect on the health status of mothers and newborns (33). Barriers to institutional delivery. Identifying the factors related to the experience of disrespect and abuse helps make the study address a critical gap related to barriers to institutional delivery. This serves as a valuable guideline to facilitate interventions to improve the use of maternal healthcare services (22). The prevailing rate of abuse/disrespect associated with institutional childbirth indicates critical issues prevailing within the healthcare system that require necessary attention to strengthen the provision of quality services and contribute to improved health statuses of women. The study emphasizes the need to systematically address policies and strategies to promote appropriate 'respectful maternity care practice', of which the critical aspect relates to training providers to act respectfully as a critical strategy to address behaviors of healthcare providers (22, 23, 33). The research addresses a gap related to disrespect and abuse experienced during childbirth at healthcare facilities in resource-limited settings and improves awareness about a critical question related to childbirth (22).

2.3. Conceptual framework

Healthcare Disrespect and Abuse (DA) can also be viewed from an elaborate conceptual framework, which takes into account elements in four categories: client factors, provider factors, process of care, and facility factors. Regarding client factors, cultural factors as well as patients'

expectations concerning healthcare play important roles in shaping experiences in healthcare facilities, where obstacles to seeking healthcare might worsen experiences of disrespect. Other factors from the provider-level perspective include healthcare providers' knowledge about respectful maternity care (RMC), provider sex and level of faculty expertise, number of healthcare staff members, healthcare workloads, as well as healthcare providers' attitudes toward their clients. The process of providing healthcare is also very important since communication, informed consent, respect for patients' dignity, as well as respect in healthcare, are fundamental aspects for potentially ensuring respect in healthcare or worsening patient experiences in healthcare facilities where disrespect and abuse might also take place. Facility factors also play important roles in creating an enabling environment where respect is valued in healthcare.

Conceptual Frame Work

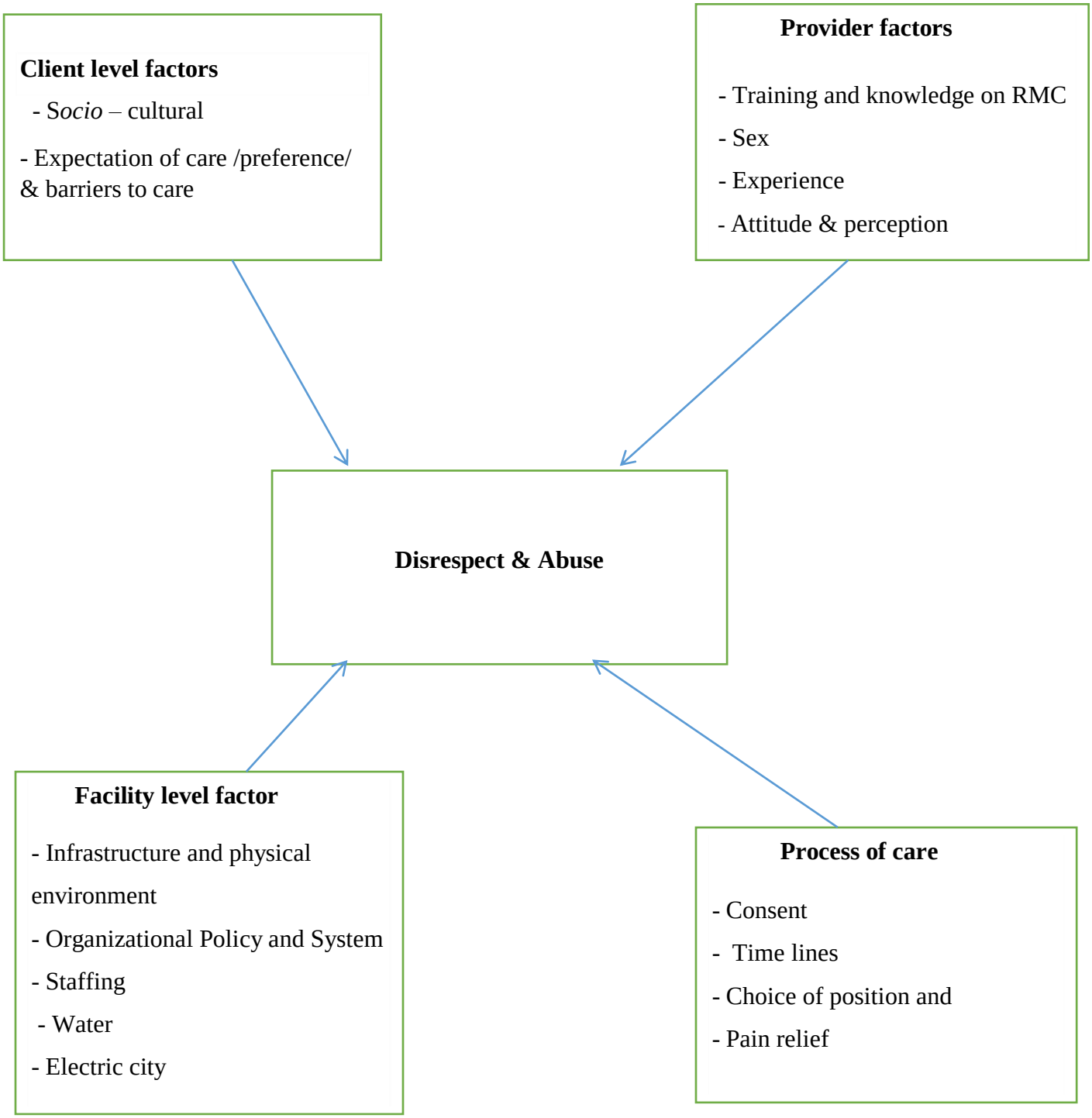

Figure 1: Conceptual framework of prevalence, and factors associated with disrespect and abuse during childbirth Sodo Woreda East Gurage Zone, Central Ethiopia 2025.

CHAPTER 3: OBJECTIVES

3.1- General Objective

- To assess the prevalence and factors associated with disrespect and abuse during childbirth in public health facilities in Sodo Woreda, East Gurage Zone, Central Ethiopia, 2025.

3.2-Specific Objectives

- To determine prevalence of disrespect and abuse during childbirth in public health facilities in Sodo Woreda. East Gurage Zone of Central Ethiopia, 2025.
- To assess factors associated with disrespect and abuse during childbirth in public health facilities in Sodo Woreda, East Gurage Zone of Central Ethiopia, 2025.
- To investigate why women experience disrespect and abuse during childbirth in public health facilities in Sodo Woreda, East Gurage Zone of Central Ethiopia, 2025.

CHAPTER 4: METHODS & MATERIALS

4.1. Study area

The study was conducted in central Ethiopia, East Gurage zone, Sodo Woreda. It's found 100 km from Addis Ababa in the direction of the south through the Alemgena road. It has a total of 46 kebeles with a total population of 129,358 based on the 2022/2023 population projection. Regarding health facilities in the Woreda, there are a total of 5 governmental health centers, 44 rural and 2 urban health posts. In addition to this, there are 9 primary and 1 medium clinic in the private sector. The Woreda has a total staff of 345, and of these, 92 were professionals having different professions from diplomas to 1st degrees. Its boundaries include North Oromia, South Sodo to the east and west, also the Oromia region.

4.2. Study design and period

A mixed-method study design was used in 5 health centers in Sodo Woreda by using an interview questionnaire, and an audio record was used to measure the prevalence and associated factors of disrespect and abuse during facility-based childbirth. Qualitative insights into the experiences and perceptions of disrespect and abuse during the period from the month January to March,2025.

4.3. Population

4.3.1. Target population

Women, who were in labor and delivered within the Woreda.

4.3.2. Source population.

All women, who were in labor and delivered within the Woreda who meet the eligibility criteria,.

4.3.3. Study population-

All women were in labor and delivered within Woreda who participated in the study during the study period, and front line health care providers working in MCH.

4.4. Inclusion and Exclusion Criteria

Inclusion criteria: Pregnant mothers who consented and gave birth within the facility during the data collection period.

Exclusion criteria: Mothers who are severely ill and /or have known mental problems.

4.5. Sample size and sampling process

4.5.1. Sampling size

The sample size in this cross-sectional survey was determined using a single population proportion formula [N = (Zα/2)2 *P (1-P) / d2] .To determine the sample size for this design, Where n =the required sample size, Z =standard score (1.96) corresponding to a 95% confidence interval, P = the estimated proportion of the impact assumed to be 0.5, d = the margin of error (precision) 5% & adding 11 % for non-response rate.

$N = (Z\alpha/2)^{2*}P (1-P) / (d),^2$ $N= (1.96)^2 *0.5(0.5) / (0.05)^2$ = 0.96/0.0025 = 384 So the final sample size was: N= 384 x 0.11 +384 = 427. Study participants were selected by a random sampling technique until the required sample size was achieved. The data saturation principle, which states that data collection should continue until no new analytical information emerges, was used to establish the sample size for the qualitative portion of the study. As a starting point, eighteen individuals participated in an in-depth interview.

