ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

ASSESSMENT OF MOTHERS' EXPERIENCE OF DISREPECT AND ABUSE DURING MATERNAL HEALTH CARE PROVISION AND ASSOCIATED FACTORS, IN PUBLIC AND PRIVATE HEALTH FACILITIES IN ADDIS ABABA

BY

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Addis Ababa, Ethiopia

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This is to certify that the thesis by Abdulkadir Gelegelu Gemeda entitled ***Assessment of Mothers' Experience of Disrespect and Abuse, during Maternal Health Care Provision and Associated Factors in Public and Private Health Facilities in Addis Ababa*** and submitted in partial fulfilment of the requirements for the degree of master of science in population studies (Reproductive Health) complies with the regulations of the university and meets the accepted standards with respect to the originality and quality.

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Abbreviation

D&A	Disrespect and Abuse
RMC	Respectful Maternal Care
SNNP	Southern Nations, Nationalities and People
ANC	Antenatal care
LIC	Low Income Country
WHO	World Health Organization
FMoH	Federal Ministry of Health
GMH	Gandhi Memorial Hospital
Y12	Yekatit 12 Hospital
DHMT	District level health management team
SHMT	Sub city level health management team
GOE	Government of Ethiopia

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Abstract

Disrespect and abuse of women during labor and delivery is becoming recognized as a violat ion of their rights and a barrier to using life-saving, facility-based labor and delivery care. In Addis Ababa, the rate of expert birth attendance is 97 percent, with the remaining women giving birth at home. From the viewpoints of both providers and mothers, this study investiga tes the experiences of disrespect and abuse in maternal care, as well as the factors associated with facility-based maternal care.

We conducted 455 interviewer-administered structured interviews at two randomly selected governmental health facilities with their four-catchment health centers and two hospitals of privately owned hospitals in Addis Ababa Ethiopia with midwives, health officers, nurses, and medical doctors, and women who had given birth within the three months prior to the survey date. In addition to the quantitative survey, the mothers who experienced disrespect and abuse took part in an in-depth interview.

We discovered that during labor and delivery, both health care providers and women who pa rticipated in an in-depth interview reported physical and verbal abuse, as well as non-consented care. Most abuse, according to providers, is unintentional and stems from the over crowding of the labor ward as a result of inappropriate referrals. We uncovered no evidence of more systematic types of abuse involving the detention of patients from living with her new-born rather than restraining women in the facility because they failed to pay health care fees. Most of the mothers reported that they were never asked to know the position she prefers to deliver in yet and also, they were denied to deliver in the position she preferred. However, it is small in number the disrespect and abuse that they shy away to report also appeared during the quantitative survey.

Our findings recommend that respectful care training, which is included in the national midw ifery curriculum's professional ethics modules, be expanded to include a stronger emphasis on counseling skills and rapport building. Our findings also suggest that all treatments aimed at improving midwives' interpersonal contacts with women should be supplemented by addre ssing structural concerns related to provider workload.

Keywords: *Midwives, Respectful maternity care, Disrespect and abuse, Maternity care, Quality, Patients' rights, unnecessary referrals*

CHAPTER 1

INTRODUCTION

This study assessed the relationship between disrespectful maternal care and factors associated with facility-based ANC, delivery, and postpartum. Factors associated with mistreatment in this study are conceived as the independent variables where disrespect and abuse are conceived as the dependent variables. The factors associated to commit mistreatment measured in form of individual (providers holding authority or empowering him/herself over the patients, specific provider's individual behaviour, qualification of service provider) and system or structural factors (over crowdedness of obstetric ward, under staff facility, poor physical infrastructure…) while our dependent variables was quality of respectful maternal care as world health organization claimed seven articles to inhibit the Disrespect and abuse (Windau-Melmer, et al. 2013) such as, Every woman has the right to be free from harm and ill treatment; Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care; Every woman has the right to privacy and confidentiality; Every woman has the right to be treated with dignity and respect; Every woman has the right to equality, freedom from discrimination, and equitable care; Every woman has the right to healthcare and to the highest attainable level of health and, Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion.

1.1 Background

The study strived to assess the women's experience of respectful maternity care and the factors associated with, through profound investigation using mixed method approach with reproductive-age women from service seeker side and physicians, midwives, health managers, and nurses from health provider side in both privately-owned health facilities and state running health facilities.

It is near past that human rights organizations began collecting evidence and made the record on disrespect and abuse in 2007, though it remained the challenge of women to give birth at the facility since 1950 (Bohren M, et al.2015; Kruk ME et al,2014). In light of the fact recorded, the world health organization revealed a statement on disrespect and abuse, during

pregnancy and childbirth. The statement emphasized the importance of respectful maternal care and women's rights during pregnancy and labor as well as the need for immediate attention to this global phenomenon.

It is persisting concern that disrespect and abuse of women during pregnancy and delivery has become an increasingly recognized phenomenon over the past decades. Global public health norms now explicitly condemn such practices, admit them as both a violation of a woman's rights and also, instrumentally, as significant deterrent to the use of life-saving facility-based labor and delivery services (White Ribbon Alliance 2016; World Health Organization 2015;. Hastings MB, et al 2015). The enormous number of women across the globe experience disrespectful, abusive, and neglectful treatment during childbirth in facilities (Silal SP.et, al.2011; Small R et al.2002 d'Oliveira AFPLA et al.2002). This creates a violation of trust between women and their healthcare providers and can also be a powerful discourage for women to seek and use maternal health care services (Bohren M et al.2014).

While disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth, and the postpartum period, women are particularly vulnerable to disrespect and abuse during childbirth. Such practices may have direct adverse consequences for both the mother and infant. Unfortunately, disrespect and abuse of patients, particularly during childbirth, persist globally and are prevalent throughout African countries (Bohren M, et al.2015; Kruk ME et al,2014; Leonard K (2014), Mannava P et al.2015; Freedman LP et al 2014). The WHO emphasized the important role of RMC in statements entitled "RMC improves lactation" (WHO 2007) and "recommendations for improving the childbirth experience" (WHO recommendations 2018).

D&A can violate human rights and exacerbate women's mental health conditions such as sleep disorders and post-traumatic stress disorder (PTSD) (Swahnberg K et al.2007). Despite the abundance of research on D&A prevalence, few studies have investigated effective measures for reducing and preventing the prevalence of D&A behaviors during labor and birth (Abuya T. et al.2015; Ratcliffe HL et al.2016 Kujawski SA et al.2017). The identification of both aggravating and mitigating factors of negative and abusive care provider-patient relationships has been neglected in health systems. Quantitative studies conducted in African countries to determine the level and type of D&A show high disrespect and abuse rates (Okafor II, et, al.2015; Sando D, et, al.2016). Few studies were found to

assess women’s D&A experiences during pregnancy and childbirth (Orpin J, et, al. 2018; Balde MD et, al. 2017; Bohren MA et, al. 2016 Schroll A, et, al.2013).

In Ethiopia, no rigorous study was found to use relevant definitions or a standard measurement tool to assess and manage RMC. The quantitative studies conducted given more attention to cultural, economic, and social differences among various societies, rather than emphasizing maternal mistreatment and the factors associated with it. Regarding the importance of pregnancy, labor, and birth, and the impact of D&A on women’s decisions on where to give birth it is necessary to assess the status of D&A and its related factors. Assessing the quality of respectful maternal care the level and type of D&A show high abuse rates, especially in African countries (Okafor II et al. 2015; Sando D, et al, 2016).

Recent studies showed that the prevalence of disrespect and abuse of mothers is worse in Sab-Saharan African countries. Bowser and Hill (2010) conducted an analysis with a global perspective and identified seven categories for disrespect and abuse including physical abuse, discrimination, non-consent clinical care, undignified care, non-confidential care, abandonment of care, and detention in health facilities. According to the study, the range of prevalence is so wide: 20% in Kenya and extended to 98% in Nigeria Bowser and Hill (2010). Many women did not have procedures or the labor process not explained to them and did not hear about the findings of medical inquiry. Disrespect and abuse during pregnancy and childbirth have been ascending over the past decades (Burrowes S.et al.2017). A review of relevant articles, some determinants including lack of professional support for health care staff, hierarchical work relations, the excessive workload in the labor ward, the inadequate staff at different levels, and poor infrastructures can contribute to the increased prevalence of disrespect and abuse (Bowser D, et al. 2010; Freedman LP et al.2014).

Despite Ethiopia's Ministry of Health's focus and unwavering support for measures to minimi ze maternal and newborn mortality, the absence of critical staff, the unavailability of supplies, the inadequacy of facilities, and poor quality of staffing contributed to the poor performance of the health care sector (Burrowes, S., et al 2017). The problems of emulation to check and balance, the bribery requested by recruiting body of health care providers, the absence of proofing the forgery educational award and the appearance of nepotism in the sector exacerbate the problems; and if economic and political instabilities are added to the list, it is simple to imagine the predicament of the maternal health care seeker. From standpoint of the

service seekers the age, personal attributes and the health status of maternal service seekers contribute to the RMC service quality.

In Ethiopia from a reviewed article, it is found that both health care providers and patients reported that physical abuse, verbal abuse, and non-consented care during pregnancy and delivery are the most frequent type of mistreatment (Burrowes, S. et al. 2017). The providers reported that most abuse is unintended and results from weaknesses in the health system or from medical necessity. Despite showing good basic knowledge of confidentiality, privacy, and consent to health care providers, training on the principles of responsive and respectful care, and on counseling is largely absent. Patient responses suggest that women are aware that their rights are being violated and avoid facilities with reputations for poor care (Burrowes, S. et al. 2017).

Underutilization of health facilities remains a concern in Ethiopia and contributes to the countries high mortality rate. It is alarming that albeit inadequate (underestimation) figure, 412 women die for every 100,000 live births in the country and maternal death constitute 21% of all death to women of reproductive age, though the ministry of health prioritizes and pose vigorous support of an effort to reduce maternal and child mortality (CSA and ICF, 2016). In Ethiopia, only 28% of women receive skilled health care in a health facility during labor and childbirth and 3% of Addis Ababa reproductive age women experienced home delivery (CSA and ICF, 2016). The women's educational level, residence, ethnicity, parity, autonomy, household wealth are associated with low utilization of health facilities (Memirie ST et al. 2016; Mengesha ZB et . 2013; Tarekegn SM et al 2011). As studies in Ethiopia demonstrated, perception of poor quality of care such as lack of privacy and lack of psychosocial support, are significant factors in women deciding whether or not to give birth at a health facility (Sheferaw ED et al.2016; Roro MA, et al. 2014).

Moreover, recent studies revealed evidence of disrespect and abuse in Ethiopian facilities (Asefa A et al 2015; Kruk ME et al.2010,). The study conducted in primary health care units in two regions: SNNP and Tigray found that 21% of post-partum women surveyed reported disrespect and abuse, non-consented care (17.7%), lack of privacy (15.2%), and non-confidential care; and 82% of providers cited occurrences of disrespect and abuse in their facilities John Snow International (2010). Nonetheless, Ethiopia has enshrined the promotion of women's rights and status in its constitution and subsequent national policies (Wada T.et

al. 2008) and has supported the core United Nations General Assembly resolutions and other international agreements that acknowledge the rights of childbearing women to respectful maternity care (White Ribbon Alliance 2011). However, individual patients are unlikely to know about, much less use, any mechanisms to address rights violations.

In an effort to reduce maternal morbidity and mortality, Ethiopia's government has both expanded health care infrastructure and coverage and has undertaken initiatives to make care more hospitable. These include expanding numbers of midwives trained and posted in rural areas (matched with their region of origin); operationalizing a Women's Health Development "Army" to conduct health outreach to rural women, and providing traditional foods to women who give birth in rural health centers (Getahun H et al.2002; Federal Ministry of Health Ethiopia 2015). According to the Ethiopian Midwives Association (2012), due to new, exam-based selection criteria, a distinctive aspect of the midwifery profession's expansion is the growing share of male midwives (22 percent). Ensuring the quality of these services and understand women's readiness to use them are two relatively understudied difficulties of this scale-up. Despite doing research in several parts of the country, there is no comprehensive study that covers all aspects of respectful maternal care and the factors that influence it.

1.2 Statement of the problem

The articles found from different scholars mainly asking some group of women whether they experienced disrespect and abuse in the hand of health care providers or not; but there was insufficient research that reveals the sources or the factors associated that come with the health care providers to commit the mistreatment.

Evidences gathered on disrespect and abuse during pregnancy and childbearing in health facilities show only some types of disrespect and abuse albeit partial and how frequent they are. Studies covering incidences of all forms of disrespect and abuse that are against the rights of mothers to respectful maternity care are very limited. Moreover there are no sufficient works found that assess the factors associated with disrespect and abuse from point of view of both service providers as well as service seekers during facility based delivery and postpartum service in Ethiopia.

Henrico Dolfing said "understanding your problem is half the solution (Actually the most important half)". In light of the fact, by knowing the factors associated with disrespect and

abuse during facility-based delivery and postpartum; the health facilities owners and managers decide to improve both system-driven and provider behaviors driven factors.

According to recent studies, contempt and maltreatment of mothers is more common in Sub-Saharan African countries (Miller S, Lalonde A 2015). According to Bowser and Hill (2010), in Kenya, Tanzania, Ethiopia, and Nigeria, women's experiences during childbirth were studied to estimate the prevalence of disrespect and abusive treatment (20%, 20–28%, 78, and 98%), respectively. Many women did not have procedures or the labor process not explained to them and did not hear about the findings of the inquiry. In Ethiopia, only 16% of Women asked whether they had any questions or not (Gebremichael, et al.2018). Respectful maternity care (RMC) is a universal human right for every childbearing woman in every health system. It is not an option. It is not a luxury awarded only to women in certain geographies or demographic groups. It is a right (Bohren MA, et al. 2015).

Some determinants: lack of professional support for health care staff, hierarchical work relations, the excessive workload in the labor ward, the inadequate staff at different levels, and poor infrastructures have a negative association with respectful maternal care (Bowser D, et al. 2010; Freedman LP et al.2014). The absence of critical staff, the unavailability of supplies, the inadequacy of facilities, and poor quality of staffing positively contributed to the poor performance of the health care sector (Burrowes, S., et al 2017). The problems of emulation to check and balance, the bribery requested by recruiting body of health care providers, the absence of proofing the under standard educational award, and the appearance of nepotism in the sector also associated negatively with respectful maternal care. Moreover, the age, personal attribute, and the health history of the service seekers have also negatively contributed to the quality of respectful maternal care and is becoming an area of increasing concern, particularly in developing countries. When women experienced disrespect and abuse during facility-based delivery, and postpartum they become reluctant to use health facilities to seek maternal service and choose to give birth at home over time, leading to an inclination of maternal and neonatal morbidity and mortality. Addressing this problem will have practical benefits for Addis Ababa and contribute to the understanding of this widespread phenomenon.

In the literature on maternal services, these dehumanize treatment are sometimes characterized as a flexible active choice which is committed unintentionally for seeking a

medical inquiry and sometimes as disrespect and abuse. To gain a fuller understanding of why maternal service providers commit disrespect and abuse, both quantitative and in-depth qualitative research is required. Focusing on reproductive-age women service seekers' and maternal service providers' experiences can help develop more robust theories to avoid flexibility and precarious anecdotes in quality of respectful maternal care scenario, as well as potentially informing future maternal care policy objectives.

1.2 Research objectives.

The overall objective of this study was to assess the prevalence and the factors associated with maternal disrespect and abuse committed by health care providers during facility base maternal care.

The specific objective of the study

The study directed or guided by the following specific objectives;

1. To identify the prevalence of disrespectful and abuse of mothers attending delivery and postpartum service during facility based maternal care in Addis Ababa.
2. To identify factor associated with disrespect and abuse of mothers.

1.4 Research questions

Question1

What is the most frequent type of mistreatment observed among seven categories of disrespect and abuse?

Question 2

What are the factors associated with the quality of respectful maternal care?

Question 3

What are the disrespect and abuse during facility based maternal services that women shy away to report it?

1.5 Significance of the research.

There is no adequate data on the magnitude of disrespect and abuse of reproductive age women in Addis Ababa city that assess concurrently state running health facilities and privately owned health facilities, regarding disrespect and abuse committed during labor and childbearing by health care providers and the factors associated with it. This study pull back

the curtain of disrespect and abuse, and its effect that supports the public health facilities and the owner of the private health facilities to evaluate their services using the clue listed in the WHO statement and to develop a new guideline to improve maternity care in Addis Ababa. Moreover, it hoped that the results of the study would give clue to policymakers on the understanding of factors associated with disrespect and abuse during labor and childbirth in the country and, serve as an important tool for any possible intervention aimed at improving low utilization of maternity care services in the city. Therefore, this study can fill the gap of knowledge in the area of the magnitude of D&A in both state running health facilities and privately owned health facilities of disrespect and abuse; and act as a stepping stone for other researchers to research the issue in Ethiopia. Health care providers working on the maternal issue can also use the findings of this study to inhibit D&A which may lead to low utilization of the facility.

1.6 Scope and limitations of the research

The study endeavour to reflect the close relationship of independent variables, and dependent variables. Our independent variables were individual (providers holding authority or empowering him/her self over the patients, specific provider's individual behaviour, qualification of service provider) and system or structural factors (over crowdedness of obstetric ward, under staff, poor physical infrastructure…) while our dependent variables are quality of respectful maternal care. This study was conducted in selected private health facilities and public health facilities in Addis Ababa city administration. During data collection, the researcher engaged in quality control of interviews in health facilities. Eight data collectors, who trained before the survey date, conduct the structured interview using CsPro software. Four interviewers for public health facilities and four interviewers for private health facilities were assigned to conduct interviews. This data collection was conducted for one month period from May 1 to 31 2021 for approximately eight hours per day. In the study, 456 women were interviewed by data collectors using a structured questionnaire. Juxtapose the researcher conducted the in-depth interview with staffs and reproductive-age women at both public health facilities and private health facilities.

The very dominating limitation of this study was the recalling problem of the women, as the women were supposed to recall the quality of respectful maternal care she received since her recent pregnancy or give birth of the last child three months back to the survey dates; and non-random selection of mothers, as interviews conducted on a consecutive basis. The other

limitation was social desirability bias that mothers being in the fearing state by suspecting the data collectors to tell the response to health care providers the women may not give real response, that they respond only positive side of the services and this might result in under reporting of disrespect and abuse committed by health care providers. To overcome this limitation the data collectors and the researcher conducted skilful probing, assuring the confidentiality of the data during data collection and encourage the women to reflect their feeling to get a real response. Not least but may be the last limitation was being in the era of COVID19 coronavirus risk the woman might have felt as if she was disrespected while the health care provider take action concerning take the head for the virus this might led to over estimation of the response.

1.7 Operational definitions

Disrespect and abuse during facility-based maternal services is any act of physical abuse, non-confidential care, non-consented care, and undignified care, abandonment of care, discrimination, and detention in the facility.

CHAPTER 2

LITERATURE REVIEW

2.1 Concept and measurement of disrespect and abuse

Since the outcome is not known, almost all women felt frightened of childbirth, but it should also be a lovely occasion, that every woman should feel valued, respected, and appreciated by those who aid her in her journey of bringing life into the world. Pregnancy and childbirth signal great ambition and momentous events in the lives of women and her family in every Country and community worldwide that represent a time of intense vulnerability.

Though child bearing is also an important rite of passage, with deep personal and cultural significance for a women and her relatives, most of the time the concept of motherhood restricted to physical safety. (Windau-Melmer, et al. 2013). On her journey of bringing the life into the world, complication or miscarriage could happen at any time to the pregnant woman that necessitates the help of skilled health care providers. The health care attendee should offer respectful maternal care during prenatal, labor, and postnatal care. By definition, respectful maternal care during labor and childbearing is a universal human right that encompasses the principles of ethics and respect for women's feelings, dignity, choices, and preferences. The evidence showed that women worldwide are subjected to disrespectful and abusive treatment in the hands of maternity care providers. Disrespect and abuse of women during maternity care are problems that have been obscured by a "veil of silence," and they can significantly impact women's willingness to seek out life-saving maternity care (Bowser & Hill, 2010).

The state-run health care delivery system of most developing countries is characterized by very poor government spending and inconsistent policies. As a result, the system is poorly developed, and the staff is poorly motivated. Besides, the health care providers in these health facilities are often unfriendly to the patients, do not respect their cultures and sometimes, exploit them. Patients wait for long periods to be attended to by providers who are indifferent to their problems (Obi Betrand Nwosu et al. 2012)

In contrast, the health care providers in private health facilities are more patient-friendly and attend to the patients within shorter periods (UNFPA 2003). The studies conducted in Nigeria corroborate that privately owned hospitals play major roles in the provision of obstetric

services in the country (Okonkwo JE et. al.2006; Olusanya BO et, al. 2010; Lamina MA et al. 2006). It, therefore, becomes imperative that any strategy to reduce the high maternal mortality rate in the sub-Saharan region will not succeed without the involvement of privately owned health facilities (Obi Betrand Nwosu et. al. 2012).

Accompanying the growth of private health care facilities, especially in Addis Ababa, it is important to assess the quality of respectful maternal care services delivered by these establishments. While this emerging of private health facilities is encouraging, the perceptions that people have about, not only maternal health care quality but also general medical care services quality in the country may not be so favorable. This assessment is important because even if the problems of access were to be substantially alleviated, quality factors are likely to strongly influence patients' choice of health facilities. Apparently, quality is important and demands continuous attention. A poor status of facilities and the inconsistent behavior of the health care providers in public health facilities act as a push factor for those who can afford maternal care service fees to private health facilities was a key finding of Andaleeb SS. (2000).

In general, the quality of institutional delivery in the private sector is better than in the public sector. Relatively the rich segment of the society benefits from access to both better quality health care from the private sector as well as subsidized health care services from the public sector. The poor segment of the communities loses the services from the private sector due to a lack of money to afford. In fact, the difference in the quality of service in maternity care in the public health facility and private health facility is among the biggest determinant to decide seeking service from public health facilities or private health facilities even to stop seeking services from both of the health facilities …Andaleeb SS. (2000).

In particular, it is important to assess the quality of respectful maternal care services provided by private health facilities and public health facilities. If quality issues are being compromised by these establishments, it calls a country for the re-evaluation of policy measures to redefine their role, growth, and coverage, and to seek appropriate interventions to ensure that these institutions are more quality-focused and better able to provide the most attainable maternal care service to meet the needs of reproductive age women seeking service from. A search of the literature suggests that such a specific and inclusive both, state-run health facilities and privately owned health facilities, the study has not been undertaken in

Addis Ababa yet. While anecdotal evidence suggests, the existence of serious service-related problems in both sectors, this study is designed to determine the quality of respectful maternal care services provided by both privately owned and state-run health facilities and the factors associated with, in Addis Ababa.

The theoretical basis of this study is that the quality of services provided by the health facilities is contingent on market incentives: because private health facilities are not subsidized and depend on income from clients, as a result, that they will be more inclined than public health facilities to provide quality services and to meet patients' needs better. By doing so, they will not only be able to build satisfied and loyal clients who will revisit the same facility for future needs; but also, they build their image in the client to recommend those private establishments to friends and family, thereby sustaining the long-term viability of private health facilities Andaleeb SS. (2000).

In public health facilities, on the other hand, there is little or no market incentive to motivate the staff to take extra initiative or effort to improve the condition of patients and ameliorate their suffering. Tax subsidies and other sources assure these organizations of their survival. Harsh as this may sound, evidence of their lack of responsiveness, dedication, or quality assurance in media reports is often stark. This suggests that their service quality will be rated lower than private health facilities Andaleeb SS (2000). Respectful maternal care Quality assessment, however, requires careful consideration. According to Andaleeb SS (2000) quality of care may be defined as the degree of excellence in overall care, the judgment of quality may depend on whose perspective is sought. Accordingly, the magnitude of quality of maternal care determination depends on the service seeker's perspective is sought.

Assuming that, customers or clients of health facilities have the most direct experiences with the services provided by these institutions, this study focuses on mothers' perspectives. Thus, we will take the reproductive age women's and health care providers' perspectives on maternal service quality as the heart of the study since their opinion can provide valuable, albeit partial, insights, and as their opinions should drive meaningful changes in the system. This is because; a woman's satisfaction with health care services is associated with her utilization of those services; When women feel that their rights are violated during healthcare, it can undercut their satisfaction and trust in health care facilities and providers (Kujawski et al., 2015; Kowalewski et al., 2000; Bohren et al., 2014; Turan et al., 2008). A woman's satisfaction with health care services is tied with her utilization of those services; a study

conducted in Tanzania conveyed that women who experienced D&A reported lower satisfaction and not interested to seek service from the facility (Kujawski et al., 2015). Delayed utilization of health facilities can in turn affect women's health. Women delaying care-seeking either by skipping prenatal care or laboring at home to minimize experiences of D&A can lead to additional complications or put their health or their baby's health at risk (Bowser & Hill, 2010). Women who gave birth at home without the assistance of a professional attendant to address clinical complications had a greater risk of maternal and neonatal morbidity and mortality (Gao et al., 2010; Kowalewski et al., 2000; Bradley et al., 2016; Oyerinde et al.,2013; Moyer et al., 2014; Bohren et al., 2014).

Furthermore, according to some study, abuse by clinicians during pregnancy or delivery discourages mothers from using public health facilities in the long run, even for their children. Women's prior experiences with the health-care system, as well as their views of facility quality, can impact their decision to seek care for their babies and children (Atuyambe et al., 2009; Syed et al., 2008; Colvin et al., 2013).

Poor pregnancy outcomes are highly linked to D&A. Neglect or abandonment on the part of the provider, for example, can preclude timely or accurate diagnosis and treatment of problems. Overmedicalization of childbirth, particularly the overuse or misuse of unpleasant treatments, can increase morbidity and mortality. These techniques, such as induction, augmentation, continuous electronic fetal monitoring, episiotomies, cesarean section, and enemas, might induce maternal or newborn issues, such as uterine rupture, perineal laceration, or uterine prolapse, when overdone (Miller et al., 2016). In a survey of public health services in Uttar Pradish India , it was discovered that mistreatment during childbirth were more likely to experience complication during delivery and postpartum period.

Poor physical outcomes are not the only health impact of disrespectful and abusive care. D&A can adversely affect mental health by creating a fear of childbirth… (Lukasse et al., 2015; Schroll et al., 2013), affecting sexuality and desire to have children (Schroll et al., 2013), and generating life-long feelings of guilt and grief (Forssén, 2012). …Some women have even shared that their experience with D&A in childbirth had triggered memories of sexual assault… (Reed et al., 2017).

Disrespect and maltreatment of women during childbirth in a facility is not a new occurrence. Women's health and rights campaigners have long lamented the inadequate treatment of poor

and marginalized women in reproductive and maternity health services. The subjective character of experience, as well as the normality of some disrespectful and abusive practices, confound the definition and measurement of D&A. Because the acts are normal and even expected in their health care setting, many women may not regard them as rude or abusive. Similarly, because it is ingrained in their profession, women may see a behavior as D&A that providers do not (Freedman et al., 2014). A comprehensive definition of D&A must "[capture] the intricate interaction between expectations, normalcy, and rights while noting the link between individual action and the institutional conditions that sustain it" (Freedman & Kruk, 2014).

Disrespect and abuse during facility-based labor and giving birth has a socio-economic impact on the family as it comes with protectable maternal morbidity and mortality. When the mother dies, her family and community suffer, and surviving children often face a higher risk of poverty, neglect, and mortality. In Ethiopia, following the death of the mother, the infant under one month and the children under five are likely to die; the daughters are more likely to get married before turning her 15 birthdays, siblings subjected to separate and forced to live with relatives. The girl (orphan) who lives with her relative is subjected to the loss of her childhood right and forced to care about the children in the house. The household subject to disintegrate and the girls get more risk of harassment that may result in unintended pregnancy may come with maternal death or contribute to rapid population growth.

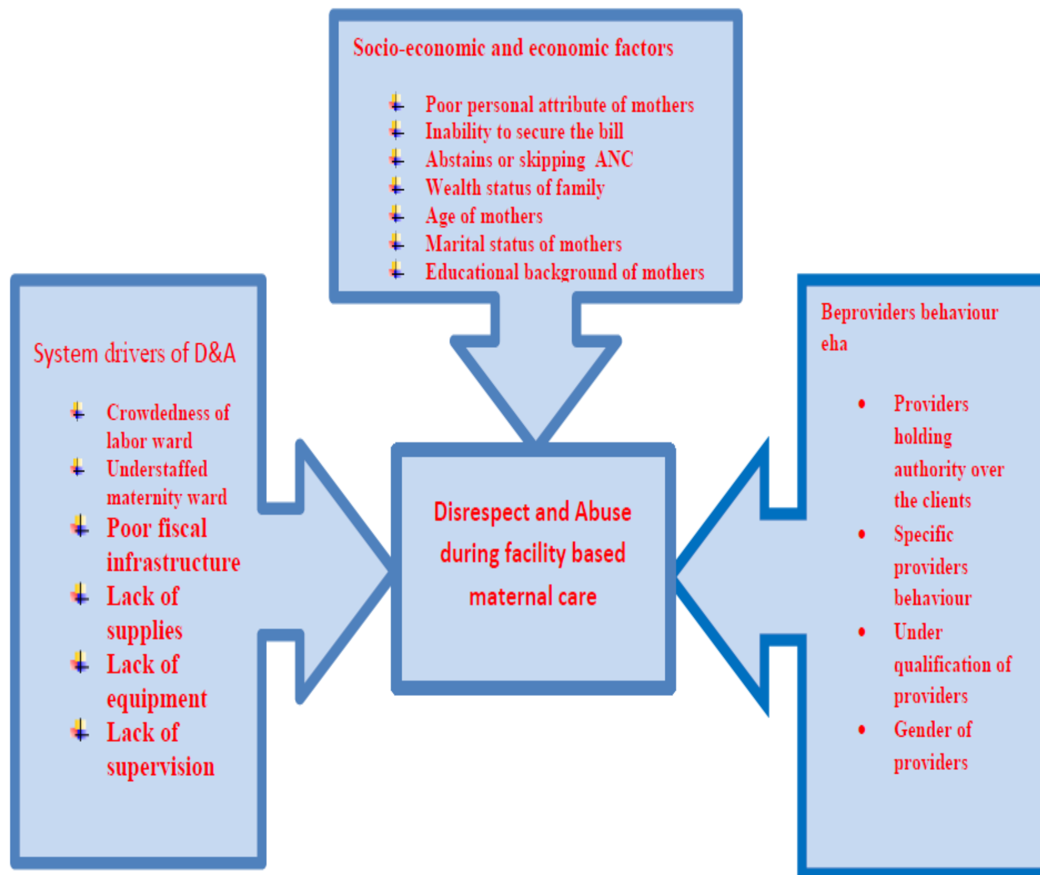
Beyond socioeconomic deterioration disrespect and abuse during facility-based labor and childbearing extends to adversely affect mental health by creating fear of childbirth, affecting sexuality and desire to have children, and generating life-long feelings of guilt and grief that come with the contribution of population aging that imbalance the demographic structure (Forssén, 2012). According to United Nations, Department of Economic and Social Affairs, Population Division (2018) *World Population Policies (2015),* in the next decades, virtually all countries in the world are expected to experience population aging, although at varying levels of intensity and in different time frames. Once limited to countries in more developed regions, concerns over the consequences of aging have been growing in less developed regions as well. As a result of that, over the last five years, many countries have taken steps to address population aging.