4.5.2. Sampling procedure

In Sodo Woreda, there are 5 health centers: Gereno, Tiya, Wacho, WulaWula, and Endebuyo. Based on delivery service performance evidence of the nearby 3 months (September, October, and November (2024) an average of 174,159,151,196,148 mothers were delivered in Gereno, Tiya, Wacho, WulaWula, and Endebuyo health centers, respectively. These amounts(828/3) to 276 in one month. Based on this, the number of women to be selected from each health center proportionally allocated as follows: Gereno health Center: 427/828*174 ≈ 90. Tiya health Center: 427/828*159≈82, Wacho health Center: 427/828*151 ≈ 78, WulaWula health center: 427/828*196 ≈ 101 and Endebuyo health center 427/828*148 =76

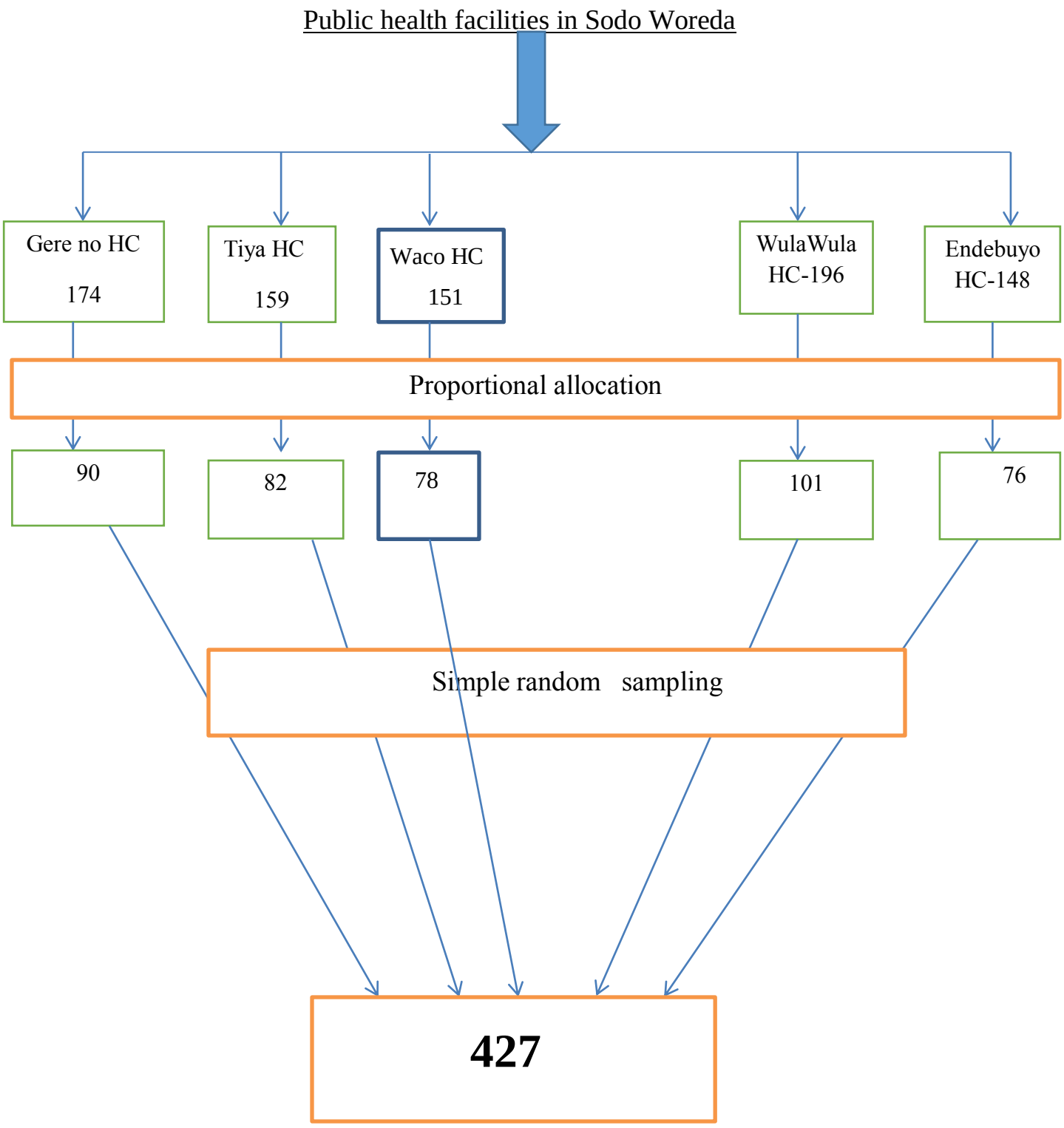

Figure 2*;* Schematic presentation of sampling procedure for assessing prevalence, and factors associated with disrespected, and abuse at public health facilities of Sodo Woreda East Gurage Central Ethiopia 2025.

4.6. Variables of the study

4.6.1. Dependent Variable

Disrespect and abuse (D&A) is the outcome variable of the study and is measured as Yes or No. Disrespect and abuse during childbirth are measured using seven categories of disrespect and abuse, and their respective verification criteria were developed by the Maternal and Child Health Integrated Program[35]. A total of 25 verification criteria of disrespect and abuse were used. For quantitative measures, structured and pre-tested questionnaires were used to collect data from the study participants. The tool consisted of three sections. The first section is used to assess the socio-demographic characteristics of the mother. The second section is used to assess the obstetric characteristics of the participants. The third section is used to assess seven categories of disrespect and abuse that women experienced during childbirth at a health facility (physical abuse, non-confidential care, non-consented care, undignified care [including verbal abuse], discrimination, abandonment or denial of care, and detention in facilities). A woman who reported at least 1 incident corresponding to the criteria asked about in a given category was considered to have experienced disrespect and abuse in the respective category [36]. The D&A was created based on the 7 categories of D&A as a binary variable. For qualitative measures, interviewing health care providers and mothers using audio records was used.

4.6.2. Independent Variables

The independent variables include age, religion, ethnicity, marital status, educational status, address, monthly income, health care provider, and service-related factors.

4.7. Data Collection Process

Quantitative data was collected by using a pretested and structured questionnaire by interviewing study subjects face to face after delivery at the postnatal unit. Eligible participants who are attending the selected health centers were invited to participate. Participants were given information about the study through an information sheet, and

they signed a consent form if they agreed to be part of the study. The data collection instrument was translated into Amharic and Guragigna. Pretesting was conducted before the actual study by the investigator, and the pretest result was not included in the study. Two supervisors and five data collectors were recruited and trained for one day on the objectives and data collection tools by the principal investigator. For the qualitative part of the study, in-depth interviews (IDIs) were carried out. The IDI was done using an interview guide prepared using semi-structured questions. The qualitative data were collected via face-to-face interviews. The interviews were audio-recorded.

4.8. Data Quality Assurance and Control

Data collection was done using a pre-tested and validated questionnaire. Data collectors and supervisors were trained on the study objectives and tools by the principal investigator. A pre-testing of the tool was done to ensure its adaptation to the local context and to ensure clarity. Supervision was provided during the data collection phase and checked for completeness and consistency of responses.

4.9. Data Management and Analysis

Data were collected through structured questionnaires were checked for completeness and consistency daily by supervisors and principal investigators. After data collection, all completed questionnaires were coded and entered into EpiData version 3.1 to minimize data entry errors. The cleaned data were exported to SPSS version 26 for analysis. Double data entry and validation were conducted to ensure accuracy and reliability. Descriptive analyses were performed to summarize the socio-demographics of the study participants. Measures such as frequencies, percentages were used. The prevalence of disrespect and abuse (D&A) during childbirth was calculated as the proportion of women who reported experiencing at least one form of D&A out of the total number of respondents. Each form of D&A, like physical abuse, verbal abuse, was also reported separately. To identify factors potentially associated with D&A, All variables with a p-value <0.25 in the bi-variable logistic regression analysis were selected as candidate variables for multivariable logistic regression analysis to control for confounding. A multivariable logistic regression model was used to determine factors independently associated with D&A during childbirth. Adjusted Odds Ratios (AORs) with 95%

Confidence Intervals (CIs) and p-values < 0.05 were used to declare statistically significant associations. All qualitative data were collected through in-depth interviews (IDIs) with women who recently gave birth in public health facilities within Sodo Woreda, as well as with healthcare providers. Interviews were audio-recorded with participant consent and supplemented with field notes, and Recordings were transcribed verbatim in the original language, Guragigna, and then translated into English for analysis. Thematic analysis was used to analyze the qualitative data. Data collectors read and re-read transcripts to gain an in-depth understanding of participants' experiences and perspectives regarding disrespect and abuse during childbirth. Open coding was conducted using the qualitative data analysis software of MAXQDA**.** Related codes were grouped into categories and themes**.** To ensure rigor and trustworthiness, the study applied Credibility, Transferability, and Dependability**.**

4.10- Operational Definitions

- Disrespect and abusive maternity care**:-** Means mothers who face one of the following abuses, physical abuse, non□consented clinical care, non□confidential care, non□dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities (39).
- Physical Abuse – This means mothers who replied 'yes' to any of these actions, health provider(s) hitting, slapped, pushed, pinched, or otherwise beat her, used force as a restraint during labor/ delivery/ examination, and procedures were done without anesthesia or other forms of pain relief (40).
- Non-consented care - Means mothers who replied 'yes' to surgical or other procedures done without asking her consent (41).
- Non-dignified care- This means mothers who replied 'yes' to any of these actions, health providers shouting at or scolding her, making negative comments about her, or threatening to withhold treatment because she could not pay or did not have supplies (42).
- Non- confidential care- Means mothers who replied 'yes' to any of these actions, health providers discussed her private health information in a way that others

could hear, Your body was seen by other people (apart from health providers) during delivery (41).

- Discrimination- This means mothers who replied 'yes' to any of these actions were treated poorly because of poverty, ethnicity, religion, or tribe, her age, or her marital status (41).
- Abandonment of care- This means mothers who replied 'yes' to any of these actions, the health providers ignored or abandoned them when they called for help and delivered without any assistance (41).
- Detention in facilities- This Means mothers who replied 'yes' to any of these actions are not allowed to leave the health facility due to failure to pay, and health providers suggest or ask for a bribe or informal payment for better care (43).
- Immediate postpartum period is a period that extends from the time of delivery till their time of discharge from the health facility (44).

4.11. Ethical considerations

Ethical clearance was obtained from the Scientific and Ethics Review Committee of the School of Public Health and the IRB of the College of Health Sciences, Addis Ababa University. A formal letter for cooperation was obtained from the AAU School of Public Health to the zonal health department, and the zone accepted it and then wrote a supportive letter to the entire Woreda where the research was conducted. Verbal/signed/ consent was obtained from respected participants after necessary explanations about the purpose, benefits & risks of the study. They were informed that they have the full right to say "no", and it was clearly stated that their decision of "no" by any means cannot affect the service that they obtain from those facilities. Confidentiality was maintained by conducting the interview privately in a single room and omitting their names on the questionnaire; instead, a unique identification number was assigned. In addition, the confidentiality of the information is maintained.

CHAPTER 5: RESULT

5.1. Socio-demographic characteristics of the respondents

A total of 427 mothers responded to the survey question, making the response rate 100%. The mean ±SD age of the respondents was 28.04 (± 5.55) years. More than one-third (37.7%) of the respondents were in the 25-29 years age group, more than 80% of the study participants were rural dwellers, and almost all of the study participants were married (97%) and followers of the Orthodox religion (99%). About one-third, 133 (31.1%) of the respondents have attended primary education, and 330 (77.3%) of the respondents were housewives by occupation. In addition, more than half of the respondents 238 (55.7%) have an average household monthly income of less than 1500 Ethiopian Birr.

Table 1: Socio-demographic characteristics of mothers who delivered in Sodo Woreda, East Gurage, Central Ethiopia, 2025 (n=427).