Despite the existing evidence that suggests women's experiences of disrespect and abuse during facility-based childbirth are widespread, (Silal SP et al. 2011) there is currently no

international consensus on how disrespect and abuse should be scientifically defined and measured. Consequently, its prevalence and impact on women's health, well-being, and choices are not known. Although it has been recognized as a problem since the 1950s (Diniz et al., 2015), human rights organizations did not begin to formally document incidences of disrespect and abuse (D&A) in maternity care until 2007. (Ogangah et al.,2007; Amnesty International, 2010). Since then, the field of D&A research has expanded, as has the difficulty of describing and quantifying such a complicated phenomenon. Accordingly, the world health organization reveals the statement of important components of facility-based respectful maternal care during pregnancy and delivery services. The components albeit inadequate of disrespect and abuse as derived from WHO statement calling for advocating inhibiting disrespect and abuse of reproductive age women were as follows:

- Every woman has the right to be free from harm and ill treatment.
- Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care.
- Every woman has the right to privacy and confidentiality.
- Every woman has the right to be treated with dignity and respect.
- Every woman has the right to equality, freedom from discrimination, and equitable care.
- Every woman has the right to healthcare and the highest attainable level of health.
- Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion.

Figure 1 Conceptual framework of factors associated with disrespect and abuse



2.2 Theoretical literature

When urgent maternal care is requested, the women contact with nearest health facilities, as delaying to get service results in another complication. Whenever the institution fails to offer the highest attainable health service the reproductive age women switch to alternative health facilities. Thus, the women's satisfaction with health care services ties with her utilization of those services; and a study revealed that women who had experienced disrespect and abuse reported lower satisfaction and intent to deliver at the facility (Windau-Melmer, et al. 2013). Mistreatment of women during labor and delivery has occurred throughout history and has been labelled variously as "obstetric brutality" and "dehumanized care" (Freedman et al., 2014). Systematic evaluations of research on disrespect and abuse during pregnancy and delivery point to both systemic and individual factors. They discover that abuse is not restricted to a few individuals or institutions, but is a result of both systemic failures and deeply established provider attitudes and beliefs (Bohren MA et al 2014; Freedman LP et

al.2014 Bowser D,et al 2010; Bradley S, et al 2016 ; Kujawski S et al.,2015; Filby A, et al 2016).

The individual drivers (specific provider behaviours experienced or intended as disrespect or humiliating) which is difficult to measure and Structural factors identified include provider shortages/heavy workloads, poor physical infrastructure, lack of supplies and equipment, and lack of supervision (Mannava P,et al, 2015). Such conditions are particularly prevalent in sub-Saharan Africa and are often associated with individual-level drivers of abuse such as provider stress, overwork, low motivation, and stigmatizing attitudes. General lack of supportive care and poor rapport between providers and patients are also often considered forms of disrespect and abuse. Systematic reviews show that patients view both intentional and unintentional mistreatment as abusive.

A 2015 systematic review of 65 qualitative, quantitative, and mixed-method studies proposed a seven category model for classifying instances of disrespect and abuse: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care (lack of informed consent and confidentiality, painful examinations and procedures and failure to provide pain relief and neglect and abandonment); the poor rapport between women and providers; and health system constraints. Health system constraints include lack of resources such as infrastructure to ensure privacy, supplies to ensure standards of care are met, and personnel to ensure that providers are not overly stressed and can effectively attend to the needs of each woman and baby. They also include a lack of policies sanctioning inappropriate behaviour and facility cultures that promote bribery and extortion, have unclear fee structure, or make unreasonable requests of women by health workers (Bohren et al., 2015).

There is a growing global commitment to addressing this problem, as evidenced by policy statements from the World Health Organization, the Lancet, and, most notably, the White Ribbon Alliance's facilitation of the Respectful Maternal Care Charter in 2011, a global consensus statement on a positive vision for respectful maternity care that includes a definition of disrespect and abuse, as well as the consequences of both. (see Table 1 below). Accordingly, the researcher will be guided most generally by the interpretive perspective of the above listed seven category model for classifying instance of disrespect and abuse of reproductive age women that is encompassed in (Windau-Melmer, et al. 2013) and as far as

the Empirical review is concerned, (Windau-Melmer, et al, 2013.) can be quickly cited as it is the reflection of the WHO statement on respectful maternal care.

Our research adds to this growing body of knowledge in two ways. It is one of the only researches that thoroughly assesses the disregard and misuse of maternal care in both state-run and privately owned health institutions. It also provides a fresh look at the relationship between disrespect and abuse, as well as the elements that influence it, from the perspectives of both clients and providers.

Table 1 Respectful Maternity Care: Charter on the Universal Rights of Childbearing Women

No	Category of disrespect and abuse	Corresponding right
1	Physical abuse	Freedom from harm and ill treatment
2	Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
3	Non-confidential care	Confidentiality, privacy
4	Non-dignified care (including verbal abuse)	Dignity, respect
5	Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6	Abandonment or denial of care	Right to timely healthcare and to the highest attainable level of health
7	Detention in facilities	Liberty autonomy self-determination, and freedom from coercion

Sources White Ribbon Alliance, 2011

2.3 Empirical literature

Quantitative studies have reported prevalence rates of mistreatment of women in facility childbirth ranging from 15% to 98% (Bohren et al. 2018; Afulani et al. 2018; Abuya et al. 2015a; Sando et al. 2016; Okafor et al. 2015; Raj et al. 2017). Verbal abuse is the most commonly described form of mistreatment in studies from countries around the world to date. However, mistreatment types and prevalence across studies are limited by differences in the

definitions and methods used to measure mistreatment. Measurement challenges include inconsistent definitions of mistreatment and the use of varying tools and study designs in studies (Sando et al., 2017).

The recent review by Sando et al. of methods used in the first five prevalence studies of disrespect and abuse in facility-based childbirth. There are no defined “definitions, tools, or study procedures employed to date [affecting] generalizability and comparability of disrespect and abuse prevalence estimates across studies,” according to the paper for example, rates of client-reported mistreatment may vary with the timing and place of questionnaires. According to a study conducted in Tanzania, reports of any disrespectful treatment varied from 19 percent at the time of exit to 28 percent at the time of community follow-up, with ignoring, screaming, and derogatory comments being the most commonly reported events. From the review of mentioned literature proportion of women reporting mistreatment during facility, childbirth increased from 19% during maternity exit interview to 28% during home-based interview conducted six weeks after birth (Kruk et al. 2014). This made the study result change with the time and place of the interview.

In 2019, Bohren and colleagues published a cross-sectional four-country study of how women are treated in childbirth, with a focus on mistreatment, using common measurement methods across countries (Bohren et al. 2019). In their study, 41.6% of 2016 observed women, and 35.4% of 945 women surveyed postpartum in the community experienced physical or verbal abuse, or stigma or discrimination across countries (Burma, Ghana, Guinea, and Nigeria). Their study was implemented in two phases. The first phase consisted of qualitative formative research to explore manifestations and drivers of mistreatment during childbirth using focus group discussions and in-depth interviews with women, providers, and administrators. A second phase measured the prevalence of mistreatment using direct observation and a community postnatal survey based on the formative phase findings (Bohren et al. 2016, Bohren et al. 2017, Balde et al. 2017a, Balde et al. 2017b). The study generated an important measure of mistreatment prevalence in four countries using common methods and instruments across countries. However, labor observations and postnatal community surveys require significant resources which are likely to limit their usefulness for assessing and monitoring mistreatment in large MNH programs outside of research studies.

"Status of respectful and non-abusive care during facility-based birthing in Addis Ababa hospital and health facilities," Asefa and Bekele published in 2015. According to the study,

71.8 percent of multigravida mothers (n = 103) had previously had an institutional birth, and 78 percent (75.3 percent in health centers and 81.8 percent in hospitals; p = 0.295) had encountered one or more categories of disrespect and mal-treatment All women who gave birth in hospitals and 89.4 percent of respondents at health centers claimed violations of their right to information, informed consent, and choice/preference of position during labor. In 39.3 percent of instances, mothers were left alone during childbirth (14.1 percent in health centers and 63.6 percent in hospitals; p 0.001). Only 22 (16.2 percent) of respondents subjectively experienced disrespect and abuse, despite the fact that 78.6% (n = 136) of respondents objectively suffered contempt and abuse. There is a limitation within the study as the investigator recognize that exhaustively addressing all types of disrespect and abuse that might have been practiced but not captured; delineating urban-rural differences, the other limitation identified during article review is that, the representativeness of the facilities' sample and the unit target population is under the question mark.

Sheferaw and colleagues released a cross-sectional design study in 2017 that was done in Ethiopia's four regions: Tigray, Amhara, Oromia, and SNNP. It was discovered that on average, women received 5.9 (66%) of the nine suggested RMC procedures. RMC performance was higher in health centers than in hospitals. In 36% of the observations, women were subjected to at least one form of abuse (38 percent in health centers and 32 percent in hospitals). Despite its tangibility, the study's prevalence was underestimated due to the hypothetical Hawthorne effect, in which service providers would display acceptable conduct because they knew they would be judged.

2.4 Synthesis of the literature review

John M.E., Duke E.U., Esienumoh E.E. (2020) very recently reported that from the study conducted in Nigeria RMC was reported by 58 (69.9%) clients while 25 (30.1%) reported a lack of it in different categories. Maternal service accompanied with disrespect and abuse that included lack of privacy, lack of information about the progress of labor, denying preference and choice of childbirth position, lack of sensitivity towards clients' pain and culture, verbal abuse, detention in the facility for non-payment of bill. Attending midwives confirmed not adequately screening or draping women (because of lack of screens and drapes); restricting women to deliver in the dorsal position and detaining women if they cannot pay the bill (because of health facility policy). Common acts of disrespectful care experienced by women in this study fit into some of the categories identified in the literature. Appropriate maternity

care must be respectful and rights-based to enhance the utilization of maternity services and access to skilled care. Though we take the literature as evidence of disrespect and abuse, for a country like Nigeria that with a leading population size the representativeness of sample size is insignificant.

Sheferaw, *et al*, (2017) reported 36% mistreatment in Ethiopia in the form of physical abuse, verbal abuse, violated privacy, and abandonment. Such disrespect and abuse are reportedly more common in single mothers (Amroussia, Hernandez, Vives-Cases, and Goicolea, 2017). This observation-based study has subjected to Hawthorne effect to underestimate the mistreatment as a result of that providers will show acceptable behavior during service provision because they know that they were being observed.

Singh, Chugani, and James (2016) reported 98% mistreatment of patients during labor and delivery in India, particularly verbal abuse, being left without care, lack of information, and detention or confinement against the will. Research in Nigeria (Okafor, Ugwu, and Obi, 2015) report disrespect and abuse during maternity care as high as 98%. Such poor practice of respectful maternity care may discourage many women from facility-based births, make them report to the health facility only as a last resort, and therefore poses a burden to quality health care delivery in these countries. Although the proportion of women who experience disrespectful maternity care in Nigeria is not generally documented, such mistreatments along with the poor quality of care have been cited as barriers to access to skilled care by pregnant women in the country (Dahiru and Oche, 2015; Yahaya, Bishwajit, Uthman, and Amouzou, 2018).

Burrowes et al. BMC Pregnancy and Childbirth (2017) Reported that both health care providers and patients report frequent physical and verbal abuse as well as non-consented care during labor and delivery. Providers report that most abuse is unintended and results from weaknesses in the health system or medical necessity.

CHAPTER 3

METHODOOGY

3.1 Setting

This study was conducted in randomly selected government running hospitals and health centers and privately owned hospitals in Finfine (Addis Ababa), which is the capital city of Ethiopia during May 1 to 31 2021 at maternal care service delivery points. Administratively, Addis Ababa is divided into 11 sub-cities and more than 116 weredas with an area of 541 sq. kilometers and hosting more than 5,005,524 populations. There are 12 public hospitals, 40 private hospitals, 95public health centers, and more than 850 private clinics which provide different health care services (CSA, 2014).

3.2 Study Design

An institutional-based descriptive design of cross-sectional study with a mixed-method approach was employed. A Mixed method research can provide the best approach to identify the indicators of D&A while women's experience is explored and considered in developing new guidelines. The mixed-methods approach emphasizes epistemological pluralism; hence, it supports the integration of different and even contradictory theories, approaches, and methods, it helps researchers better understand various concepts (Tashakkori A, Creswell JW2007).

3.3 Population

The subjects of study for this assessment were both reproductive-age women who seek maternal service from state-run or privately owned health facilities and maternal health care providers in the health facilities.

3.3.1 Source population

From the service recipient side, the source population was all postpartum women who gave birth in past three months of survey and visited maternity health facilities in Addis Ababa for delivery. From the health care service providers' side, the source population of the study was all physicians, health managers, midwives, and nurses who had been providing maternal health care service in Addis Ababa.

3.3.2 Study population

Thus, the study population was the women attending delivery and postpartum service in selected health facilities within three months of the study date and arrived at selected eligible public health facilities and privately owned health facilities of Addis Ababa during the data collection. From maternal health care service provider perspective selected physicians, health managers, midwives, and nurses who were attending maternal health care service at least for six months in the selected eligible maternal health facilities who were willing to participate as key informant interviewees.

3.3.3 Inclusion criteria

Reproductive age women who have been pregnant in the past one year or had given birth within three months before the survey (From February 2021 to April 2021) and arrived at selected public health facilities and private health facilities of Addis Ababa during the data collection and willing to participate in the study; and the health care providers: physicians, health managers, midwives and nurses who had been attending births at least for six months and willing to participate as a key informant interviewee.

3.3.4 Exclusion criteria

Reproductive age women who gave birth before three months of the study date, mentally incompetent, women who are seriously ill and not willing to participate in the study were excluded. The providers who served below six months in the selected health facilities or the providers not willing to participate in the study were also excluded.

3.4 Sampling for the quantitative study

3.4.1 Sample Size Determination

The sample size was determined using Fischer's method (Hassan T. Inferential statistics year?)

$$n = \frac{Z^2_{\frac{\alpha}{2}*} P(1-P)}{d^2}$$

Where:

n = Minimum sample size for a statistically significant survey

Z = Normal deviant at the portion of 95% Confidence interval = 1.96

p = Proportion of disrespect and abuse prevalence from previous study report and q=1-p

d = Margin of error acceptable or measure of precision = 0.05, and a 10% non-response rate was added.

From the article reviewed 16.2% of laboring mothers in Addis Ababa experience at least one form of disrespect and abuse during childbirth and postpartum. This figure took from a previous study conducted in Addis Ababa in which 16.2% of mothers reported subjectively experienced disrespect and abuse from health providers during childbirth and postpartum services (Asefa A. et al. 2015). This proportion was used to obtain a proxy estimate of the sample size n required to assess the level of disrespect and abuse

$$n = \frac{1.96^2 * 0.162(1-0.162)}{0.05^2} = 209$$, accordingly

n =209 +10% non-response rate =230

A sample size of 460 mothers who delivered (live birth or not) in past three months of the survey was used to improve the power of the study by assuming that the proportion of women prevalent to disrespect and abuse in a public health facility is equal to the proportion of prevalent women in private health facilities that the researcher took double of sample size calculated above as there was no such kind of study before in private health facilities. Accordingly, the total sample size requested to collect data, was 460. The quantitative data was collected through face-to-face interviews using a structured questionnaire. The data collection conducted through collaboration with service providers to identify eligible clients after they receive service to smooth the journey of data collection.

3.4.2 Sampling Technique

To select the eligible study units from the service delivery points (health facilities) simple random sampling technique was utilized. Two hospitals from eligible public hospitals available in Addis Ababa has been randomly selected: Gandhi Memorial Hospital and Yekatit 12 hospital; eligible health centers selected randomly from catchments of each public hospital: Shiro Meda health center and Maichew health center from Yekatit hospital catchments; and Gotera health center and kadsico health centers from Gandhi Memorial Hospital catchments. From private General hospitals which include maternal care in their services two eligible hospitals were selected randomly: Anania mothers' and children's Hospital and Bethazatha General Hospital were selected. The total sample size was proportionally allocated to the 4 hospitals and 4 health centers based on the average number of daily delivery number per month was taken from the registration book. The sample size

was proportionally allocated to the health facilities based on the average number of deliveries. Finally, all eligible and available moms during the study period who met the inclusion criteria were enrolled in the study. Two in-depth interviews with reproductive-age women who gave birth within 3 months or experienced gravidity in the year prior to the survey were conducted at each of the designated health facilities. In addition, using relevant techniques, an in-depth interview was done with clinicians or managers of chosen health facilities to study the predictive variables related with disrespect and abuse during facility-based delivery, and postpartum.

3.5 Sampling for the qualitative part of the research

Qualitative study was needed to know the factors associated to commit disrespect and abuse during facility based maternal health care. Thus in addition to quantitative survey qualitative study had undergone through indepth interview with selected and relevant mothers and health care providers. The sample sizes for qualitative part was determined on the basis of saturation point in data collection when new data no longer bring additional insights to the research questions. Accordingly, the qualitative data was collected from 12 mothers and 11 health care providers. During the in-depth interview, the interviewees were given an explanation and explanation of why the in-depth interview was necessary, and they were asked whether they were willing to participate in the study. The in-depth interview was completed after the consent of the persons was confirmed.

Figure 2 Selected health Facilities Diagram

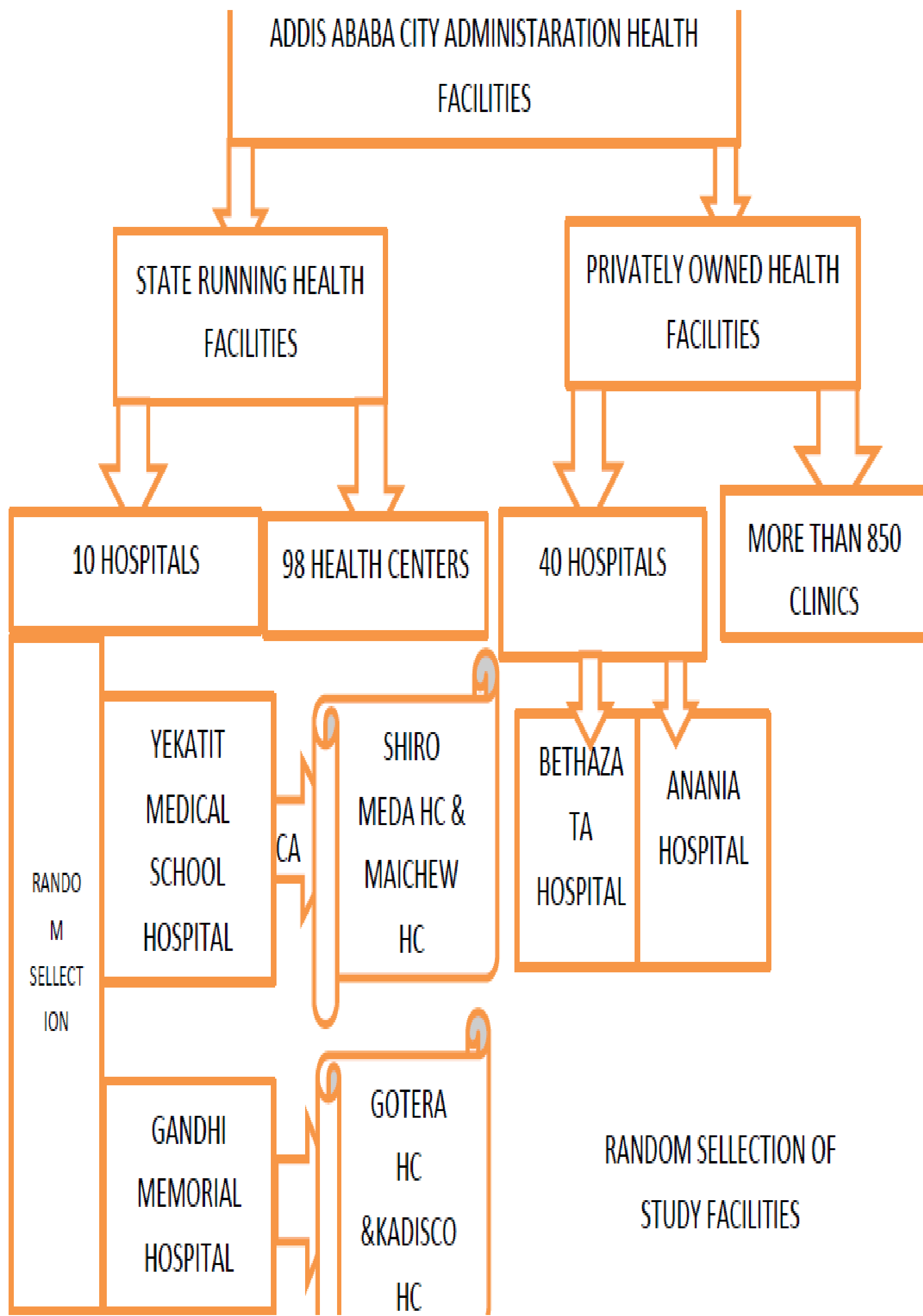


Table 2 Study unit Sample Allocation for quantitative study

S.N	Facility Name	Daily admitted maternal care in the facilty	Quota of sample per facility
1	Yekatit Medical college Hospital	44	80= $\frac{44}{250} * 460$
2	Gandhi Memorial Hospital	54	98=, $\frac{54}{250} * 460$
3	Anania mothers and children hospital	26	47=, $\frac{26}{250} * 460$
4	Bethazatha General hospital	27	49= $\frac{27}{250} * 460$
5	Gotera health center	27	50= $\frac{27}{250}$*460
6	Kadsco health center	30	54=$\frac{30}{250} * 460$
7	Shiro meda Health center	23	42=$\frac{23}{250} * 460$
8	Maichew	19	35=$\frac{19}{250} * 460$
Total		250	460

3.6 Study Variables

3.6.1 Dependent variable

- Maternal disrespect and abuse during facility-based delivery and postpartum.

3.6.2 Independent variables.

- System condition such as over-crowding and heavy workload; shortage of care equipment; type of maternal care, ANC, labor and delivery, and, PNC
- Mothers personal attribute.
- Socio demographic characteristics of women such as Age, Parity, household income

3.7 Data Collection Procedure

Data collection was started within 3 days of confirmation of the proposal by the advisor and Addis Ababa administrative health bureau IRB committee. It was collected by conducting an interview with women who gave birth within 3 months of the survey date regardless of the outcome of the pregnancy. The interviewers conducted the interview using the Amharic version and use English version as a reference when necessary. Eight data collectors who have BSc degrees in nursing and midwifery were involved in the study. The investigator conducted supervision and in-depth interview with women and providers selected for the qualitative part of the study. The Advisor supervised the overall process of data collection.

For data collectors, one-day training was given on study objectives and data collection techniques. Informed Consent was taken from each participant for quantitative and in-depth interviews. Each filled questionnaire was checked for completeness and consistency by the researcher and supervisor on spot.

3.8 Data Quality Management

Pre-test of the tool was conducted by using 23(5%) of the study participants on facility that were not selected in Addis Ababa, following the result from pre-test the necessary amendment was made on the questionnaire. To maintain the quality of the data the English version of questionnaire was translated to Amharic by researcher and verified by advisor. The data collection process was closely monitored and collected data was checked for any incomplete content by supervisor assigned and trained from the facility.

3.8.1 Quantitative data entry

Quantitative data entry was conducted on the spot as the data collection was collected by using Cspro data entry version 7.5 that CAPI questionnaire developed by the researcher. The data cleaning process was made to assure necessary data consistency and completeness. The data was exported to the statistical package for social science (SPSS) version 23 to conduct analysis.

The verification criterion was counted within their respective categories of disrespect and abuse. The criterion had dichotomized response, “yes” or “No”, to objectively identify reported events of disrespect and abuse. For categories of disrespect and abuse with more than one verification criterion, a woman was labelled as “disrespected and abused in the respective category” if she reported “yes” for that specific question. If a mother identified as having faced disrespect and abuse in at least one of the seven categories, she was considered as a “disrespected and abused woman”. As the screening question, the mother who reported “yes” to the question “Do you think that you had been disrespected and abused during your recent delivery and postpartum” was categorized as a mother who experienced disrespected and abused.

Descriptive statistics employed to display the values of the variables and the odds and odds ratio were calculated to display the relative occurrence and likelihood of the response by comparing categories. The strength of association between dependent and independent variables and their significance was computed using an odds ratio with a 95% confidence

interval. Bivariate and multivariate regression analysis was conducted to evaluate the relation of the independent and dependent variables

3.8.2 Qualitative data

For the qualitative study, each of the in-depth interviews was recorded by using tape-recorder for volunteer participants and then transcribed and translated. The qualitative part of the data was analysed by conducting the critical content analysis of recorded sound, then the result of qualitative study included in this thesis write-up.

3.9 Ethical Considerations

The research proposal was approved by the Center for Population Studies, College of Developmental Studies of Addis Ababa University. Ethical clearance was obtained from Institutional review board (IRB) Committee of Addis Ababa Health Bureau. Participants were informed about the objective of the study before the data collection and they were asked for their consent before participating in the study. Participation was voluntary and participants were informed that they have the right to refuse or withdraw whenever they want in the middle of data collection. Confidentiality was maintained by omitting their names and personal identifiers throughout the study. As much as possible, the rights of patients was protected in this research work and questionnaire was administered to women who gave their consent, after due counselling.

3.10 Dissemination of Results

The result of this study was submitted to Addis Ababa University, College of Development Studies, Center for Population Studies, and to Addis Ababa Health Bureau. The finding of the research is presented in a public defines for assessment.

CHAPTER FOUR

RESULTS

4.1 Socio-demographic characteristics of the respondents

A total of 455 (98.1% of planned sample) women participated in the research and 9 (1.9%) of the selected women did not consent to participate for various reasons. Moreover twelve health care providers and twelve women participated in in-depth interview of the survey.
The mean age of the participant women was 27.65 with standard deviation of 4.387 and the range age is 24 and the minimum and the maximum age were 19 and 43 respectively. Age group 25-29 was the most frequent 247(53.2%) and encompassed the mean age of the participants. Regarding the residence of the participants 402(86.6%) came from Addis Ababa while the remaining proportion came from out of Addis Ababa. Most of the women who participated for interview which accounted for 95.9% were married. Regarding educational status of the respondents, 282 or more than half of the participants, completed secondary school and above.

Regarding birth order of the women 222(47.8%) of women reported that they gave birth for first time and 233(50.2%) gave 2nd or more births. 134(28.9%) of participant women desired to have four children. 71(15.3%) of women experienced pregnancy terminated with abortion. Majority of the respondent's monthly household income was above 4000 that accounted for 69.2% of the respondents

4.2 Socio- demographic factors of mothers in immediate ANC, Delivery and post-partum

Table 1 shows the socio demographic and obstetric characteristics of women. Majority of the respondents use governmental health facilities. Almost all of the mothers participated in the survey as well as in qualitative research in marriage union. Regarding the time of birth attending most of them give birth at night.

Table 3 Socio- demographic characteristics of the study participants

		Frequency	Percent	Valid Percent	Cumulative Percent
Mothers Age category	15-19	3	.7	.7	.7
	20-24	86	18.9	18.9	19.6
	25-29	247	54.3	54.3	73.8
	30-34	86	18.9	18.9	92.7
	35-39	23	5.1	5.1	97.8
	40-44	10	2.2	2.2	100.0
	Total	455	100.0	100.0	
Marital status	Single	4	.9	.9	.9
	Married	445	97.8	97.8	98.7
	Divorced	4	.9	.9	99.6
	Separated	2	.4	.4	100.0
	Total	455	100.0	100.0	
Education	Illiterate	33	7.3	7.3	7.3
	Primary	140	30.8	30.8	38.0
	Secondary	97	21.3	21.3	59.3
	Technique	4	.9	.9	60.2
	Diploma	75	16.5	16.5	76.7
	Degree	90	19.8	19.8	96.5
	MSc	16	3.5	3.5	100.0
	Total	455	100.0	100.0	

Figure 3 Bar chart of Educational status of respondents

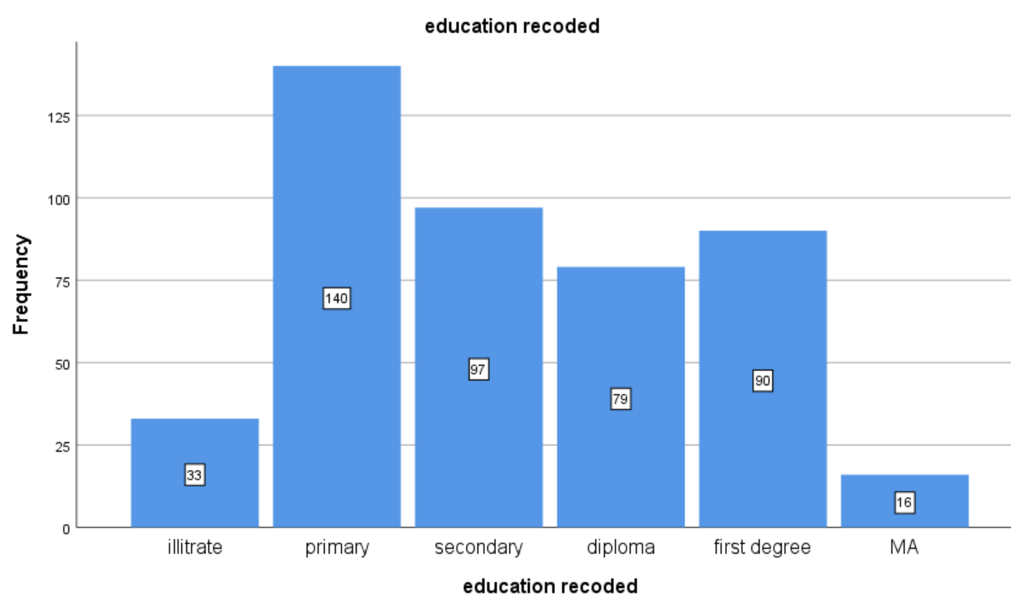


Table 4 Socio- Economic characteristics of the household

Monthly household income

		Frequency	Percent	Valid Percent	Cumulative Percent
Monthly house hold income	<=1000	14	3.1	3.1	3.1
	1001-2000	41	9.0	9.0	12.1
	2001-3000	50	11.0	11.0	23.1
	3001-4000	29	6.4	6.4	29.5
	4001-5000	63	13.8	13.8	43.3
	>5000	258	56.7	56.7	100.0
	Total	455	100.0	100.0	

Table 5 Service delivery related variables

		Frequency	Percent	Valid Percent	Cumulative Percent
FACILITY CATEGORY	Governmental	361	79.3	79.3	79.3
	Private	94	20.7	20.7	100.0
	Total	455	100.0	100.0	
FACILITY TYPE	Hospital	272	59.8	59.8	59.8
	Health Center	183	40.2	40.2	100.0
	Total	455	100.0	100.0	
The time at your delivery or labor	Day	210	46.2	46.2	46.2
	Night	245	53.8	53.8	100.0

attended	Total	455	100.0	100.0	

Provider factors for respectful maternity care

Most of the delivery attendant health care provider gender was male, their qualification was midwife and medical doctors, though the dominating number of the survey participants couldn't identify the qualification of the maternal care attendants.