Variable	Frequency (n)	Percentage (%)
Age in years		
15-19	24	5.6
20-24	127	29.7
25-29	161	37.7
30-34	63	14.8
35+	52	13.1
Place of Residence		
Urban	81	19
Rural	346	81
Marital status		
Unmarried	13	3
Married	414	97
Religion		
Orthodox	426	99.8
Ethnicity		

Gurage	348	81.5
Silte	54	12.6
Others (Amhara, Oromo, Tigre, Wolayta)	25	5.8
Educational level		
No formal education	131	30.7
Can write and read	68	15.9
Primary (1-6)	133	31.1
Medium (7-8)	60	14.1
Secondary and above	35	8.2
Occupation		
Housewife	330	77.3
Farmer	19	4.4
Merchant	57	13.3
Civil servant	16	3.7
Others (Daily laborer, student)	5	1.2
Household monthly income		
<1500	238	55.7
1500-3000	136	31.9
>3000	52	12.2

5.2. Prevalence of Disrespectful and Abusive Care during Childbirth:

The overall prevalence of disrespectful and abusive care among mothers during childbirth in health facilities was 42.4%.

Table 2: Category of disrespect and abuse during facility-based childbirth, Sodo Woreda, East Gurage Zone, Central Ethiopia 2025 (n=427)

Disrespectful and abusive care dimensions	Yes, n (%)	No, n (%)
Physical abuse	18.30	81.70
Health provider slapped, kicked me for a pinch, bite, or restraint during labor	78(18.3)	349(81.7)
Verbal abuse	25.80	74.20

Health workers shouted at me by giving bad comments	110 (25.8)	317(74.2)
Failure to meet professional standards of care	35.22	64.78
Health care provider ask for permission/consent before providing any care to you?	151(35.4)	276 (64.6)
Health providers provide timely care	240(56.2)	187(43.8)
Health provider is present during your labor	144(33.7)	283(66.3)
Health provider participated in the decision of your care	147(34.4)	280(65.6)
Health provider selected your able choice position	104 (24.4)	322(75.6)
Health provider creates a comfort examination room	143 (33.5)	284(66.5)
Health provider explains a procedure what they do	139 (32.6)	288(67.4)
Health provider talked positively about pain and relief	262 (61.4)	165(38.6)
Service provision was delayed due to the health facility's internal problem	(5.4)	404(94.6)
Stigma and discrimination	60.90	39.10
Some of the health providers did not treat me well because of some of my attributes.	260 (60.9)	167(39.1)
Poor rapport between women and provider	71.64	28.36
Give attention when you need help	285(66.7)	142(33.3)
Give emotional, and reassurance during labor and delivery	296(69.3)	131(30.7)
Give supportive care when needed	301(70.5)	126(29.5)
Interest of the provider to respond to any question	296(69.3)	131(30.7)
Communication of the provider the ways understood by women.	352(82.4)	75(17.6)

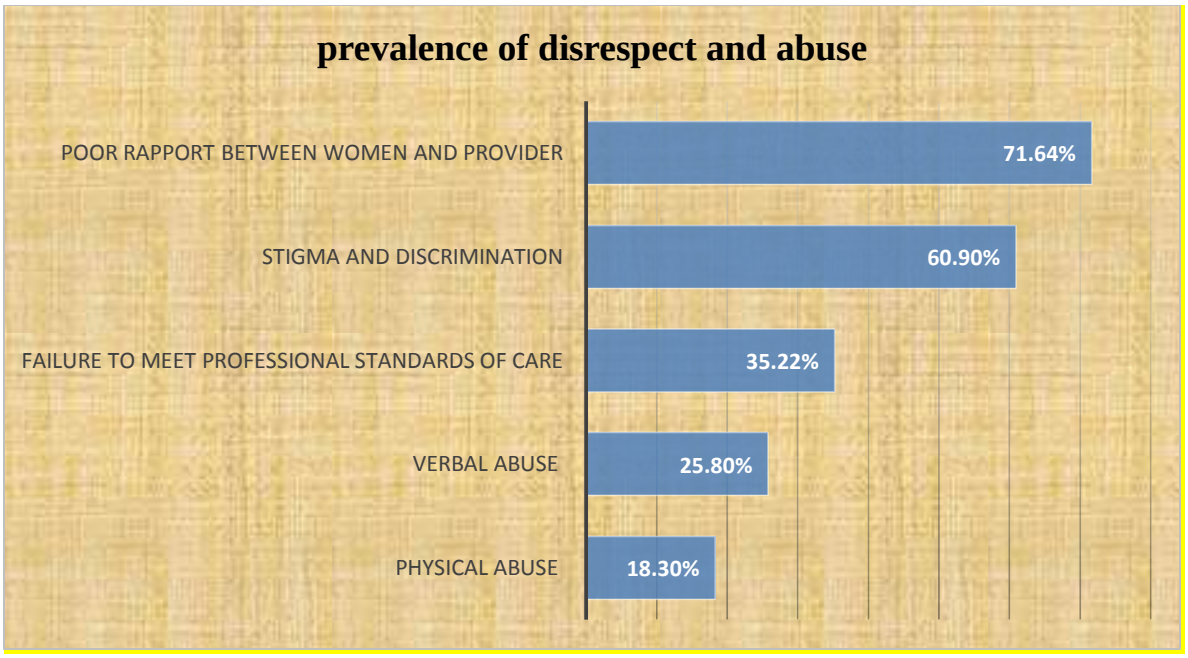

Figure 3: Prevalence of each categories of disrespected, and abuse care among respondents of Sodo Woreda, East Gurage Zone Central Ethiopia, 2025.

5.3. Types of disrespectful and abusive care during childbirth;

From all childbirth giving mothers, 110(25.8%) have reported being pushed, beaten, slapped, pinched, physically restrained, or gagged, or received a bad comment. Close to two-thirds, 276 (64.6%) of the respondents reported that they were not asked permission/consent from a health professional to get care, and similarly, 67.4% of respondents reported that healthcare provider didn't explain to them the procedure/ examination that they have done. Fewer than one in five, 75 (17.6%) of mothers reported disrespectful and abusive care, of poor rapport between women and providers The disrespectful and abusive care was a failure to meet professional standards of care; the most reported form was health workers not responding to mothers' needs, 131 (30.7%), and 165 (38.6%) mothers did not receive any help from health professionals to control their pain. In addition, 145(34.6%) of mothers did feel safe in health facilities, and 65.6% of mothers did not participate in a decision regarding their care.

5.4. Factors associated with disrespectful and abusive care during childbirth birth

The multivariable logistic regression revealed several significant factors associated with disrespectful and abusive care during labor and delivery. Women who had the presence of a relative during childbirth were 34 times more likely to report experiencing disrespect and abuse compared to those without a relative present (AOR = 34.894, 95% CI: 15.208,80.059),

suggesting a strong association between family presence and the likelihood of reporting mistreatment, possibly due to increased awareness or advocacy. Conversely, women who were allowed to deliver in a position they felt comfortable with had significantly lower odds of reporting abuse (AOR = 0.062, 95% CI: 0.025, 0.152), indicating that respectful maternity care practices greatly reduce perceived abuse. Support from health workers also played a critical role; those who felt supported were 81% less likely to report abuse (AOR = 0.199, 95% CI: 0.085–0.465). Interestingly, deliveries attended by male health workers were associated with nearly four times greater odds of disrespect and abuse compared to those attended by female providers (AOR = 3.946, 95% CI: 2.068,7.528). Feeling safe within the health facility also dramatically reduced the likelihood of reported abuse (AOR = 0.197, 95% CI: 0.096, 0.403). Furthermore, when women reported that their cultural preferences were not respected during labor, they were over six times more likely to report abusive care (AOR = 8.464, 95% CI: 3.645,19.654), which may reflect complex cultural interpretations or unmet expectations. Overall, respectful communication, patient autonomy, cultural sensitivity, and provider gender dynamics significantly influence women's experiences of care during childbirth.

Table 3:Multi-variate logistic regression analysis of factors associated with disrespectful, and abuse care, Sodo Woreda, East Gurage, Central Ethiopia 2025.

Variable	**Category**	**D & A Care**		**COR (95%CI)**	**AOR (95% CI)**	**P-Value**
		Yes	**No**			
Presence of relative during labor &delivery	Yes	115	66	13.04(7.97,21.32)	34.894(15.208,80.059)	<0.05
	No (Ref.)	29	217	1.00(Ref)	1.00(Ref)	
Birth Position you feel during delivery	Yes	19	162	0.22(0.13,0.38)	0.062(0.25, 0.152)	<0.05
	No	85	161	1.00(Ref)	1.00(Ref)	
Supportive care from health worker	Yes	110	191	0.446(0.292,0.681	0.199(0.085, 0.465)	<0.05
	No (Ref.)	71	55	1.00(Ref)	1.00(Ref)	
Sex of health worker matters	Yes	92	65	2.878(1.917,4.322	3.946(2.068,7.528)	<0.05
	No (Ref.)	89	181	1.00(Ref)	1.00(Ref)	
Mother feel safe in	Yes	94	188	0.333(0,22,0.504)	0.197(0.096, 0.403)	<0.05

health facility	No (Ref.)	87	58	1.00(Ref)	1.00(Ref)	
cultural preferred incorporated during labor	Yes	159	136	5.846(3.504,9.752	8.464(3.645, 19.654)	<0.05
	No (Ref.)	22	110	1.00(Ref)	1.00(Ref)	

AOR = Adjusted Odds Ratio; **CI** = Confidence Interval; **Ref.** = Reference category, statistically significant associations at $p < 0.05$.

5.5. Qualitative Results

5.5.1. Socio-demographic characteristics

Table 4: Socio-demographic characteristics of the mother recruited as participants.

No	Age	Occupation	Parity
1.	25	Housewife	1
2.	36	Housewife	5
3.	33	Housewife	6
4.	28	Housewife	3
5.	23	Housewife	1
6.	39	Housewife	6
7.	29	Housewife	3
8.	24	Housewife	2
9.	37	Housewife	4
10.	27	Housewife	3
11.	39	Housewife	7
12.	33	Housewife	3
13.	37	Housewife	4
14.	33	Housewife	3
15.	26	Housewife	2
16.	37	Housewife	2
17.	29	Housewife	1
18.	38	Housewife	4

In this study, the researcher recruited 18 participants, with a mean age of 31 (ranging from 23 to 39). All participants are mothers who have had at least one childbirth experience at a public health center

Emerged themes

Experience of mothers, Attitude of health professionals, and Quality of care are the three emerging themes based on the data analysis of disrespect and abuse during childbirth among mothers who deliver at public health facilities. Initially, the codes were 36, but later were reduced to 24 and included 102 quotations.

Table 5: **Theme and code**

Theme	Description	Code
Experience of mothers	The experiences of mothers when interacting with	I don't have any experience
		I delivered my previous children here
Attitude of health professionals	The attitude of health professionals includes their mindset, behaviors, and emotional responses when interacting with mothers.	inappropriate word or upsetting
		there were moments of scolding
		I don't have any experience or observed verbal abuse
		forced to lie on the bed
		not forced to lie on one side
		No slapping or physical hurt
		Not experienced sexual abuse
		not experienced discrimination
Quality of care	Quality of care for mothers refers to the standard of services and support provided to women before, during, and after childbirth. It encompasses several key	Do not feel mistreated
		I have felt mistreated
		not felt excluded
		I am excluded from decision-making
		felt unsupported
		I did not feel unsupported
		not fully informed
		I do not believe I received adequate care
		I didn't feel that the attention given to me was minimal
		not restricted

	components.	Not given sufficient privacy
		haven't the freedom
		Do not feel forced to accept unwanted care
		medical interventions without prior consent

Theme 1: Experience of mothers

The majority of participants expressed that they have little to no interaction or experience with health professionals during labor and delivery. "I don't have any experience with health care providers during labor and delivery" (interview 11, 39 years*)*. Some participants expressed that they have interacted with healthcare professionals when they delivered their previous child and during pregnancy. "I delivered my previous children here, and I am currently receiving follow-up care here as well. I have interactions with the health professionals, but the delivery ward has issues related to cleanliness, maintenance, and visible disorganization" (interview 4, 28 years).

Theme 2: **Attitude of health professionals**.

Some participants reported instances where healthcare providers scolded them or made unsettling remarks. During the provision of services, I also observed cases of verbal abuse from healthcare professionals. *"*There were moments of scolding and some unsettling remarks. I observed verbal abuse from healthcare providers during service provision"(interview 6, 39 years). Another respondent also noted as follows: "Both in the past and currently, while giving birth at this health facility, I have received irrelevant comments, insulting and degrading remarks from a female midwife. I have observed similar behavior directed at others before as well" (interview 16, 37 years).

Most participants noted that they were forced to lie on the bed during labor and delivery. While they weren't compelled to lie on one specific side, they were advised to position themselves on their left side for medical reasons, as this can enhance the progression of labor. They do not have experience with pushing, striking, or restraining during service provision. They noted that there is no slapping or intentional physical harm involved in the process. "I was forced to lie on the bed during labor**.** I was not forced to lie on one side, but I was advised to lie on my left side for medical reasons, such as to facilitate better progression of labor**.** I am not experienced in pushing, striking, or restraining during service provision**.** There is no slapping or physical hurt during service provision" (interview 1, 25 years).

Most participants expressed that they had not experienced any sexual abuse during their pregnancy or childbirth. Additionally, they reported not undergoing any repeated vaginal examinations. “I have not experienced any sexual abuse during your pregnancy or childbirth. I haven’t experienced ay repeated vaginal examination” (interview 3, 33 years). All participants expressed their perspectives, noting that they had not encountered any form of discrimination based on ethnicity, cultural practices, language, age, gender, physical or mental conditions, religion, appearance, education, income, or socio-economic status during the provision of services. “I have not experienced any kind of discrimination based on ethnicity, cultural practices, language, age, gender, physical or mental conditions, religion, appearance, education, income, or socio-economic conditions during service provision”(interview 5,23 years).

Theme 3 - Quality of care

The majority of participants stated that they did not experience any mistreatment during labor and delivery. “I have not felt mistreated in the care I have received”(interview 11, 39 years). Some participants reported feeling excluded from decision-making during labor and delivery, noting that healthcare professionals often worked silently without involving them. “I have felt excluded from decision-making during labor and delivery, the professionals often worked quietly without involving me” (interview 16, 37 years). Another respondent also expressed their perspective as follows: “I felt excluded from decision-making during labor and delivery, as the healthcare professionals frequently worked silently without engaging me in the process” (interview 17, 29 years).

Some participants described feeling a lack of support during labor and delivery. They expressed that healthcare providers did not offer the guidance, reassurance, or involvement they had hoped for during these critical moments, leaving them feeling isolated or neglected during their experience. “I experienced a lack of support during labor and delivery, feeling neglected and without the assistance or reassurance I needed during that critical time.”(Interview 7, 29).

The majority of participants shared their view as follows: During their stay at the health center, they felt that the attention given to them was sufficient, and they did not experience any instances of being neglected. “During my stay in the health center, I didn’t feel that the attention given to me was minimal or remained unattended. I did not encounter any problems, healthcare

provider was willing to assist me (For example, support in going to the restroom, assistance with showering, help in managing wounds)" (interview 8, 24 years).

Most participants noted that they had undergone medical interventions, including vaginal examinations, episiotomies, membrane rupturing, and post-delivery injections, without proper consent forms or agreements. "Without proper consent forms or agreement I have experienced medical interventions, such as vaginal examinations or episiotomies, membrane rupturing, injection after delivery" (interview 2, 36 years*).*

The majority of participants reported that Privacy measures during the service provision were insufficient. While the door and windows were closed, these efforts did not provide them with a sense of comfort. "During service provision, no adequate measures were taken for privacy, apart from closing the door and windows, it was not give me comfort"(interview 9,37 years)

5.5.2. Socio-demographic characteristics of health professionals

Table 6: Socio- demographic characteristics of the recurred health profession participants

	Sex	**Age**	**Profession**	**Experience (years)**
1.	F	25	Midwife	5
2.	F	28	Midwife	6
3.	F	27	Midwife	5
4.	F	23	Midwife	5
5.	F	26	Midwife	5
6.	F	28	Midwife	5

In this study, the researcher recruited 6 participants, all of whom are female with a mean age of 26 years (ranging from 23 to 28 years). All participants are midwives; they have work experience of more than 5 years.

Emerged themes

Respectful maternity care, and guidelines or manuals are the emerging themes based on the data analysis of disrespect and abuse during childbirth among mothers who deliver at public health facilities. Initially, the code was 16, but was later reduced to 9, and included 30 quotations.

Emerged themes

Respectful maternity care, and guidelines or manuals are the emerging themes based on the data analysis of disrespect and abuse during childbirth among mothers who deliver at public health facilities. Initially, the code was 16, but was later reduced to 9, and included 30 quotations.

Table 7: Theme, and code

Theme	Description	Code
Respectful Maternity Care	It emphasizes the importance of treating women with respect, providing them with information and choices regarding their care, and involving them in decision-making processes.	providing proper reception
		supporting mothers
		Ensuring the safety of mothers
		women feel respected
		I have observed a lack of respect
		I haven't observed any lack of respect
Guidelines, or manuals	These documents provide clear instructions and protocols for various procedures, clinical practices, and patient care standards.	No guidelines or manuals
		Manuals are available
		Not received training

Theme 1: Respectful Maternity Care

According to this, most health professionals defined respectful maternity care as ensuring the safety of mothers and newborns, providing care with professionalism, and attending to mothers with dignity. This idea is supported as follows:-*"*ensuring the safety of mothers and newborns, providing care with professionalism, and attending to mothers with dignity, providing proper reception and allowing mothers to share their concerns freely" (interview 3, 27 years). Other respondents also defined "respectful maternity care as "offering care that encompasses follow-up and comprehensive support for mothers" (interview 5, 26 years).

In this in-depth interview about how they know the feeling of women on the services provided during labor and delivery, most healthcare professionals describe it as We know women feel respected and supported when we send them home and they express gratitude, as well as through the feedback they provide during maternal health conferences.

"We know women feel respected and supported during childbirth. Through their expressions of gratitude when we send them home, and during maternal health conferences where they provide feedback" (interview 4, 27 years). Another participant also described as "We know women feel respected and supported during childbirth when we send them home, and they express gratitude. Additionally, during maternal health conferences, mothers provide feedback. Furthermore, when they come for postpartum follow-ups at 45 days, they also express appreciation. Monthly evaluations using community scorecards help gather public feedback" (interview 6, 28 years).
Most health professionals responded that they haven't observed any disrespect or instances of abuse in the service delivery process.

"I haven't observed any lack of respect or instances of abuse in the service delivery process" (interview 1, 25 years). But one respondent explains as "I have observed a lack of respect or instances of abuse in the service delivery process, which is due to Ethical problems among professionals. The solution will be to provide timely training for professionals, promote accountability, and develop foundational behavioral practices within teams. There is no system in place in our facility to address these issues" (interview 6, 28 years).

Theme 2 guidelines or manuals

All healthcare professionals who participated in the study reported that they had not received any form of training focused on the principles of respectful maternity care. This lack of training highlights a significant gap in their education and preparation for providing compassionate and respectful support to expectant mothers during their maternity experiences. "I have not received training specifically on respectful maternity care. I am currently working based on what I learned" (interview 5, 26 years). Most participants indicated that there are no guidelines or manuals regarding respectful maternity care at their workplace. Instead, they rely on what they learned before their current roles. "There are no guidelines or manuals in our workplace related to respectful maternity care. I am currently working based on what I learned" (interview 3, 27 years) But one respondent reported as "Manuals are available in our workplace related to respectful maternity care, but they are rarely used, they are outdated" (interview 5, 26 years).

CHAPTER 6: DISCUSSION

This study reviewed the prevalence and factors associated with D&A in childbirth and its associated factors with respect to the findings of the study and other existing systematic reviews and research articles on D&A in childbirth practices prevailing in SSA and Ethiopia, respectively, which stand at 42.4% as against the existence of D&A practices in SSA and Ethiopia at 49.4% and 44.09% as per recent systematic reviews and meta-analyses. In fact, even this is surprisingly high and comparable with those of SSA and Ethiopia, as cited in both systematic reviews and meta-analyses (45, 46). However, this rate is higher than that found in Tanzania (15%) (47). and is much lower than in Addis Ababa at 78.6% (12), and Bahir Dar (67.1%) (33). and much lower than the existence in SSA at 15%(44), whereas it is much lower than Addis Ababa and Bahir Dar studies, respectively. In fact, even this rate is much lower than the systematic reviews prevailing in LMICs, among which it stood between 10-98% (26).