Table 6 Providers related factors

Provider factors for respectful maternity care among mothers in ANC, delivery, and post-partum period in Addis Ababa health facilities					
		Frequency	Percent	Valid Percent	Cumulative Percent
Service provider Gender	Male	246	54.1	54.1	54.1
	Female	209	45.9	45.9	100.0

Table 7 Fertility related characteristics of study participants

Last birth/pregnancy		Frequency	Percent
The current baby was the first baby for woman?	Yes	222	48.8
	No	233	51.2
	Total	455	100.0
pregnancy terminated with abortion	Yes	71	15.6
	No	384	84.4
	Total	455	100.0
Parity/Birth order	Gave birth to the first baby	221	49
	Gave birth to two children	133	29
	Gave birth for three children	66	15
	Gave birth for four children	31	6.1
	Gave birth for five children	4	0.9
	Total	455	100.0
For which service the women came? (During the data collection)	Labor and delivery	254	55.8
	Family planning	8	1.8
	EPI	97	21.3
	Treatment or consultation	96	21.1
	Total	455	100.0

Birth spacing between the last consecutive children	She gave birth for first time	222	48.8
	Gave birth after one year	35	7.7
	Gave birth after two years	59	13.0
	Gave birth after three years	41	9.0
	Gave birth after four years and above	98	21.5
Total		455	100.0
Intention to have more children	No more children is desired	84	18.5
	Want to have a child after one year	28	6.2
	Want to have children after two years	79	17.4
	Want to add children after three years	79	17.4
	Want to add children after four or more years	52	11.4
	Not decided to add or not more children	133	29.2
	Total	455	100.0

Our research was conducted in labour ward department of a hospital for a care and admission of women in the process of child birth, postnatal wards and sick new born critical unit. Majority of the participant women were present for labour and delivery

As presented in the **Table 7** above the highest proportion of women participated in the study gave birth for first time. The shortest birth interval which was giving birth after one year was reported by 15.4% of the participant women. The median birth interval reported by women was 3.00 years

Most of the participants planned to have more children two or three years later and 84(18.1%) didn't need more children while 133(28.7%) of the participants reported that they didn't decide to have more children.

4.3 Disrespect and Abuse during Labor and Postpartum

Results are presented starting assessment from the women anti-natal care follow up, and structured based on the typology of the mistreatment of women during childbirth. The criterion had dichotomized response, "yes" or "No", to objectively identify reported events of disrespect and abuse. For categories of disrespect and abuse with more than one verification criterion, a woman was labeled as "disrespected and abused in the respective category" if she reported "yes" to at least one of the verification criteria during childbirth. If a mother identified as having faced disrespect and abuse in at least one of the seven categories, she considered as "disrespected and abused woman". As the screening question, mother who reported "NO" to the question "Do you think that you had got respectful maternal care during

your recent pregnancy, childbirth or complication?" was categorized as a mother who experienced disrespect and abuse.

To further assess the nature of disrespect and abuse that women experienced questions were asked in relation to categories of disrespect and abuse and the result was described below and in table 9. From article 1 the most common type of mistreatment was shouting at the clients with frequency of 95 (21.1%) showed above. From measurement of Article 2 of statement of WHO, not asking which position the mother would like to deliver in her baby is reported by 271(60.1%) women and was more frequent than the other mistreatments. In both type of facilities, government and private, the providers failing to tell the client that she can refuse any treatment if she doesn't like it, was the most frequent mistreatment for article 3. For Article 4 stated by WHO, denying for reassuring touch during care was most frequent of others. From article 5 measurements women were asked the question "Do you think that all patients are treated equally in the facility?" and 136(29.9%) reported "NO". From Article 6 of the WHO statements, women being kept for a long time in the health facility before receiving any service were more frequent than others. However, there was no preventing of mothers from living with her new-born baby because she fails to pay her bill, there was detaining of mothers in the facility because she was insecure service fee. The survey reflected; those 62 (17.4%) women who seek maternal from government facility detained in the facility as a result of insecure their bill. The most dreadful outcome of maternal disrespect and abuse during facility-based care was physical abuse or harm that can result in complicated health problem. It was the alarming and shocking outcome which may lead to maternal mortality.

Interviewing 455 women about the quality of ANC, about a quarter 103(22.1%) of the women reported that the health care provider didn't explain types of laboratory investigation in a satisfactory way (see table 9). Regarding the disrespect and abuse during labour, delivery and PNC, shouting on the client women was more frequent 95(21.1%) both in public and private health facilities. Deny informing the women about the care provided 126(27.9%) was the most frequent practice the mothers experienced. The other most frequent type of disrespect and abuse during delivery was deny asking the position the women prefer to deliver in, 282(62.5%) and bypassing to allow the position she would like to deliver in 271(60.1%) was the most frequent type of disrespect and abuse.

In Government health facilities 29(8.0%) of 361 and from private 8(8.5%) of 94women experienced forceful downward abdominal pressure, and in government facilities 43(12.0%) and in private health facilities 3(3.2%) totally 46(10.2%) of women experienced denied liberty of movement during labour or forcefully held down to the bed. One of the specific objectives in research proposal was investigating the disrespect and abuse that the women shy away and reported rarely. 53(14.7%) Women seeking maternal health care from governmental health facilities and 7(7.4%) of women seeking maternal health care from private health facilities experienced undergoing unnecessary and extensive episiotomies. 38(10.5%) of survey participant women reported that they have experienced postpartum suturing of vaginal tears or episiotomy cuts without the use of anaesthesia. 16(4.4%) of women who seek maternal care from governmental health facilities felt inappropriate touching of genitalia/thigh during general examination and labour accordingly. 21(4.6%) of the participant women experienced complication as a result experienced different types of disrespect and abuse during facility based maternal care.

Table 8 Respectful maternal care experience measurements during ANC, reported by participant women

RMC measurements		Frequency (%)
Respect culture and religion during the general examination		392(84.5)
explain procedures by giving a greeting before the examination		381(83.7)
health care provider treat you in a friendly manner		359(77.4)
The Health care provider showed his/her concern and empathy		368(79.3)
The Health care provider explain types of laboratory investigation in a satisfactory way		352(75.9)
health care provider caring for you with a kind approach by calling your name		390(84.1)
responded to clients' needs whether or not you asked during counselling on birth preparedness and complication readiness		367(79.1)
The health care provider assure your privacy during the examination		450(97.0)
waiting time fair for examination		373(80.4)
treated you compassionately and respectfully during ANC follow up		402(86.6)
The woman involved in decision making as much as she can.		341(73.5)
Did you have well informed and good communication with the staffs		388(83.6)
Did you receive individualized care during the ANC visit?		430(92.7)
health care provider promotes your partner/accompany during ANC		314(67.7)
happy with the over all services she got then		420(90.5)
what decision did you make for the non-respectful care you received during facility based maternal care	Shift to another government facility	9(1.9)
	Shift to private facility	1(0.2)
	I have written on the comment book	3(0.6)
	Nothing	151(32.5)
	There was no disrespect and abuse	290(62.5)

Table 9 Disrespect and abuse during Labour, Delivery and PNC by facility category

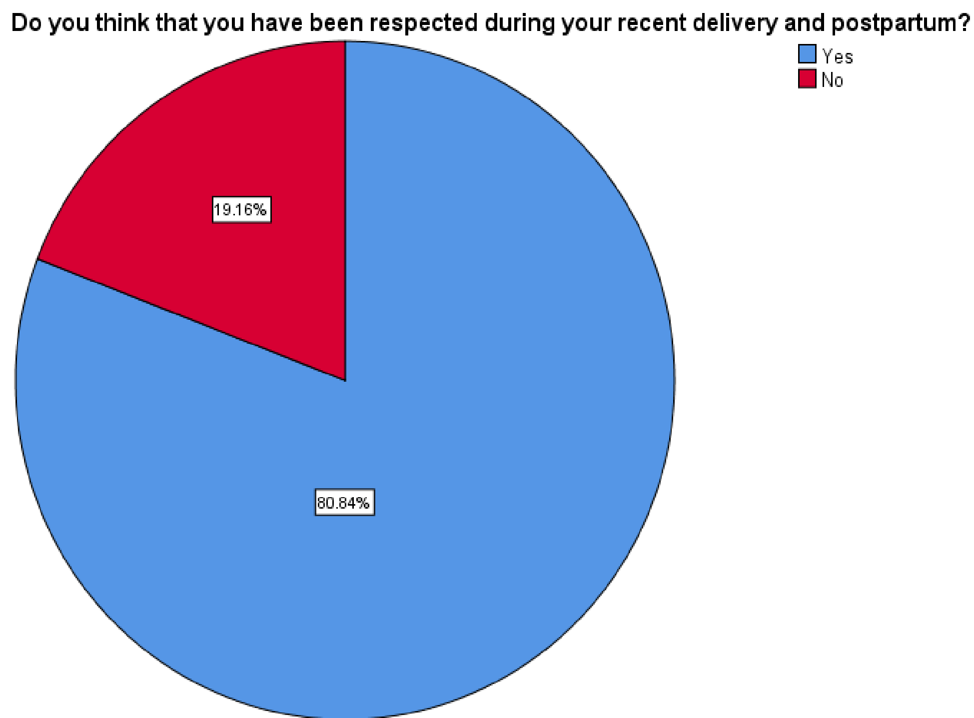
Every woman has the right to be free from harm and ill treatment(Physical Abuse)						
RMC Measurements of the article: Experience reported:	Category of the facility				CI for the proportion difference	
	Governmental (n=361)	Private (n=94)	Difference of proportions	Total (n=455)		
Statement of Article 1 by WHO						
Pinched or slapped, during getting maternity care.	70(19.4%)	7(7.4%)	12% *	77(16.6%)	3.43%	20.45%
Verbal abuse (insult, intimidation, threats)	26(7.2%)	3(3.2%)	4%	29(6.4%)	-1.53%	9.55%
shouted upon clients/women	82(23.0%)	13(13.8%)	9.2%	95(21.1%)	-0.34%	18.11%
Denying liberty of movement during labour	43(12.0%)	3(3.2%)	7.8% *	46(10.2%)	1.88%	15.56%
Undergone unnecessary and extensive episiotomies.	46(12.8%)	5(5.3%)	7.5%	51(11.3%)	0.26%	14.58%
Postpartum suturing of episiotomy cuts without the use of anaesthesia	35 (9.8%	-	9.8% *	35(7.7%)	3.65%	15.74%
pushing on the abdomen to force the baby out,	29(8.0%)	8(8.5%)	(0.5%)	37(8.1%%)	-6.68%	5.73%
Statement of Article 2 by WHO Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care.						
Lack of information about the care provided	102(28.5%)	24(25.5%)	3%	126(27.9%)	-7.43%	12.88%
coerced into a medical procedure	8(2.2%)	2(2.2%)	0	10(2.2%)	-3.24%	3.42%
not asking which position the mother would like to deliver in	231(64.7%)	51(54.3%)	10.4%	282(62.5%)	-1.28%	20.75%
Denying choice of position for birth	224(62.7%)	47(50%)	12.7% *	271(60.1%)	0.91%	23.19%
Not requesting mothers consent for all the care she received	144(40.3%)	19(20.2%)	20.1 *	163(36.1%	8.79%	30.56%
Not communicating by HWs with simple and	37 (10.4%)	10(10.6%)	(0.2%)	47(10.4%)	-7.30%	6.52%

Every woman has the right to be free from harm and ill treatment(Physical Abuse)						
RMC Measurements of the article: Experience reported:	Category of the facility				CI for the proportion difference	
	Governmental (n=361)	Private (n=94)	Difference of proportions	Total (n=455)		
local language						
Statement of Article 3 by WHO Every woman has the right to privacy and confidentiality						
Examination, labour, and deliver in view of others	9(2.5%)	-	2.5%	9(2.0%)	-0.667%	5.653%
sharing sensitive information, such as a patient's HIV status, age, marital status, and medical history, in a way that other people can hear	-	-	-	0%	0.000%	0.000%
Denying to tell the client to refuse any treatment if she doesn't like.	264(73.9%)	52(55.3%)	18.6% *	316(70.1%)	7.357%	28.265%
Statement of Article 4 by WHO Every woman has the right to treated with dignity and respect						
Not showing concern and empathy	84(23.5%)	19(20.2%)	3.3%	103(22.8%)	-6.442%	12.554%
felt inappropriate touching of genitalia or thigh during examination	16(4.4%)	-	4.4% *	16(3.5%)	0.252%	8.613%
felt that the HWs showed you animosity because of your personal attribute	4(1.1%)	-	1.1%	4(0.9%)	-1.011%	3.227%
The HWs have not made reassuring touch during care/examination	140(39.2%)	37(39.4%)	(0.2%)	177(39.2%)	-11.645%	10.484%
You haven't been treated respectfully by all HWs	62(17.4%)	10(10.6%)	6.8%	72(16.0%)	-1.747%	14.819%
The health worker didn't respond to clients' needs whether or not they asked	43(12.1%)	4(4.3%)	7.8%*	47(10.5%)	0.749%	14.563%
the service provision delayed due to the health facilities problems	62(17.4%)	12(12.8%)	4.6%	74(16.4%)	-3.967%	12.784%

Every woman has the right to be free from harm and ill treatment(Physical Abuse)						
RMC Measurements of the article: Experience reported:	Category of the facility				CI for the proportion difference	
	Governmenta l (n=361)	Private (n=94)	Difference of proportions	Total (n=455)		
HWs shouted on client during care giving or physical examination	51(14.4%)	11(11.7%)	3.7%	62(13.8%)	-5.361%	10.211%
You haven't been treated by HWs in a friendly manner	97(27.0%)	13(13.8)	13,2% *	110	3.323%	22.757%
the HWs didn't called the client with her name	25(6.9%)	4(4.3)	2,6%	29(6.4%)	-2.874%	8.214%
Communicating client/ companion politely	66(18.6%)	9(9.6%)	9% *	75(16.7%)	0.287%	17.129%
Statement of Article 5 by WHO: Every woman has the right to equality, freedom from discrimination and equitable care.						
Insulting client/companion because of client's personal attribute	30(6.3%)	-	(6.3%) *	30(6.6%)	2.678%	13.943%
all patients are not treated equally in the facility	110(30.5%)	26(27.7%)	2.8%	136(29.9%)	-7.578%	13.201%
heard of woman discriminated because she was HIV positive	20(5.5%)	7 (7.4%)	1.9%	27 (5.9%)	-7.269%	3.455%
Statement of Article 6 by WHO Every woman has the right to the highest attainable level of health						
left alone for a long time	66(18.3%)	35(37.2%)	(-18.9%) *	101(22.2%)	-28.383%	-9.520%
kept for a long time in the health facility before receiving any service	96(26.6%)	15(16.0%)	10.6% *	111(24.4%)	0.888%	20.382%
Have you been detained by HWs because you don't have money to pay	62(17.4%)	1(1.1%)	16.3% *	63(14.0%)	8.272%	23.949%
complicated health problem due to abuse or physical harm during facility based maternal care	18(5.0%)	3(3.2%)	2.8%	21(4.6%)	-2.967%	6.557%
Do you think that you have been respected					4.448%	22.298%

Every woman has the right to be free from harm and ill treatment(Physical Abuse)						
RMC Measurements of the article: Experience reported:	Category of the facility				CI for the proportion difference	
	Governmental (n=361)	Private (n=94)	Difference of proportions	Total (n=455)		
during your recent Pregnancy, childbirth or complication	79(21.9%)	8(19.1%)	2.8% *	87 (19.1%)		

Figure 5.Pie chart for reported prevalence of respectful maternal care



4.4 Predictors of respectful maternity care in health facilities - Bivariate associations and multivariable analysis

In bivariate logistic regression analysis, association of each explanatory variable with outcome variable (respectful maternity care) was assessed and the observed associations were reassessed by multivariate analysis to identify adjusted association with the probability of receiving disrespectful care. By adjusting the dependent variables for facility category (governmental or private) the findings conveyed that monthly household income is associated with almost all types of mistreatments. Women with monthly household income less than 2000 birr significantly more likely to be subjected to inappropriate touching around gentelia/thight (AOR=8.671 CI (1.348, 55.789)), Women with monthly household income less than 2000 Eth birr triple times more likely to experience staying for a long time in the health facility before receiving any services compared to women with monthly household income >=5001 Eth.Br (AOR=3.000 CI(1.352,6.655)). Women who came from household earning monthly income less than or equal to 2000 are more than double time likely to experience being shouted at and threating from their providers (AOR=2.300 CI(1.024,5.164)) than women with higher income.