International studies further support this fact. For example, in some studies conducted in India, the combined prevalence of disrespectful maternity care ranged from 65.38% in facility-based studies to 77.32% in community-based studies (48). In this study, 60.9% of women experiences discrimination in maternity care, which is relatively higher and is especially worrisome. This value is higher than that in Nigeria (47%) (49). Additionally, the value of 25.8% for verbal abuse is similar to that in some studies conducted in India with a value of 28% (50). However, this value is higher than those in studies conducted in some other countries including Tanzania with 19.48%, Nigeria with 4.3%, and Malawi with 1.9% (6, 19, 51). In contrast, a study from Jordan found that 37% of women experienced verbal abuse, suggesting that cultural norms and provider-patient communication patterns may also influence these experiences(52). These variations could be attributed to differences in socio-cultural norms, economic conditions, and health system performance across countries.

The survey also showed that 18.3% of the participants had been subjected to physical abuse during the time of delivery. This value, while still low, falls within the range (1%-31%) found in the systematic review (26).It, however, is more than twice the value recorded in the study conducted in Tanzania (53), but still much lower compared with the values recorded in India (30.4%) and Enugu, Nigeria (35.7%) (19). Physical abuse of women during the time of delivery can be seen to be contrary to the rights of women. In addition, the survey showed that 35.2% of

the participants had not received the minimum standard care. This can be attributed to the various systemic challenges. A study conducted shows the principal bottlenecks to the provision of respectful maternity care to be the lack of skilled health staff, lack of appropriate infrastructure, and untrained staff in the Ethiopian context (54, 55).

Multivariable logistic regression analysis in this study further aids in understanding the underlying significant predictors of D& A. Of particular importance is that the presence of a companion in birth was a strong positive predictor of D& A (AOR=34.094). This is consistent with previous research conducted in Ethiopia, which indicates that the presence of others may increase the awareness of the woman on the abuse, thus increasing its chances of being reported (56). However, it is evident that women who could choose the preferred position of birth remained less likely to report D& A (AOR=0.062), which is in line with previous research conducted on the significance of bodily autonomy in increasing disrespectful maternity care (57). Those who could access support from health care providers also remained less likely to report D& A (AOR=0.199), which is consistent with the assertions described by Freedman (58). This highlights the protective role of compassionate, empathetic care providers.

Notably, having the health providers of the same sex was a significant aspect, with women who received care from health providers of the male gender being near four times more likely to experience D&A (AOR = 3.946). This is consistent with the literature that indicates the gender of health providers could affect women's comfort and perception of care, especially within contexts where gender-based cultural norms are deeply rooted (59). Feelings of being safe within the health facilities were, again, a significant protective aspect (AOR = 0.197), thereby confirming the WHO framework on the importance of women's feelings of security within the maternity experience (60). Where the first was unexpected, on the other hand, was that women who had their cultural preferences met during childbirth had higher odds of suffering D&A (AOR = 8.464). This is unexpected, given that the literature, including Downe (61), which suggests that cultural sensitivity enhances respectful care. The discrepancy may reflect complexities in how cultural practices are interpreted and operationalized within health facilities, possibly leading to unmet expectations or tokenistic implementation.

A systematic review in the general context of Ethiopia reported that the overall prevalence of D&A was 49.4%, attributing this to the limitation in the country's health system, providers' attitude, and resource shortages as key to the dissatisfaction (62). On the other hand, Ethiopia's

South Gondar Zone studies revealed the importance of facility and provider preparedness and support in ensuring that women receive respects in maternity settings (63). Moreover, another facility-based assessment in the Addis Ababa setting revealed that 78% of the women received at least one form of D&A, although only 16% could see that it was abuse. On the other hand, in the Addis Ababa evaluation, the 78% of the women received at least one form of D&A, although only 16% could see that it was abuse (64). Moreover, in the qualitative phenomenology in Ethiopia's northern part, it was seen that women reported being "overlooked" in terms of being unsupervised and unattended to in process of giving birth through "repeated exams without proper explanation and giving birth in unclean facilities or in the absence of basic supplies in the facility's delivery area" (65). Complaints led by poor and dirty environments in the birthing area and that the service providers' competence was in doubt correlated well to the women's report that the "delivery area was disorganized and unclean" (62). That the women reported "no experience in the presence of health care providers in giving birth" could fit well into the preceding definition to be seen as "non-consented care," "abandonment," or "non-dignified"(66). The issue of verbal abuse, scolding, or unwarranted or disrespectful maternity care practices during childbirth has been reported in many Ethiopian peer-reviewed sources. For instance, the occurrence of verbal abuse during maternal health care practices during childbirth has been found common among both women and midwives surveyed in health facilities across Ethiopia (67). In a similar qualitative study conducted with midwives or providers of maternity health care in central Ethiopia, the participants recognized that disrespect and abuses sometimes occur due to a number of health system deficiencies, stress, or burnout, or the need to tackle "problem" or "difficult" clients, especially if there are pressures related to outcomes (68).e participants considered the need to shout or scold the client in the process of childbirth in order to make the client comply with health requirements or to ensure that the client has a safe delivery, they, however, recognized that such practices amount to disrespect. The occurrence of verbal disrespect does not, however, confirm that the act is committed out of ill intent, but due to the attitude of health professionals, likely stress or work load, and the absence of a focus on respectful maternity care practices (RMC).

Evidence of involvement of women in decision-making during childbirth does exist. Current international guidelines as well as patient-provider approaches to health define that maternity care should take into account the woman's preferences and involvement in decision-making. A

qualitative study to investigate clients' health-literacy skills and needs regarding decision-making in maternity care showed an overwhelming number of women wished to take a major role in these decisions (69). Likewise, in a study from central Ethiopia in the community, it was found recently that autonomy in decision-making is not much in place; yet many women had little involvement in their own use of maternal and neonatal health care (70).

In the qualitative study Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia, both the patients and the providers described many instances of lack of confidentiality and privacy, women reported being examined in multipatient rooms with many healthcare providers or students present, with inadequate use of curtains or partitions, and with no apparent concern for their dignity or comfort (67).

Respectful maternity care (RMC) refers to care that sustains dignity and privacy, as well as confidentiality. The care should be free from harm and violence and should support women in decision-making and continuous support in the process of labor and delivery (71). On the same note, respectful maternity care (RMC) can be considered the key fundamental right, with an emphasis on women's autonomy, informed decision-making, the value and respect for women's values, as well as continuous support in the process of women's delivery and in the journey related to the aspects of women's childbirth care services (72). In the study that was conducted using the midwives in South Africa qualitatively, respectful maternity care was established to encompass aspects of empathy and kindness, delivered in a respectful way that values women's ideas and beliefs, and in a humane way whilst considering the needs of the woman in the process of delivery and in the aspects related to women's needs in the entire process of pregnancy and women's delivery services (73). Our results are supported by other evidence suggesting that training in RMC, although increasingly recognized as a crucial aspect that is, in fact, increasingly recognized and valued, is still not universally practiced. Notably, a recent scoping review of training packages for RMC concessioners across sub-Saharan Africa showed that despite the existence of a number of training packages for RMC, there is still an unequal distribution of these, with most health care providers still excluded from these training packages, especially those who are non-clinical (74). Additionally, the scoping review showed that there is a wide range of training packages with varying levels of training contents, delivery, and evaluation, which is an indication that systematic training and systemic training guidelines are still lacking, which might lead to the lack of systematic delivery of RMC. As indicated in a previous study

conducted in a health facility in the North Showa Zone, a lack of training and systematic support of training in RMC indicates low practice of respectful maternity care and an indication of high levels of disrespect and abuse (75).

Strengths & Limitations of the study

Strengths of the studies

Utilizing both quantitative and qualitative methods allows for a comprehensive understanding of the prevalence of disrespect and abuse during childbirth. The quantitative data can provide statistical insights, while qualitative interviews can capture personal experiences and contextual factors.

- ✓ Conducting the study in a specific cultural setting (Sodo Woreda) provides valuable insights into local practices and attitudes toward childbirth. This context-specific approach can help tailor interventions to address the unique challenges faced by mothers in this region.
- ✓ The study includes a diverse sample of mothers of varying ages, socio-economic backgrounds, which can provide a broader understanding of the factors associated with disrespect and abuse during childbirth.

Limitations of the studies

- ✓ Discussing issues related to disrespect and abuse may be culturally sensitive, potentially affecting participants' willingness to share their experiences openly. So D&A might be underreported due to fear or stigma.
- ✓ Participants may underreport their experiences due to fear of stigma or repercussions, leading to an underestimation of the prevalence of disrespect and abuse.

CHAPTER 7- CONCLUSION & RECOMMENDATIONS

CONCLUSIONS

The particular study attempted to offer a glimpse of the disrespect and abusive forms of care that women are undergoing in Sodo Woreda, East Gurage Zone. The study also indicated that the rate of disrespect and abusive forms of care in Sodo Woreda, East Gurage Zone health facilities is found to be high. Avoiding disrespect and abusive forms of care for women is not a matter of luxury but a human rights issue, whereby a woman has the right to the highest possible standard of health, including sympathy and respectful health care. From the findings of the particular study, we recommend that the lead organizations by hierarchy should advocate the principle of Respectful Maternity Care (RMC) in enhancing the positive outcome of "mother's childbirth.

RECOMMENDATIONS

A -To Central Ethiopia health bureau, East Gurage zone health department, and Sodo Woreda health office.

1-Arrange regular training and supervision of the health facilities and health providers to make services respectful and morewomen-friendly, which could help to reduce disrespect and abusive care given to mothers who deliver at public health facilities at a regional and zonal level.

2-Be tries to fulfill the need for human resources, especially for maternal and child health care services, in collaboration with others.

3 -Equip the health facilities with the necessary instruments and materials, including some basic drugs needed to give appropriate labor and delivery service.

4 - Assess the health facilities' need and then respond as much as possible.

B -To researchers-

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

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ANNEXES

Annex I; Information Sheet

Addis Ababa University School of Public health information sheet on the Assessment of respectful maternity care during child birth: Experiences & associate factors among mothers who delivered at public health facilities in South Sodo Woreda, East Gurage zone, Central Ethiopia, a cross sectional study.

Hello! How are you? My name is _____.I am a health professional and I am collecting data for the research being conducted to assessment of respectful maternity care during child birth in Sodo by Mesele Zewdie, who is working on his thesis for an award of master's in public health in Addis Ababa university college of health science. If you agree to be part of this study, I will ask you some questions, which will take 20 to 25 minutes. All the information obtained from you will be strictly kept confidential, your participation is purely voluntary, and no monetary incentives will be given for your participation in the study. You are free to refuse to take part in the study. You have a right to withdraw at any giving time if you choose to. The report produced will be used mainly for academic purposes shared with the University, COHRA, and stake holders in the research area including the Woreda & zonal health department to understand the impact of respectful maternity care during child birth care and treatment services. Your name will not be recorded on this form. If you have any question Mr. Mesele Zewdie is the contact person and can be reached through Mobile No. 0928707751.

Are you willing to participate in the interview and stay with me?

□***Yes, Go to the next page*** □ ***No, Thanks!*** ***If No, Proceed to the next eligible participant)***

Annex II; Consent Form

I am informed that my identity and the information I give will be treated confidentially. I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study. I understand that in any report on the results of this research, my identity will remain anonymous. I understand that I am free to contact any of the people involved in the research to seek further clarification and information. I am informed that no monetary incentives will be given for my participation in the study.

I have read this form, or it has been read to me in the language I comprehend and understand the condition stated above, therefore, I am willing and confirm my participation by signing the consent.

Name of the participant _____

Agreed to participate in the study: Yes /No (mark one of them for verbal consent)

Signature _____ (if written consent)

Name of witness---------- (Data collector, supervisor, any third person)

Signature _____ Date_____

Annex III; Questionnaire English Version

Good morning/after noon. This is ----------. I am a member of research team on assessment of respectful maternity care and factors during child birth among mothers who delivered at public health facilities in Sodo Woreda, East Gurage zone, Central Ethiopia. This is going to be carried out by Addis Ababa University. I would like to ask you a few questions.

NO	QUESTIONS /VARIABLES	CODING CATEGORIES
101	How old are you? (in completed years)	…….Years
102	Sex	Female…… ……... 1
103	What is your religion?	Orthodox… … … ……. 1 Protestant…… …… ……2 Muslim…… 3 Catholic……..…….…… 4
104	What is your ethnicity?	Amhara…… …1 Gurage…….……... ….2 Oromo…….…….. ..3 Silte …….…… ……. 4 Tigre…….……..…. 5 Wolayta……..… .6 Other (Specify)…….....……88
105	What is your occupation,/ what kind of work do You mainly do as a means of livelihood?/	Housewife……....…….. …….. 1 Farmer……..…..... …… …..2 Merchant/ Petty trader ……...3 Student……... .....… 4 Civil servant…….....5 Daily laborer…… 6

		Other(Specify)……..……..88
106	What is your education level?	Cannot read and write…… ……0 No formal school but, can read & write…….. ...1 Primary……2 Secondary school…… ……..3
107	What is your marital status	Never married……...…… …... 1 Currently married or living together……... ....2 Separated/divorced/……...…….…… 3 Widowed…….…… 4
108	Where is the mother residence	Urban ……...1 Rural ……2
109	How much is your monthly income (in birr)	<1500…….……...…….…… 1 1500-3000……..……..2 above3000 ……..…… 3
	Part 2-service delivery	
201	Did the doctors, nurses, or other health-care providers pinch, bite, or restrained during labor time.?	Yes……..... 1 No……..……...2
202	Do you feel like you were treated roughly like pushed, beaten, slapped, pinched, physically restrained, or gagged ,bad comment ?	Yes…… ……..…….. 1 No……..…….....2
203	Did the doctors, nurses, or other staff at the facility ask permission/consent before providing any care to you?	Yes…… ……1 No……..…… ……..2
204	Did the doctors, nurses, and other staff at the facility provide timely care to you?	Yes……1 No……..…… …… ……2
205	Did doctors, nurses, or other health providers present during you labor and birth?	Yes…… …… ……... 1 No……..…… ……2
206	Do you have your husband or any family member besides you during labor and birth?	Yes…… ……1 No……..…… ……2
207	Did you feel like the doctors, nurses, or a staff at the facility involved you in decisions about your care?	Yes…… …… ……...1 No……..…… …… ……2
208	During the delivery, do you feel like you were able to be in the position of your choice?	Yes…… …… … ……..1 No……..…… …… ……. …2

209	During examinations in the labor room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed?	Yes…… …… ……..…… 1 No……..…… …… …… …… …2
210	Do you face delay in the health facility after delivery due to payment requested or other reason?	Yes…….. … 1 No……..…… …… 2
211	Did birth attendant Explain to you why they were doing examinations or procedures on you	Yes……1 No……..……..…2
212	Did health care providers communicate using language you understands	Yes……...….1 No……..…… ……. …2
213	Did you feel you could ask the doctors, nurses, or other staff at the facility any questions you had?	Yes……1 No……..…… … ……. …2
214	Supportive care Did the doctors and nurses at the facility talk to you about how you were feeling?	Yes…… ……. ….1 No……..…… …… ……. …2
215	Did health care providers providing emotional support and reassurance throughout labor and delivery	Yes…… …… ……. ….1 No……..…… …… ……. …2
216	When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention?	Yes…… …… ……..….1 No……..…… …… ……. …2
217	Do you feel the doctors or nurses did everything they could to help control your pain?	Yes…… ……1 No……..…… …… ……..…2
218	Were you allowed to have someone you wanted to stay with you during labor?	Yes…… …… ……..……1 No……..…… …… ……...…2
219	Do you feel like your health information was or will be kept confidential at this facility?	Yes……....1 No……..……..…2
220	Do you feel that sex of health worker matters you during your labor and birth?	Yes……..…… ….1 No……..…… …… …2
221	Trust Did you feel the doctors, nurses, or other staff at the facility took the best care of you?	Yes……..…… ….1 No……..…… …… ……2
222	Did you feel you could completely trust the doctors, nurses, or other staff at the facility with regard to your	Yes……..…. ….1 No……..…… ……..…… …2
223	Do you think there was enough health staff in the facility to care for you?	Yes……..…… ….1 No……..…… …… …2
224	Thinking about the labor and postnatal wards, did you feel the health facility was crowded?	Yes……1 No……..…… …… …2
225	Thinking about the wards, washrooms, and the general environment of the health facility will you say the facility was clean?	Yes……,,,,,,,,,,,,,,,,,,,,…… ….1 No……..……..…… ……2

226	Was there water in the facility?	Yes……1 No……2
227	Was there electricity in the facility?	Yes……1 No ……..2
228	In general, did you feel safe in the health facility?	Yes……...……1 No……..……...……2
229	Did the doctors, nurses, or other staff at the facility ask you or your family for money other than the official	Yes……...……1 No……..……...……2
230	Were you or your family asked to buy anything from outside the health facility for your care?	Yes……...……1 No……..……...…2
231	Did you get sufficient care with regardless of your age, race, socioeconomic status, or health condition factor?	Yes……...….1 No……..……...……2
232	Do you feel that your cultural preferences, beliefs, and traditions were incorporate during your labor time	Yes……..…..……1 No……..……..……2

ANNEX IV- QUESTIONAIRE AMHARIC VERSION (የአማርኛ ማጠይቅ)

የመጠይቁ መለያ ቁጥር.---------

የጤና ጣቢያው ስም----------

	ጥያቄና ማጣሪያ	የኮድ ምድቦች
101	ዕድሜዎ ስንት ነው? (በተጠናቀቁ ዓመታት) ዓመታት	……ዓመት
102	ፆታ	ሴት……..
103	ሃይማኖትዎ ምንድን ነው?	ኦርቶዶክስ ……1 ፕሮቴስታንት…… …2 መስሊም…… 3
104	የዘር ሐረግዎ ምንድን ነው?	አማራ…….. .1 ኦሮሞ…… …….. ….2 ትግሬ…… …3 ጉራጌ…… …….. 4 ስልጤ…….. .5 ወላይታ…… .6 ሌላ/ይገለፅ/ ……88
105	በዋናነት ለኑሮ ምን ዓይነት ስራ እየሰራሽ ነው ?	የቤት እመቤት…….. …….. 1 አርሶ አደር…… …… ….2

		ነጋዴ ……. ….3 ተማሪ…… …….. …….. 4 የመንግስት ሰራተኛ……..……..5 የቀን ጉልበት ሰራተኛ… ……. ……. .. .6 ሌላ/ይገለፅ/……..……..
106	የትምህርት ደረጃሽ/እስከ ስንተኛ የትምህርት ደረጃ ደርሰሻል;	ማንበብና መጻፍ አልችልም ----------0 ማንበብና መጻፍ እችላለ----------1 የመጀመሪያ ደረጃ ……..2 የሁለተኛ ደረጃ
107	የጋብቻ ሁኔታሞ ምን ይመስላል?	ያላገባች-……...1 ያገባች.----------2 የፈታች----------3 ባል የሞተባት----------4
108	ዋና መኖሪያ የት ነው ?	ከተማ…….. 1
109	ወርሃዊ የቤት ገቢሞ ስንት ነው;	<1500 ETB……..……1 ከ1500-3000…… ..……..…… … 2
		ክፍል 2-ከአገልግሎት አሰጣጥ ጋር ተያይዞ የሚቀርቡ ጥያቄዎች
201	ዶክተሮች፣ ነርሶች ወይም ሌሎች የጤና እንክብካቤ ሰጪዎች በወሊድ ጊዜ ቁንጥጫ ፣ንክሻ ደርሶብሽ ወይም ይገድቡ ነበር?	አዎን…… …1 የለም…….…… 2
202	ያለ አግባብ እንደተገፉ፣ እንደተደበደቡ፣ አካላዊ እገዳ እንደተደረገብሞ ወይም መጥፎ ንግግር እንደደረሰብሞ ይሰማሞታል?	አዎን…… 1 የለም…….……