Age is also associated with disrespect and abuse those women younger than 30 years are more likely subjected to experience pinching and slapping than older women. (AOR=2.144 CI(1.083,4.245)). As the adjusted OR revealed younger women less or equal to 30 are more than double time likely to experience pinching and slapping.

Getting maternal health service in the hands of male health care providers seem more protective from maternal services accompanied with disrespect and abuse during facility based maternal health care than getting maternal health care service in the hands of female health care providers. As the multiple logistic regression models revealed below women got maternal service in the hand of male health care providers are fifty seven percent less likely to experience insulting and threating than those who got maternal service in the hands of female health care providers (AOR=0.426 CI(0.189,0.962))

Mothers attitude towards service received during facility based maternal services adjusted for facility category (screening question to determine prevalence rate)

	Sig.	Exp(B)	95% Confidence Interval for Exp(B)	
			Lower Bound	Upper Bound
Intercept	.224			
FACILITY CATEGORY (control variable)	.033	1.983	1.058	3.718
[Education illiterate and primary school]	.152	1.535	.854	2.757
[Education secondary technic diploma]	0.008*	2.459	1.259	4.804
[Education for D&A first degree master degree]	Refer(1).	Refer(1)..	Refer(1)..	Refer(1)..
[Age 15 through 24]	.071	2.000	.942	4.244
[Age 25 through 30]	.660	.891	.534	1.489
[31 Thru. Highest	Refer(1).	Refer(1)..	Refer(1)..	Refer(1)..
[Service provider gender=1	.000*	2.151	1.401	3.301
[Service provider gender=2]	.	.	.	.
[Is the recent child the first baby for you?If YES=	.870	1.039	.654	1.651
[Is the recent child the first baby for you?No =1	Refer(1).	Refer(1)..	Refer(1)..	Refer(1)..
[MONTHELY HH INCOME <=2000]	.019*	.405	.191	.861
[MONTHELY HH INCOME beteween 2001 through 5000]	.153	.646	.355	1.176
[MONTHELY HH INCOME >=5]	Refer(1).	Refer(1)..	Refer(1)..	Refer(1)..

	Physical Abuse (pinched or slapped)	Insult or Threats	shouted upon clients/women	Restrained or tied down	Unnecessary and extensive epistomy	Pushing on the abdomen to baby out	Felt inappropriate touching around genitalia/thigh	keeping for a long time in the health facility before receiving any service
Household Monthly income								
[MONTHELY HH INCOME=>=5001]		Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)
[MONTHELY HH INCOME ,=<2000BR]	P=0.585 AOR=0.778 CI(.315,1.917)	P=0.875 AOR=1.131, CI(0.245,5.224)	P=0.044* AOR=2.300 CI(1.024,5.164)	P=0.990 AOR=0.994 CI(0.369,2.679)	P=0.203 AOR=1.831 CI(0.721,4.650)	P=0.427 AOR=1.696 CI(0.460.6.252)	P=0.023 AOR=8.671 CI(1.348,55.789)	P=0.007 AOR=3.000 CI(1.352,6.655)
[MONTHELY HH INCOME=2001 THROUGH 5000]	P=0.315 AOR =0.695 CI(0.342,1.413)	P=0.180 AOR=2.130 CI(0.705,6.439)	P=0.652 AOR=1.168 CI(0.594 2.297	P=0.160 AOR=.545 CI(0.233,1.272)	P=0.086 AOR=0.442 CI(0.174,1.123)	P=0.613 AOR=0.735 CI(0.224,2.419)	P=0.773 AOR=1.370 CI(0.161,11.642)	P=0.027* AOR=2.121 CI(1.089,4.129)
Age of the respondents								
31 Thru. highest	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)

25 years thru. 30 Years	P=0.029* AOR=2.144 CI(1.083,4.245)	P=0.691 AOR=1.231 CI(0.443,3.423)	P=0.424 AOR=0.796 CI(0.456,1.391)	P=0.565 AOR=0.793 CI(0.360,1.748)	P=0.049* AOR=0.482 CI(0.233 .997)	P=0.475 AOR=0.669 CI(.223,2.012)	P=0.063 AOR=0.200 CI(0.037,1.093)	P=0.284 AOR=1.403 CI(0.755,2.604)
15 years thru 24 years	P=0.096 AOR=2.149 CI(0.874,5.285)	P=0.431 AOR=1.709 CI(0.451,6.483)	P=0.996 AOR=0.998 CI=(0.459,2.170)	P=0.627 AOR=0.777 CI(0.281,2.146)	P=0.117 AOR=0.466 CI(0.179,1.210)	P=0.904 AOR=0.922 CI(0.244,3.481)	P=0.793 AOR=1.248 CI(0.238,6.544)	P=0.079 AOR=2.008 CI(0.922,4.374)
Educational background of the participants								
Dip,BA,MA(Rf	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)
Secondary Techn	P=0.602 AOR=0.814 CI(.376,1.763)	P=0.256 AOR=0.459 CI(0.120,1.759)	P=.000* AOR=0.198 CI(0.091,0.434)	P=0.081 AOR=2.519 CI(0.892,7.110)	P=0.157 AOR=0.426 CI(0.131 1.389)	P=0.162 AOR=3.127 CI(0.632 15.473)	NA	P=0.173 AOR=0.596 CI(.283,1.256)
Illiterate and primary	P=.827 AOR.925 CI(0.459,1.865)	P=0.876 AOR=0.914 CI(0.295,2.829)	P=0.005* AOR=0.385 CI(0.196,0.755)	P=0.003* AOR=4.104 CI(1.610,10.458)	P=0.251 AOR=1.590 CI(0.720 3.509)	P=9.033 AOR=4.871 CI(1.137,20.865)	P=0.421 AOR=0.471 CI(0.075,2.946)	P=0.781 AOR=0.913 CI(0.478,1.742)
Service provider's gender								
Female(reference)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)

Male	P=0.801 AOR=0.936 CI(0.560 1.564)	P=0.040* AOR=.426 CI(0.189,0.962)	P=0.002* AOR=0.479 CI(0.299,0.76 5)	P=0.416 AOR=0.761 CI(0.395,1.4 69)	P=0.190 AOR=0.657 CI(0.350,1.231)	P=0.467 AOR=.715 CI(.290,1.76 5)	P=0.654 AOR=0.765 CI(0.237,2.4 68)	P=0.394 AOR=0.814 CI(0.508 1.305)
Being giving the first baby								
The recent child is the first baby (No ref	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)	Ref(1)
yes	P=0.434 AOR=0.798 CI(0.453 1.405)	P=0.577 AOR=0.779 CI(0.325,,1.871)	P=0.007* AOR 0.487 CI(0.289,0.823)	P=0.474 AOR=1.301 CI(0.633,2.6 74)	P=0.120 AOR=1.741 CI(0.866 3.500)	P=0.743 AOR=1.184 CI(0.432.3.2 48)	P=0.462 AOR=0.576 CI(0.132,2.5 08)	P=0.661 AOR=1.123 CI(0.668,1.887)

4.5 Qualitative Result

In-depth interviews was used to explore key issues around the factors associated with committing disrespect and abuse during facility-based maternal care, and the rarely reported disrespect and abuse. As part of this larger study, we targeted 11 service provider and 12 mothers from service provision points (health facilities) which were selected for the quantitative study. As the data sources we used the woman experienced mistreatement and never experienced from Yekatit medical college hospital and the same scenario has taken from Gandhi memorial hospital. From Anania mothers and children hospital and Bethazata general hospital the two women participated in the qualitative study with out selection criterion while from Gotera health center and shiromeda health center two women one from mistreated and one from never mistreated took as the participants. In addition to that from kadsco health center and Maichew health center two women who experienced disrespect and abuse participated in the indepth interview.

On the other hand providers interviewed to got precarious evidence on the maternal mistreatment (see table 12 below). Accordingly the interview conducted was a long interview with providers and more brief in-depth interviews with mothers who experienced disrespect and abuse and with mothers who never experienced mistreatment yet as well.

Table 11 qualitative research participant mothers information

Mothers	Facility	Age	Education status	Service status
M1	Shiromeda health center	32	Secondary Edu	mistreated
M2	Shiromeda health center	28	Elementary edu	Never mistreated
M3	Mayichew health center	25	technique	Mistreated
M4	Anania mothers and children hospital	22	Degree	Never mistreated
M5	Gandhi Memorial hospital	24	Diploma	Mistreated
M6	Gandhi memorial hospital	30	certificate	Never mistreated
M7	Yekatit 12 medical college Hospital	28	Diploma	Mistreated
M8	Yekatit 12 Medical college hospital	26	illiterate	Never mistreated
M9	Bethazata General hospital	25	Elementary	Never mistreated
M10	Kadsco health center	19	secondary	mistreated

M11	Gotera Health center	34	Diploma	Mistreated
M12	Gotera Health center	30	Degree	Never mistreated

Table 12 Interview participant service provider information

Providers	Facility	Age	Gender	Qualification
P1	Shiromeda health center	42	F	Midwife
P2	Shiromeda health center	34	M	HO
P3	Mayichew health center	29	F	Midwife
P4	Anania mothers and children hospital	52	F	Midwife
P5	Gandhi Memorial hospital	34	M	Midwife
P6	Gandhi memorial hospital	36	F	Midwife
P7	Yekatit 12 medical college Hospital	56	F	Midwife
P8	Yekatit 12 Medical college hospital	38	M	Midwife
P9	Bethazata General hospital	52	F	Midwife
P10	Kadsco health center	31	F	Nurse
P11	Gotera Health center	36	M	Midwife

The in-depth interviews are described below.

One of the rights of women to be protected as part of respectful maternal health service, in the WHO guide is **"Every woman has the right to be free from harm and ill-treatment": or no physical harm is done**

Study participants about this were asked about their experience of the care that they were given during labor and delivery. We started interviews by asking women to describe their experiences during childbirth at the facility of care and their perceptions of its quality. Most of the patients interviewed reported satisfaction with their care during labor and delivery. Whereas, women who experienced disrespect and abuse during labor and delivery reported lower satisfaction with the care. Patients were aware that health facilities offer life-saving care and seemed to appreciate the access, particularly because services were offered free of charge. Regarding the experience of lack of respect and abuse, women reported cases of

abandonment of them by the provider without giving them proper treatment for long hours. Forceful downward abdominal pressure to push the baby out and slapping on the leg are physical abuse reported by mothers. Shouting at mothers/accompanying relative and spoke to them using harsh tone has repeatedly been reported by mothers. Not admitting the mothers with labor by giving reason such as "shortage of bed in the facility"; a rushed checking/care/ without listening to clients and unnecessary referrals were reported by mothers. Undergoing extensive surgery by medical student was among the reported disrespect and abuse during the in-depth interview;

A case of disrespect and abuse during labor and delivery by women is described below.
Not providing the appropriate service/care on time and neglect without service
A woman of 24 years old who gave birth at governmental hospital was shifted from the catchment health centre where she experienced disrespect and abuse. "There was no attention given for the mother's problem in the health center, there was extreme patient abandonment by providers. I think that was due to over crowdedness of the labour ward. After starting of labor I have arrived to health centre. The health care provider has referred me to Gandhi hospital because there was severe bleeding at a time [placenta previa]. *As a result of that I had delivered the baby by operation (Caesarean Section) method and I went home after 48 hours of stay in the hospital. If the provider at the hospital had not given me the care, my baby and I would not have been saved. But again the suture was so extensive and ruptured after seven days. The wound was severely bleeding and I had to go back to the hospital after a midnight around 1:00 am and I have stayed for a long time in the hospital without getting any care. I think that the delivery process had made by Medical student who was practicing in the hospital. I got the medical care on the next day at 4:00 pm. Thus I had to stay for such a long time without getting the maternal care."*

Experience of verbal abuse (insult, intimidation, threats)
6.4% of participants in the quantitative survey reported verbal abuse. In the qualitative research, both mothers and providers interviewed reported incidences of verbal abuse. Clients /mothers reported that providers often shouted at them or spoke to them using harsh tone.
A young woman,24 years old who delivered in a hospital her first baby experienced verbal abuse and described her experience below: "Since I was in pain I couldn't open my legs as the midwife wanted, He shouted at me saying 'open your legs as you opened when enjoying

sex and then he laughed at me saying, 'you enjoyed then and complain now', but I was suffering from pain of labour."

Experience of physical abuse

We found significant difference in reporting of physical abuse both in quantitative survey and qualitative assessment between service seekers and providers. There was insignificant reporting of physical abuse in quantitative survey of mothers. In contrast midwives reported that they had personally did physical abuse to mothers. They were slapping on the legs in order to get the mothers to comply with their (providers) instructions for positioning for labour.

A male senior midwife of 56 years old reported that "some of the younger mothers who gave birth for the first time do not usually obey the instruction of the care provider were expected to be pinched and slapped on her thigh. Even the family expected that she would be pinched by providers."

A female senior Midwife of 52 years old from private hospital reported that
"The mothers who came to our hospital want to give birth in the hand of specialists/ gynaecologists. Most of the time husbands accompany their wives and we encourage this practice. Creating good rapport with providers not being aggressive toward the providers and the entire staffs of the facility and giving the necessary respect to providers contribute to good outcome of the labor"

"Apart from hearing about disrespect and abuse I haven't seen any provider committed mistreatment intentionally yet. The verbal abuse and speaking in a harsh tone to make the mothers cooperative and to save her from rupturing of different maternal organs. This type of reaction toward mothers ensure successful outcome."

The midwife continued replying "The pain due to labour is not comparable with pain of pinching or slapping. The mother in labour obliged to close their legs from severe pain of labour that they do not feel about the pain of pinching and slapping."

Drivers of disrespect and abuse

Due to health system problem the service providers commit mistreatment. Patients reported that there was abandonment, neglect and mistreatment arising from shortage of beds as well as providers.

24 years old woman who gave birth to her first baby in government Hospital reported

" I have seen it in my naked eye that woman admitted after me, automatically gave birth on the bed I delivered on by shifting me to the chair near to the bed, I asked the service provider why he was forcing me to seat on the chair, he replied 'What can I do? As you can see, there is no even one bed to admit this woman, at least you have held the alive baby but this woman's new born is at risk."