		2
203	ዶክተሮቹ፣ ነርሶቹ፣ ወይም ሌሎች የሆስፒታሉ ሰራተኞች ማንኛውንም እንክብካቤ ከማድረጋቸው በፊት ለእርስዎ ፍቃድ ጠይቀዋል?	አዎን…… … ….. ….. 1 የለም…….…… …… ……. … 2
204	የሕክምና ተቋሙ ሐኪሞች፣ ነርሶችና ሌሎች ሠራተኞች በወቅቱ እንክብካቤ አድርገውልሻል?	አዎን…… …… …. …. 1 የለም…….…….. 2
205	በሚወልዱበት ጊዜ ሐኪሞች፣ ነርሶች ወይም ሌሎች የጤና ባለሙያዎች በአጠገብዎ ነበሩ?	አዎን…… …… … ……...1 የለም…….…… …… … ……...2
206	በወሊድ ጊዜ ባለቤትሽ ወይም ሌላ የቤተሰብ አባል አብረውሽ እንዲሆኑ ተፈቅዶልሻል ?	አዎን…… …… …… ……1 የለም…….…… …… …2
207	ዶክተሮች፣ ነርሶች ወይም የሆስፒታሉ ሰራተኞች ስለእርስዎ እንክብካቤ በሚወስኑ ውሳኔዎች ውስጥ እርስዎንያሳተፉ /የተሳተፉ ይመስልዎታል?	አዎን……..…… ..1 የለም…….…….. 2
208	በወሊድ ወቅት፣ እርስዎ በመረጡት አተኛኘት መሆን እንደቻሉ ይሰማዎታል?	አዎን…….. ….1 የለም…….……..… 2
209	በወሊድ ክፍል ውስጥ ምርመራ በሚደረግበት ወይም በሚወልበት ጊዜ፣ የተጋለጡ እንደሆኑ እንዳይሰማዎት በጨርቅ ወይም በሸራ ከለላ ተደርግዎሎት ነበር?	አዎን…… .1 የለም…….…… …… … 2
210	ከወለዱ በኋላ በጤና ተቋም ውስጥ ክፍያ በመጠየቅ ወይም በሌላ ምክንያት መዘግየት አጋጥሞዎታል?	አዎን……... …1
211	እሰዎን ያዋለዱ ባለሙያዎች ለምን ምርመራ ወይም ቀዶ ጥገና እንደሚያደርጉልዎት አብራርተውልዎታል?	አዎን…… .1 የለም
212	በወሊድ ቆይታዎ ወቅት ያዋለድዎ/ያዋለደችዎ ባለሙያ ሲያናግርዎ/ስታናግርዎ የነበረው በሚያውቁት	አዎን…….. … 1

213	ለሐኪሞችን፣ ለነርሶችን ወይም ሌሎች የሆስፒታሉ ሠራተኞችን ማንኛውንም ጥያቄ መጠየቅ እንደሚችሉ	ኣዎን..... .1
214	በጤና ተቁዋሙ የነበሩ ሐኪሞችና ነርሶች ስለህመምዎ እና ስለሚሰማዎ ነገር አነጋግሮዎታል?	ኣዎን..... ....1 የለም..... 2
215	የጤና ተቁዋሙ ባለሙያዎችና ሰርተኞች እርስዎ በሚወልዱበትና ከወለዱም በሁዋላ አይዞዎት በርቱ እያሉ ሲያበረታቱ ነበር?	ኣዎን..... ...1 የለም..... 2
216	-እርዳታ በምትፈልግበት ጊዜ ሐኪሞች፣ ነርሶች ወይም ሌሎች ሠራተኞች ትኩረት እንደሰጡህ ተሰምቶሻል?	ኣዎን..... .....1 የለም
217	ሐኪሞቹ ወይም ነርሶቹ ህመምህን ለመቆጣጠር የቻሉትን ሁሉ አድርገዋል ብለሽ ታስቢያለሽ?	ኣዎን..... ...1 N
218	በወሊድ ጊዜ አብሯችሁ እንዲቆይ የምትፈልጉት ሰው እንዲኖርላችሁ ተፈቅዶላችኂል?	ኣዎን..... 1
219	የጤና መረጃዎ በዚህ ተቁም ውስጥ ሚስጥራዊ እንደሆነ ወይም እንደሚሆን ይሰማዎታል?	ኣዎን..... .1 የለም
220	በእርስዎ ወሊድ ጊዜ የጤና ሠራተኛው/ዋ ፆታ በእርስዎ የወሊድ ሁኔታ ላይ ለውጥ ያመጣል ብለው	ኣዎን..... 1
221	በጤና ተቁዋሙ ውስጥ ያሉት ሐኪሞች፣ ነርሶች ወይም ሌሎች ሠራተኞች ጥሩ እንክብካቤ ያደርጉልዎት	ኣዎን..... .1 No
222	የሕክምና ተቁሙ ሐኪሞች፣ ነርሶች ወይም ሌሎች ሠራተኞች በሚሰጥዎ እንክብካቤ ሙሉ በሙሉ ሊተማመኑባቸው እንደሚችሉ ተሰምቶዎት ነበር?	ኣዎን..... .1 .የለም.....
223	በህክምና ተቁም ውስጥ እርስዎን ለመንከባከብ በቂ የጤና ሰራተኞች አሉ ብለው ያስባሉ?	ኣዎን..... ...1 የለም
224	ስለ የወሊድ እና የድህረ ወሊድ ክፍሎች ስታስብ የጤና ተቁሙ የተጨናነቀ ሆኖ ተሰምቶህ ነበር?	ኣዎን..... ... .1 የለም
225	የጤና ተቁም ክፍሎች፣ የመፀዳጃ ቤቶችና አጠቃላይ የግቢው አካባቢ ስታስብ ተቁሙ ንጹሕ ነበር ብለው	ኣዎን..... 1
226	በጤና ተቁዋሙ ውስጥ ውሃ ነበር?	ኣዎን..... 1

227	በጤና ተቁዋሙ ውስጥ ኤሌክትሪክ ነበር?	ኣዎን..... .1 ይልም
228	በአጠቃላይ በጤና ተቋም ውስጥ ደህንነት ይሰማዎታል?	ኣዎን..... .1
229	ዶክተሮች፣ ነርሶች ወይም ሌሎች የሆስፒታሉ ሠራተኞች አንተን ወይም ቤተሰብህን ከሕጋዊ ወጪዎች ሌላ ገንዘብ እንዳከፍሉ ተጠይቀዋል?	ኣዎን..... .1 የለም
230	እርስዎ ወይም ቤተሰብዎ ከጤና ተቋም ውጭ ለህክምናዎ የሚሆን ማንኛውንም ነገር እንዲገዙ	ኣዎን..... .1
231	እድሜዎ፣ ዘርዎ፣ ማህበራዊና ኢኮኖሚያዊ ሁኔታዎ ወይም የጤና ሁኔታዎ ምንም ይሁን ምን ተጽኖ ሳይደረግብዎ በቂ እንክብካቤ ኣግኝቶዎ ብለው	ኣዎን..... .1 የለም
232	በእርስዎ ወሊድ ወቅት ባለሙዎች ዘንድ ያላችሁ ባህላዊ ምርጫ፣ እምነትና ወግ እንደተካተተ/እንዳከበሩላችሁ ይሰማችኋል?	ኣዎን..... .1 የለም.....

ANNEX V; QUESTIONAIRE GURAGIGNA/local/ VERSION

	ጥያቄና ማጣሪያ	የኮድ መደብክነም
101	ዕድሜሽ ምን ያሂሉ	……ዓመት
102	ፆታደሽ	
103	ሃይማኖትደሽ ምንን?	ኦርቶዶክስ ……1 ፕሮቴስታንት…….. 2 ሙስሊም
104	የዘር ሐረግደሽ /ብሄርደሽ/ ምንን?	አማራ…….. 1 ኦሮሞ…….. 2 ትግሬ……..
105	በዋናነት ለኑሮ ምን ዓይነት ዎዘላን ትውዜይ ?	የቤት እመቤት…….. …… …….. …… 1 አርሶ አደር…….. ……..… …….. …..2 ነጋዴ …… ….3 ተማሪ…….. …… 4 የመንግስት ሰራተኛ…… …….. .5

		የቀን ጉልበት ሰራተኛ... 6
106	የትምህርት ደረጃደሽ ምን ያሂሉ;	ዋንበብና ምጻፍ ተሸልቦ..... 0 ዋንበብና ምጻፍ እችሉ---------- --1 የመጀመሪያ ደረጃ /1-6ክፍል /.....2 መለስተኛ/7-
107	የጋብቻ ሁኔታደሽ ምን ይመስሉ?	ያላግባት..... 1
108	ዋና መኖሪያደሽ ቢቲን ?	ከተማ---------- 1
109 ወርሃዊ የጌደሽ ገቢደሽ ምን ያሂሉ		ተ1500 ብር ታተ ....1 ተ 1500-3000 ብር... .....
		ክፍል 2- ከአገልግሎት አሰጣጥ ጎይ ተቲቲዘም የቀረብም ጥያቄዎች
201	ሀኪሞች፣ ነርሶች ወይም ሌሎች የጤና እንክብካቤ ዬብም ባለሙያዎች ብትወልጂቦ ጊዜ ቁንጥጫ ፣ንክሻ ሰላብሽም ነበር? ወይምማ ያጊድድሙች ነበር	ዬ..... 1 አደብል..... 2
202	*ያለ አግባብ ፣የትገፋሽ፣የድበደብችሆም፣ አትንቅሻቂሽ ኮም የቂነብች ወይም ጥፎ አውራር የሰላብሽ ሆም ወሽጣደሽ ይሰማሹ ወይምማ ቅር ይብቹ ?*	ዬ..... 1

203	ዶክተሮች፣ ነርሶች፣ ወይም ሌሎች ወዘልተኞች ማንሙ እንክብካቤ ለደሽ ተሞቀናህነም ይፍት ለደሽ ፍቃድ ተሻልሙችም ነበር?	ዩ..... 1
204	ሐኪሞች፣ ነርሶችና ሌሎች ወዘልተኞች ብትወልጅቦ ሰዓት በቂ እንክብካቤ ቂነሙሊም ትብሊም ቲሲቢን ?	ዩ.....1 አደብል..... 2
205	ብትወልጅቦ ሰዓት ሐኪሞች፣ ነርሶች ወይም ሌሎች የጤና ባለሙያዎች ወጣ ገባ ታይብልም በሞረደሽ ነበርም? ደጠመደሽ ነበርሽ	ዩ..... 1
206	በወሊድ ጊዜ ባለቤትደሽ ወይም ሌላ የቤተሰብ አባል አትህነም ተደሽ ጎይ ቁናየን ይሆንሙልች ሆም ፈቀድልሙም ነበር ?	ዩ..... 1
207	ሀኪሞች፣ ነርሶች ወይም የሀኪም ጌዱ ወዘልተኞች ስለደሽ እንክብካቤ ቢውስንሙዱ ውሳኔዎች ውሽጣ የደሽ ያሳትፍሙች/ያማክርሙች/ ነበር?	ዩ.....1 አደብል.....2
208	ትወልጅ ጎይ ፣ ደሽ በመረጥሹዱ ጎንደሽ ትኚ ሆም ፈቀድሙልችም ነበር?	ዩ..... 1 አደብል..... 2
209	ትወልጅ ጎይ ሌላ ሰብ ሰብነደሽ አያዥርሽ ኮም መጋረጃ ወይምማ ሌላ ከለላ ቂነልችም ነበር?	ዩ..... 1 አደብል..... 2

210	በወለድሽ ፎለ በጤና ተቋም ውሽጣ ክፍያ በዎሻልክነም ወይም በሌላ ምክንያት ተጌደሽየን	ዩ.....
211	የደሽ ያዋለድሚ ባለሙያዎች ዬምን ምርመራ ወይም ቀዶ ጥገና ይቂነሙልች ሆም ዬውድሙች	ዩ.....
212	ትዎልጅ ጎይ ያዋለደትሽ /ያዋለደንሽ ባለሙያ ያዎርሙች ጎይ ብትሽሉዩ ቁዋንቁዋ ነበር;	ዩ.....
213	ለሐኪሞችን፣ ለነርሶችን ወይም ሌሎች የጤና ጣቢ ሠራተኞች ያለንሽ ማንሙ ጥያቄ ዎጠይቅ	ዩ.....
214	በጤና ጣቢ ትዎልጅ ጎይ የነበርም ሐኪሞች ወይም ነርሶች ስለምጠጥደሽ እና ስለሚሰማሽ ነገር	ዩ.....
215	በጤና ጣቢ ትዎልጅ ጎይ የነበርም ሐኪሞች ወይም ነርሶች ትዎልጅ ጎይና በዎለድሽም ፎለ አይዞደሽ ፣ዐርቹ በዎባል ደብርቱቱሙች ነበር?	ዩ..... 1
216	-ደሽ እርዳታ በሸሸቦ ጊዜ ሐኪሞች፣ ነርሶች ወይም ሌሎች ሠራተኞች ትኩረት ለደሽ ያብሙች ሆም	ዩ.....
217	ሐኪሞቺ ወይም ነርሶቹ ያለብሽ ምጠጥ ለዎቁጣጠር የቻልሙ ያሂል እገዛ ቂነሙሊም	ዩ.....
218	ያወለደትሽ/ያዋለደንሽ ባለሙያ?	ገረድ.....
219	የደሽ የጤና መረጃደሽ በዚህ ተቋም ውሽጣ በሚስጥር የይዚሙ ይመስቹ ?	ዩ.....1
220	በደሽ የወሊድ ጊዜ የአዋላጂ ዎታ/ምሽት ወይምማ ጎሽ በወሁንክነም/ በደሽ የወሊድ ሁኔታ ላለ ለውጥ	ዩ.....1
221	ያወለድሙች ባለሙያዎች ሙያህነም ምን ነበር?	ዶክተር..... 1
222	ባጠቃላይ የጤና ጣቢ ሐኪሞች ወይም ነርሶች ወይም ሌሎች ወዘልተኞች ባብሙቺ እንክብካቤ ሙለ በሙለ አመንሽበሙም/ረካሽም/ ነበር /ቅልጥፍናህነም ፣እጭቁትክነም፣ አክበረኒትነም	ዩ..... 1

223	በጤና ጣቢ ውሽጣ የደሽ ለምንክባክብ በቂ የጤና ወዘልተኞች ያለ ሆም ቲሲቢን?/ የጉላላሽቦ	ዩ..... 1
224	ስለ የምለድሽቦ ክፍልና እና በምለድሽም ፎለ ያረፍሽቦ ክፍሎች የጭናነቀ ይመስቹ	ዩ.....
225	የጤና ጣቢ ክፍሎች፣ የመፀዳጃ ቤቶችና አጠቃላይ ግቢሀን ንጹሕን ባችም ትሲቢን?	ዩ.....
226	በጤና ጣቢ ውሽጣ ይጋ ነበር?	ዩ.....
227	በጤና ጣቢ ውሽጣ የኤሌክትሪክ መብራት ነበር?	ዩ.....
228	በአጠቃላይ በጤና በተቋሚ ውሽጣ ፈይነት ይሰማሹ?	ዩ.....
229	ሃኪሞች፣ ነርሶች ወይም ሌሎች የጤና ጣቢ ሠራተኞች የደሽ ወይም የቤተሰብደሽ አባል ከሕጋዊ ወጪዎች ሌላ ተጨማሪ ዋጋ /ለራስክነም	ዩ..... 1
230	ደሽ ወይም ከጤና የቤተሰብደሽ አባል ተጤና ጣቢ ውጪ ለህክምናደሽ ይሆን ማንሙ ነገር ትዋጅየን ተሸልሙችም ነበር?	ዩ..... 1
231	እድሜደሽ ወይምማ ዘርደሽ፣ ማህበራዊና ኢኮኖሚያዊ ሁኔታደሽ ወይም የጤና ሁኔታደሽ ምንም ይሁን ምን ተጽኖ ታይቂነብች በቂ እንክብካቤ አገኘሁም ባችም	ዩ..... 1
232	በደሽ ወሊድ ወቅት በባለሙዎች ዘባ የደሽ ያለንሽ ባህላዊ ምርጫ፣ እምነትና ወግ ያከበርልች ሆም	ዩ..... 1

ANNEX VI; conducting in-depth interview for delivered mothers

Interview Guide Questions

1. Background Information

- Can you please share some basic information about yourself (age, occupation, number of pregnancies, etc.)?

2**. General Experience with Healthcare Providers**

- How would you describe your **overall experience** with healthcare providers during your pregnancy and childbirth?

3-Verbal abuse

- Have you experienced or witnessed **any verbal abuse** from healthcare providers?

Probe: Were you subjected to insulting, harsh, unpleasant, and/or derogatory comments?

- Were you spoken to or shouted at in a harsh/rough or crude/coarse way?

-Were you verbally abused?

4- Physical abuse

- Can you share any experiences related to **physical abuse** or neglect during your labor and delivery?

Probes:

- Were you forced to stay in bed?
- Were you forced into a particular position, or were you manually restrained?
- Were you subject to rough physical treatment? (For example: pushing, pulling, pinching/ gripping, and pushing your legs in a particular position).
- Were you slapped or kicked?
- Was a (medical) intervention performed that you experienced as physical abuse?

5- Sexual abuse

- Can you share any experiences related to **sexual abuse** during your labor and delivery?
- Was a (medical) intervention performed that you experienced as sexual abuse?
- Was there repeated PV examination?

6-Communications issues

- Did you feel you were not being involved in the decision-making during labour and birth?
- Did you feel you were not being listened to?
- Did you feel you were not being taken seriously?
- Did you feel insufficiently at ease to ask questions?
- Did you feel that you weren't being given information that you should have been given? (For example: not being given full information about what was going on; not being informed about

risks and benefits; non-disclosure of test results or diagnoses; not being given information about the progress of labor, not being provided with alternative options).

7-Lack of support

- Did you feel you received too little attention, or were you left alone when you did not want to be left alone?
- Did a health care provider refuse to assist you? (For example; assistance with going to the bathroom; help with taking a shower; help with managing contractions)?
- Did you ask for pain relief and was your request either ignored or refused by the care provider without there being a clear reason for this? (For example: pain relief during labor or a local anesthetic during suturing)?
- Were you or your partner denied (physical) contact with your child, without a clear reason?
- Did you experience a lack of privacy? (For example: during a physical examination)?

7-Lack of consent

- Were you not free to decide who would be present at your delivery (other than health care providers)?
- Did you feel compelled to accept care that you didn't want?
- Were you not free to decide your position during contractions?
- Were you not free to decide the position in which you gave birth?
- Were you told there were certain things you weren't allowed to do, without there being a clear reason for this decision? (For example: not being allowed to make noise, not eating, drinking, walking around, and taking a shower?

-Was a (medical) intervention done without your having given clear permission in advance? (For example: a vaginal examination, breaking your waters, performing an episiotomy; administering an injection after the birth).

- Was a (medical) intervention continued even after you asked for it to be stopped? (For example: being restrained during a vaginal examination).

8-Discrimination

- Did you experience discrimination based on ethnicity, cultural background, or language?
- Did you experience discrimination based on age?
- Did you experience discrimination based on physical or mental disability, illness or complaint?
- Did you experience discrimination based on religion or belief?

- Did you experience discrimination based on education, class, income or other socio-economic factors?

3-Indepth Interview for health workers

- What does respectful maternity care mean to you?
- Have you received training on respectful maternity care? If yes, how has it influenced your practice?
- How do you ensure women feel respected and supported during childbirth?
- Have you observed instances of disrespect or abuse in your facility? If so, what do you think causes them?
- Is there any mechanism in the health facility to solve the problem-if yes mention?

Annex VII: Curriculum Vitiate (CV)

I. PERSONAL DATA

Name- Mesele Zewdie Haile

Gender: Male

Marital status: Married

Citizenship: Ethiopian

Date of birth: 1973 E.C

II .Contact addresses

Mobile phone 0928707751, email-meselezewde21@gmail.com

***III.* Career Objective**

to play on active role on the Promotive, Preventive, Curative and Rehabilitative health service in the country. .

IV. Education

- *BSC degree in nursing from Haromaya University &*
- BA degree in sociology and social work from Jimma University.

V- Work experience

I have a total of more than 15 years including graduating in diploma & assigned at different work positions at governmental offices &NGOs. i.e

- Works at health facilities
- Officer of RMNCH at Woreda health office

- Head of Woreda health office
- CEO of hospital
- Zonal coordinator of CBNC/NEGA project at save the children international Ethiopia

VI- Relevant *Training /Work shop*

1-Training of trainers on the integrated management of neonatal and child hood illness and community

-based new borne care with supervisory skill which organized by save the children international Ethiopia

2-Training on facilitation of training organized by save the children international Ethiopia

3- EPI training for midlevel management which organized by Ethiopian medical association & MOH.

4-Training on effective vaccine and cold chain management prepared for EPI & logistic officers which Organized by SNNPR/previous/regional health bureau b 2020Gc/updated/

5-Training on facilitation of training on integrated community case management of childhood illness which organized by save the children Ethiopia

6- Certificate of completion, Save the Children, personal safety and security from the Department of Global Safety and Security.

7-Training on IPLS/integrated pharmaceutical logistics system/

8-Training on HMIS procedures and DHIS2

9 -training on family planning, Bemonk.

10 –training on CLTSH-WASH

References

1- Mr. Samuel Darge - Central Ethiopia region health biro Head. Mob - **0911395375**

2- S/r Bereket Demere - District PHEM coordinator, Mob -**0912160787**

1- Mr. Solomon Gugisa - East Gurage Zone Health Department Head, Mob - **0911575179**

Declaration

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

Name: Mesele Zewdie

Signature _____

Place: Addis Ababa University

Date of submission_____

This thesis has been submitted for examination with my approval as university advisor.

Name	Signature
1- Assefa Seme(MD, MPHASSOCIATE PROFESSOR)	_____