A 34 years old woman who gave birth for her third child reported

"There is shortage of skilled health care attendant. I went to hospital in the evening and was admitted by a midwife that only appeared once and examined me then but he didn't come back again. perhaps other mothers are waiting for him to be assisted. I gave birth in the morning and was assisted by the morning service provider."

A mother of age 28 reported

"… The provider came after almost all part of the baby was delivered by itself, because she was assisting other woman whose baby was suffocated. In addition there was rushing in the care to reach all pregnant mothers who came for service, unsanitary rooms, as a result of over crowdedness of the labour ward, women who were there for delivery service had to wait or being left alone for a long period of time and subjected to give birth on the mattress/carpet. Sometimes the providers talk in a harsh sound that seem aggressive for no reasons, may be they are tired or they think about their unsatisfactory salary"

Factors Associated to commit disrespect and abuse

Workload and over crowdedness of the labor ward was raised by providers in both state running health facilities and privately owned health facilities. Another factor mentioned was government's disregard and nonresponse to service providers' request of different benefits

One governmental hospital 56 years old male senior midwife reported

"in addition to the routine work of the hospital there is unnecessary maternal referrals from health centers which made the hospital labor ward overcrowded. The shortage of health service providers, unavailability of health care equipment and low salary and duty payment for the providers exacerbate mistreatment of clients who come for maternal health service. The government's and the owners of the facilities disregard and nonresponse to service providers' request of different benefits: salary and duties, make the providers not to serve in full heart."

The investigator asked by restating. "You mentioned that you were hitting or shouted at clients. In your opinion, what factors influenced you to commit mistreatment? Please explain."

He continued replying

"*As they (laboring mothers) are in severing labor pain, particularly the younger mothers do not listen to the care providers when they advise them. The woman or her relatives insult or hit us. As you can see the security segment of the hospital is weak and sometimes, we face difficulty when accident (death) happened during maternal care, the relatives try to attack us."*

One female 52 years old senior midwife replied that,

"we need cooperativeness from the laboring mother as well as her relatives. I had been working as a midwife for 26 years in government facilities but now I am working in this private hospital."

The Midwife complained about the fee paid for maternal service by saying, "this service is (maternal care) offered for free in government health facilities, why so here? The person who can afford the service fee should afford it, he should take free of charge service if and only if the person couldn't afford it."

"Clients or relatives being offensive or aggressive towards service providers may subject the client to be mistreated."

In general, providers had knowledge gap on describing the WHO articles for enhancing the quality respectful maternal care. None of the providers clarify correctly the phrase "respectful maternal care." Both mothers and providers repeatedly reported that the cause of disrespect and abuse are crowdedness of the labor ward. The providers emphasized that, no providers commit disrespect or abuse intentionally, rather to ensure "good outcomes" for the baby.

One of the providers reflected that the unnecessary referral from health centers made the ward more crowded that the health care providers offer service for full time. Using harsh tone during speaking with the mothers, and discouraging the younger mothers when they disobey the command by midwives are among the reflected disrespect and abuse. The most shock and alarming thing found in both the quantitative and qualitative research was, mothers experiencing complication as a result of disrespect and abuse. The senior gynecologists being indifferent to mothers worry and invite the medical students (inter) to conduct surgery in the absence of senior surgeon and open the service system to be afforded by rehearsing students.

CHAPTER 5

DISCUSSION

Not ensuring access to maternal health services that are safe, timely, respectful, and non-abusive care is double-barrelled maltreatment as both a violation of the right for all women as well as a deterrent tool to use facility-based lifesaving maternal and new-born care. The Global Strategy for Women's, Children's and Adolescent's Health highlights the rights of women, children, and adolescents to the highest attainable standard of health (S Myers et al. 2014). The Ethiopian Government had committed to the ambitious goals outlined in millennium development goal (goal 5) improve maternal health, and sustainable development goal (goal 3) as a result of which preventable child deaths dropped by more than half, and maternal mortality went down almost as much (Kumar S. et, al 2016). Service quality improvement is key measure that contributes to better maternal and child health. The findings of this study reflect areas requiring significant attention in these quality improvement efforts and are discussed below.

The result of interviewer-administered structured and unstructured survey data collection showed experiences of mistreatment from point of view of 455 mothers and 11 service providers. 19.1% of the mothers seeking maternal services in the survey reported that they feel mistreated during service. It was found that most of the mistreatments happen during the labor and delivery time rather than during ANC follow up in the facility. This could be because providers are more likely to be overburdened around the time of birth or due to stress and frustrations experienced by the providers which are caused by un-fulfilment of resources to manage childbirth, over-crowdedness of labor ward and, younger mothers being in the state of panic, might invite the providers to commit mistreatments. The most frequent type of mistreatment was 'not asking which position the mother would like to deliver' in (62.5% of cases) and 'denying to allow the mothers the position they would like to give birth' in (60.1%), which suggest bypassing of the right to be free from harm and ill-treatment. This may be due to the familiarity of providers for mothers to give birth only in dorsal lay position (a position in which the mothers lies on the back with the lower extremities moderately flexed and rotated outward) rather than using other birth position alternatives.

This result is similar to other research finding which was conducted in Ghana, Guinea, and Nigeria (Bohren MA 2019).

According to the qualitative research conducted with providers, none of the providers clearly defined and try to list the seven articles of WHO statements which inhibit disrespect and abuse. Since the providers were not equipped with sufficient knowledge about the respectful maternal care articles, providers unknowingly misstep and fail to respect women's rights to get respectful health care. Despite showing good basic knowledge of confidentiality, privacy, and consent to health care providers, it was found that consecutive on-the-job training on the principles of responsive and respectful care, and on counselling is largely absent as aligned with (Burrowes S. et, al. 2017) findings. Moreover the findings of the qualitative research showed indeed, all mistreatments committed were unintended and had actually resulted from the intention to ensure good outcomes that were a safe motherhood and healthy new-born as mentioned in (Burrowes S. et, al.2017).

The providers described that younger mothers are "uncooperative" that physical and verbal abuses are expected even by the family of the mothers as aligned with (Bohren MA 2016) to ensure a good/safe outcome of the labour. According to qualitative research, midwives and doctors described women as "uncooperative" during this period and some justified using physical and verbal abuse as "punishment" for non-cooperation to ensure "good outcomes" for the mother and baby. However small in number, some disrespect and abuse that, women usually shy away to report also appeared in this research. Inappropriate touching of genitalia or thigh during examination in 16(3.5%) cases, undergoing unnecessary and extensive episiotomies 51(11.3%) cases, and postpartum suturing of episiotomy cuts without the use of anaesthesia 35(7.7%) were among the mistreatments that women shy away to report usually but revealed in this study.

As women want to ensure a positive outcome that fulfils or exceeds their prior personal and socio-cultural beliefs and expectations, giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from the skilled birth attendant was necessary. This study indicates that about 80.9% of mothers reported that they have received respectful maternity care in general. This result is comparable with studies done in Kenya 80%, Tanzania 85%, Zanzibar 88.3%. And it's significantly diverted from studies conducted in Nigeria 2%. The difference with Nigeria perhaps rose from time variation related with currently accelerated RH promotion activities

and women-friendly programs, different supportive pieces of training in some health institutions of the study area (Okafor II, 2015, EDHS 2016). The finding of this study revealed that facility gatory and income was predmonentely associated with receiving respectful maternity care. Accordingly those mothers who got maternal care in government health facilities are more likely experienced disrespected and abused. From multivariate analysis we learnt that women treated in state running health facilities subjected to physical abuse AOR=0.271 CI(0.114, 0.642) which is 3.7 times fold as compared as the private health facilities. Verbal abuse was also practiced in public health facilities than private health facilities.

The analysis indicated that women treated in public health facilities subjected to hospitalize shouting and harsh tone (AOR=0.098 CI(0.037,0.259) that implies the providers in public health facilities practice verbal abuse significantly. Accordingly, male health providers who attended deliveries give almost four times better respectful maternity care than female health providers. This result is consistent with a study done in urban Tanzania higher likelihood of performing respectful maternity care was found among male providers in facilities (Kruk ME et al.2010). And also the same national study implementing a quality improvement approach among laboring women accompanied by a companion indicate that male providers were practice RMC more frequently than female providers(Kruk ME et al.2010). Moreover, the women attended for birth by providers in public health subjected to restrained or tied down during labor and delivery (AOR=0.233 CI(0.065,0.829)) and unnecessary and extensive epistomy AOR=0.360 CI(0.131,0.992).

In general, women from household earning more than 5001 birr were more likely to get respectful maternal care. Accordingly a Women earned monthly income less than or equal to 2000br were subjected to experience shouted and harsh tone (AOR=0.435, 95% CI(0.194,0.976)), subjected to inappropriate touching around gentelia/thight (AOR=0.115, 95% (0.018,742)) and experience keeping for a long time in the health facility before receiving any service (AOR=0.333 CI(0.150,,0.739). Being married was not significant in the study as contrast to a previous study done in Addis Ababa health facilities, which found that married women were three times (AOR 3.65 [95 percent C.I 1.59, 8.36]) more likely to receive respectful maternity care when compared to those who are not in marital union (Martha T.et, al. 2019)Thus, Ethiopian women's practice may appear during data collection that around 96%

By adjusting the dependent variables for facility category (governmental or private) the findings conveyed that monthly household income is associated with almost all types of mistreatments. Women with monthly household income less than 2000br significantly subjected to inappropriate touching around gentelia/thight (AOR=8.671 CI(1.348,55.789)), Women with monthly household income less than 2000 Eth birr experienced triple times keeping for a long time in the health facility before receiving any services than women of monthly household income >=5001 Eth.Br (AOR=3.000 CI(1.352,6.655)), while women with household income 2001- 5000 Eth. Birr were more likely to be kept for a long time in the health facility before getting any health service (more than double times) comparing with women who came from households with monthly earning 5001Eth. birr and more (AOR=2.121 CI(1.089,4.129)). Women who came from household earning monthly income less than or equal to 2000 birr are more than double time likely to experience being shouted at and threating from their providers (AOR=2.300 CI(1.024,5.164)) compared to those with household income above 5000 birr.

Age is also associated with disrespect and abuse that a women younger than 30 years are more likely subjected to experience pinching and slapping (AOR=2.144 CI(1.083,4.245)) .As the adjusted OR revealed younger women less or equal to 30 are more than double time likely to experience pinching and slapping.

Getting maternal health service in the hands of male health care providers seem more protective from maternal services accompanied with disrespect and abuse during facility based maternal health care than getting maternal health care service in the hands of female health care providers. As the multiple logistic regression models revealed below women got maternal service in the hand of male health care providers are more than half less likely to experience insulting and threating than those who got maternal service in the hands of female health care providers (AOR=0.426 CI(0.189,0.962)) and male health care providers are less shouting up on the clients than female health care providers (AOR=0.479 CI(0.299,0.765)).

The women with educational status Illiterate and primary are subjected to physical abuse of Pushing on the abdomen to get the baby delivered by health care providers than the other women of academic status more than diploma and above (OR=0.244 CI(0.096,0.621)) According to this study, mothers, who attended secondary education and higher, tend to receive better respectful maternity care than those who have no formal education, this is in

line with studies done in Enugu, south-eastern Nigeria, educational status of mothers were significantly associated with receiving respectful maternal care, This finding is perhaps related to intellectuality, that educated women practice their rights better than non-educated women and command respect from providers.

CHAPTER 6

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

In conclusion, in light of the fact gathered from the perspective of mothers, disrespect and abuse remain the challenge of mothers to give birth in the facility. Around 20% of surveyed women experienced mistreatment by providers during childbirth. Younger (<30years old), less educated women were at the highest risk, highlighting the need for multilevel interventions.

The most frequent type of mistreatment was denying to ask the position the women want to deliver and not allowing the position the mother prefer to deliver her baby. Though the frequency was small the disrespect and abuse which the woman shy away to report were also reported in the government health facilities because of some provider's behavioural problem or lack of required resources at the facilities and over crowdedness of facilities. Addressing these inequalities and promoting respectful maternity care for all is key to improve health equity and quality. Our findings can be used to inform policies and programs to ensure that all women have positive pregnancy and childbirth experiences, and are supported by empowered healthcare providers within well-functioning health systems. Over crowdedness of the labor ward and shortages of a skilled midwives are the sources of mistreatment. The recommendation directed by the participants of the study need due consideration and action to enhance the provision of respectful maternity care in Addis Ababa.

6.2 Recommendations

As WHO recommended the respectful maternity care which is integral to the human rights refers to offering maternal health care in a manner that ensures dignity, privacy and confidentiality, freedom from harm and ill treatment, and enable informed choice and continuous support during labour and child birth.

More importantly, interventions that work towards preventing and controlling mistreatment and to guarantee the provision of respectful maternity care during childbirth must consider contextual and social norms and develop a comprehensive intervention that addresses the root causes.

In light of the evidence gathered from the participant women and health care providers involved in this study, the following recommendations are directed for reducing disrespect and abuse and improving the health care services.

1. Creating awareness and empowering clients and families: promote rights-based care by applying a human rights framework to ensure that high-quality reproductive, maternal, and new-born health care is available, accessible, and acceptable to all who need it, using different media that sponsored by the government and stakeholders. This is a guiding principle of Ending Preventable Maternal Mortality (WHO 2015).

2. Encompass the WHO recommendations of respectful maternal care in educational modules or subjects beginning from lower-level classes.

3 Operationalizing Sustainable development goal (Goal 3) reduction of maternity mortality by incorporating statements of WHO that enhance respectful maternal care may bear the significant change in maternal care service improvement.

4. In order to minimize hospital over crowdedness of labour ward measures should be taken to control unnecessary referrals to hospitals from health centers.

5. To plan an online information system which can collect data and inform upon request about vacant beds and available delivery services in different facilities at any point in time so that service seekers can avoid the 2nd delay during labor and delivery and get the required standard service without delay.

6.3 Strengths and Limitation

6.3.1 Strengths

- This study explored the state of quality of respectful maternal care observed as recommended by WHO, covering Private and Public health facilities.
- The quantitative research questions were formed following standardized measurement of respectful maternal care.
- Both qualitative assessment and quantitative survey were conducted concurrently to make the research more comprehensive.

6.3.2 Limitation

- The sample size of service point (facility) selected was not sufficient to generalize about the situation of Addis Ababa.
- Neglecting to use Observational study even though it’s powerful to study respectful maternity care

- Excluding health facilities in rural areas, because most of the problem of respectful maternal care is in rural area that results in relation to cultural, religious and social taboos and shortage of skilled provider Some variables were missed like social desirability

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Annex 1- Questionnaire for quantitative survey D and A during ANC

Socio demographic characteristics of women who came for MNCH services		
	Thems	Response
Q101	Age in completed years? እድሜ በሙሉ ዓመት	---------years ______ዓመት
Q102	Residence የመኖሪያ ቦታ	Addis Ababa =0 Out of Addis Ababa=1 አዲስ አበባ,=0 ከአዲስ አበባ ዉጪ,=1
Q104	Marital status የጋብቻ ሁኔታ	Single/ያላገባች Married/ያገባች Widowed/የሞተባት Divorced/የፈታች Separated/የተለያዩ
Q105	Educational status of the respondent. የተሳታፊዋ እናት የትምህርት ደረጃ	Illiterate/ያልተማረች=0 Primary/የመጀመሪያ ደረጃ=1 Secondary/ሁለተኛ ደረጃ=2 Technique/ቴክኒክና ሙያ=3 Diploma/ዲፕሎማ=4 Degree/የመጀመሪያ ድግሪ=5 MSc/ሁለተኛ ድግሪ=6 PhD/ዶክተሬት=7
Q106	Monthly hh income in Birr. የቤተሰቡ ገቢ በብር	_________________ብር
Q107	For which service the women came? (During the data collection) በዚህ የጤና ተቋም የተገኙት ለየትኛዉ አገልግሎት ነዉ	Labor and delivery /ለወሊድ/ለምጢ=1 PNC= ድህረ-ወሊድ አገልግሎት =2 Family planning/የቤተሰብ ምጣኔ =3 EPI/ለክትባት Treatment or consultation=4
Q108	Service provider gender የስነተዋልዶ ጤና አገልግሎት ሰጪ ፆታ	Male/ወንድ=1 Female/ሴት=2 =1 =2
Q109	Service provider qualification የሥነ-ተዋልዶ ጤና እንክብካቤ አቅራቢ የሙየ ደረጃ	Midwife/አዋላጅ ሀክም = 0 Nurse/ነርስ = 1 HO/የጤና መኮንን == 2 Medical Doctor/ጠቅላላ ሀክም = 3

		I don't know/አላዉቅም = 4 explain ሌላ=4 ይገለጽ----------
Q100	Have you given birth for the first time? Is the recent child the first baby for you ቅርብ ጊዜ የተወለደዉ ልጅ የመጀመሪያሽ ነዉ?	If YES=0 →112 NO=1
Q110	How many births have you gave? እስከ አሁን ስንት ልጆችን ወለዱ?	If yes she gave birth for first time→112 የመጀመሪያ ልጅ ወልዳ ከሆነ 112 ይሙሉ
Q111	How many of them are alive? ምን ያህሉ በህይወት አሉ?	----------ቁጥር
Q112	Desired number of children? ስንት ልጆች መዉለድ ይፈልጋሉ?	99=not decided ,99=አልወሰንኩም
Q113	Birth spacing of the last baby in years? አሁን በተወለደዉ ልጅ እና በበፊቱ ልጅ መሃል ምን ያህል የወራት ልዩነት አለ?	98=deliver is the first
Q114	When to add children? ሌላ ልጅ መቼ ለመጨመር አሰቡ?	0 =if no more children desired and 97=not decided ሌላ ልጅ አልፈልግም =0 አልወሰንኩም=97
Q115	Have you ever experienced a pregnancy terminated with abortion? በዉርጃ የተጠናቀቁ እርግዝና አጋጥሞት ያዉቃል?	Yes =0 No =1
Q116	The time at your delivery or labor attended የምጢ ወይንም የወሊድ ጊዜ	Day/ቀን=1 Nigh/ማታt=2 =2
Q NO	QUESTIONS FOR ANC	
Q201a	Did the health care provider respect your culture and religion during the general examination? በአጠቃላይ ምርመራው ወቅት የጤና እንክብካቤ አቅራቢው ባህልዎን እና ሃይማኖትዎን ያከብር ነበር?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201b	Did the health care provider explain procedures by giving a greeting before the examination? የጤና በለሙያ ምርመራ ከማድረጉ በፊት ሰለምታ በመስጠት የምርመራዉን ቅደም ተከተል አስረድቷልን?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201c	Did the health care provider treat you in a friendly manner? የጤና እንክብካቤ አቅራቢው እርስዎን በጓደኝነት መንፈስ አስተናግዷል?	Yes=0 NO=1 Not rember=2 አዎ=0

		አይደለም=1 አላስታወስም=2
Q201d	Did the Health care provider showed his/her concern and empathy የጤና በለሙያዉ የአንቺን ጭንቀት እንደራሱ በማየት ርህራሄ አሳይቶሻል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201e	Did the Health care provider explain types of laboratory investigation in a satisfactory way? የጤና በለሙያዉ የላብራቶሪ ምርመራ ዓይነቶችን በአጥጋቢ ሁኔታ አስረድቷልን?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201f	Did health care provider caring for you with a kind approach by calling your name? የጤና በለሙያዉ ስምዎን በመጥራት በደግነት አቀራረብ ተንከባክበዎት ይሆን?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201g	Did the health care provider responded to your needs whether or not you asked during counseling on birth preparedness and complication readiness የጤና እንክብካቤ አቅራቢው በምክር ወቅት ስለ ወሊድ ዝግጅት እና የተወሳሰበ የእርግዝና ችግር ዝግጁነት ላይ የጠየቁትን ወይም ያልጠየቁትን ጨምሮ ለእርስዎ ፍላጎት ምላሽ ሰጥቷል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201h	Did the health care provider assure your privacy during the examination? የጤና በለሙያዉ በምርመራው ወቅት የእርስዎን የግል ነጻነትዎን በመጠበቅ አሰተናገድዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201i	Was waiting time fair for examination. በእርሶ እይታ በጤና ተቋሙ ዉስጥ አገልግሎት ለማግኛት የጠበቁት ጊዜ አግባብ ነዉ ብለዉ ያምናሉ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2

Q201j	Did the health care provider treated you compassionately and respectfully during ANC follow up? በእርግዝና ክትትል ወቅት የጤና በለሙያዉ በርህራሄ እና በአክብሮት አስተናግዶታልን?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201k	Were you involved in decision making as much as you want? በጤናዎ ጉዳይ በተቻለ መጠን በዉሳኔ ሰጭነት ተሳትፈዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201l	Did you have well informed and good communication with the staffs ከሰራተኞቹ ጋር መረጃ ከማግኘት የተገናዘቤ ጥሩ ግንኙነት ነበራችሁ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201m	Did you received individualized care during the ANC visit? በእርግዝና ክትትል ጊዜ የግል ነጻነት የጠበቀ (ሌሎች ሊያዩ በማይችሉበት ሁኔታ ዉስጥ) እንክብካቤ አግኝተዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201n	Did health care provider promotes partner/accompany during ANC? የጤና በለሙያው በእርግዝና ክትትል ጊዜ ከአጋርዎ ጋር መገኘትን ያበረታታል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201o	Are you happy with over all the services you got then ? በእርግዝና ክትትል ወቅት ባገኙት አገልግሎት ደስተኛ ነበሩ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q200	If No for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አይደለም ከሆነ ላጋጠሞዎት ክብር የለሌዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 There is no disrespect and abuse above=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1

		ወደ ግል የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4

Annex 2. Survey Questionnaire- D and A during labor, delivery and PNC

ARTICLE 1 Every woman has the right to be free from harm and ill treatment.		
Q201A1a	Have you ever pinched or slapped, during getting maternity care, by health care providers? የወሊድ እንክብካቤ አገልግሎት ለማግኛት ወደ ጠና ተቋም መጥተዉ ፤በጤና በለሙያ ተቆንጥጦ ወይንም በጥፊ ተመቶ ያዉቃሉ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201A1b	Have you insulted or threatened during labor delivery OR PNC by health care providers? የጤና በለሙያዉ በምጥ ወይንም በወሊድ ወቅት ወይንም ከወሊድ በኋላ የጤና አገልግሎት በምሰጡበት ጊዜ ተሰድበዋል ወይም አስፈራርተዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201A1c	Have any health care worker/provider shouted on you because you fail to obey what the health care providers expected you to do? በወሊድ አገልግሎት ጊዜ የጤና በለሙያዉ ያዘዙትን ትእዛዝ በለማክበርዎ ወይንም የጤና በለሙያዉ የምጠብቅበትን በለማድረግዎ ጮሆበታል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201A1d	Have you ever restrained or tied down,	Yes=0

	during getting maternity care, by health care providers? በወሊድ እንክብካቤ ወቅት በጤና በለሙያ እንደይንቀሳቀሱ ተከልክለዋል ወይንም ታስረው ያውቃሉ?	NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201A1e	Have you ever experienced undergoing unnecessary and extensive episiotomies; by health care providers? በወሊድ ወቅት ህጻኑ በቀላሉ እንድወለድ ከመጠን ያለፈ ብሊት መቁረጥ ወይንም ብሊትዎ እንድሰፋ ማድረግ አጋጥሞታል ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201A1f	Have you ever experienced postpartum suturing of vaginal tears or episiotomy cuts without the use of anesthesia; by health care providers? **የጤና በለሙያዉ ከወሊድ በኋላ የተጎዳዉን የብሊት ክፍል መደንዘዣ ሳይጠቀም መስፋት/መጠገን አጋጥሞታል?**	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q201A1g	Have you ever subjected to pushing on the abdomen to force the baby out, or excessive physical force to pull the baby out? ሕፃኑን ለማስወጣት በሆድ ላይ መገፋትን ወይም ሕፃኑን ስቦ ለማውጣት ከመጠን በላይ አካላዊ ኃይል መጠቀም አጋጥሞታል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
	If yes for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አዎ ከሆነ ፤ላጋጠመዎት ክብር የለሌዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
Article 2 Every woman has the right to information, informed consent and refusal, and		

respect for her choices and preferences, including companionship during maternity care.		
Q202A2a	Have you got the health care, without getting proper information about medical procedures? (Healthcare providers not giving women the proper information about medical procedures;) ስለ ህክምና ሂደቶች ተገቢውን መረጃ ሳያገኙ ፣የጤና ክብካቤውን አግኝተዋልን?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q202A2b	Have you coerced into a medical procedure such as cesarean section, Episiotomies, hysterectomies, blood transfusion, sterilization and augmentation of labor, without getting your permission. (Healthcare providers not asking for women's permission to conduct medical procedures such as Cesarean sections, Episiotomies, Hysterectomies ,Blood transfusions, Sterilization Augmentation of labor. የጤና በለሙያዉ ወደ ቀዶ ጥገና ክፍል እንድገቡ፤ የብሊት መጠን ለመጨመር፤ የማህጸን ህክምና ለማድረግ፡ ደም እንድትወስጂ፤ ለማምከን ወይንም ምጥ እንድፈጥን ለማድረግ መድሃኒት ለመውጋት አስገድዶታል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q202A2c	The providers did not ask you which position you would like to deliver in? የጤና በለሙያዉ በየትኛዉ የወሊድ አቀማመጥ መዉለድ እነደምትፈሊጊ አልጠየቀሽም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q202A2d.	The providers didn't allowed you to give birth in the position you want? የጠና በለሙያዉ እርሶ በመረጡት የወሊድ አቀማመጥ እንድወሊዱ አልፈቀደሎትም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q202A2e	The providers didn't requested your consent for all the care you received? የጤና በለሙያው ለሚሰጠው አገልግሎት ሁሉ ያንቺን ፍቃዳኝነት አልጠየቀም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2

Q202A2f	you didn't communicated by HWs with simple and local language? የጤና በለሙያዉ ቀላል በሆነና በሐገር ቋንቋ አላናገሮትም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
	If yes for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አዎ ከሆነ ላጋጠመዎት ክብር የጎደለዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
Article 3 : (Every woman has the right to privacy and confidentiality.)		
Q203A3a	Have you ever experienced having to examination labor ,and deliver in view of others (without privacy barriers such as curtains?) የጤና በለሙያ ፤የግል መብትዎን ሳይጠብቅ ለሌሎች ሰዎች ሊታይ በምችል ሁኔታ ምርመራ ወይንም የማዋለድ አገልግሎት ሰጥቶታል?	Yes=0 NO=1 Not rember=2 የመረጃ ሰብሳቢ መለያ አዎ=0 አይደለም=1 አላስታወስም=2
Q203A3b	Have you ever experienced healthcare workers share sensitive information, such as a patient's HIV status, age, marital status, and medical history, in a way that other people can hear? እንደ ኤች.አይ.ቪ ምርመራ ዉጤት፣ዕድሜ ፣ የጋብቻ ሁኔታ እና የህክምና ታሪክ ያሉ ሚስጥራዊ መረጃዎችን የማይመለካተቸዉ ሰዎች በምሰሙት ሁኔታ ለጤና እንክብካቤ ሰራተኞች አጋርተዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q203A3d	Have you been told that you can refuse any treatment if you don't like? ካልፈለጉ ማንኛንም የወሊድ አገልግሎት	Yes=0 NO=1 Not rember=2

	እምቢ ማለት እንደምችሉ በጠና በለሙያ ተናግሮታል?	አዎ=0 አይደለም=1 አላስታወስም=2
	If yes for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አዎ ከሆነ ላጋጠመዎት ክብር የጎደለዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
Article 4 *(*Every woman has the right to be treated with dignity and respect.)		
Q204A4a	The providers did not show their concern and empathy? የጤና በለሙያዎቹ ያላቸውን ስጋት እና ርህራሄ አላሳዩም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4b	Have the HWs shouted on you because you were not doing what you were told to do? የጤና በለሙያዉ ያዘዘሽን ትእዛዝ ስላልፈጸምሽ ጮሆብሽ ያዉቃል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4c	Have you felt inappropriate touching of genitalia/thigh during examination? በምርመራ ወቅት ብልት/ጭን አከባቢ ተገቢ ያልሆነ መንካት ተሰምቶዎታል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4d	Have you felt that the HWs showed you animosity because of your personal attribute (being prostitute)? የጤና በለሙያዉ በግል ባህሪዎ ወይንም	Yes=0 NO=1 Not rember=2 አዎ=0

	በአለባበሶ ወይንም በምሰሩት ሥራ ምክንያት የመጠየፍ ባህሪይ አሳይቶታል።	አይደለም=1 አላስታወስም=2
Q204A4e	The HWs have not made reassuring touch during care/examination? የጤና በለሙያ በምርመራ ወቅት ትኬሻሽ አከባቢ በመንካት አላበረታታሽም ወይንም አላረጋጋሽም ።	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4f	You haven't been treated respectfully by all HWs? የጤና በለሙያዎች ሁሉ እርሶን በክብር አላከሞትም።	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4g	You weren't allowed to practice cultural rituals in the Health Facility? የጤና በለሙያዎች ባህልሽን ወይንም ሥነ ሥርዓቶች በጤና ተቋም ዉስጥ እንድትተገብሪ አልፈቀደም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4h	The health worker didn't respond to your needs whether or not you asked? የጤና በለሙያዉ ስለህክምናዉ መረጃ እርሶ ብጠይቁም ባይጠይቁም ምላሽ አልሰጠም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4i	Was the service provision delayed due to the health facilities problems? በተቋሙ ችግር ምክንያት የምያገኙት አገልግሎት ተስተጓጉሏል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4j	Did the HWs shouted on you during care giving or physical examination? የጤና በለሙያዉ አካላዊ ምርመራ ስያደረግልሽ ጮሆብሽ ያዉቃል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4k	Have you been detained by HWs because you don't have money to pay?	Yes=0 NO=1

	ላገኘሽዉ አገልግሎት የምትከፍይዉ ገንዘብ ስላልነበረሽ የጤና በለሙያዉ እንቅስቃሴሽን ገድቦታል/ አስሮሻል?	Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4L	You haven't been treated by HWs in a friendly manner? የጤና በለሙያዉ ጓደኝነት በተሞላበት መልኩ አላካመሽም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4m	Have you been told that you can refuse any treatment if you don't like? ማንኛዉንም የስነ-ተዋልዶ ጤና አገልግሎት ካልፈለግሽ እምብ ማለት እንደምትች በጤና በለሙያ አልተነገረሽም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4n	Have the HWs called you with your name? የጤና በለሙያ የስነ-ተዋልዶ ጤና አገልግሎት በምሰጥበት ወቅት በስምሽ አልጠራሽም?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q204A4O	Have you/your companion been communicated by HWs politely? የጤና በለሙያዉ እርሶንና የእርሶን አጃቢ/ወዳጅ በትህትና አናግረዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
	If No for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አዎ ከሆነ ላጋጠመዎት ክብር የለሌዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም

		መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
Article 5 :(Every woman has the right to equality, freedom from discrimination, and equitable care.)		
Q205A5a	Have you/your companion been insulted by HWs for your personal attribute? እርሶ ወይንም የእርሶ አጃቢ/ወዳጅ በእርሶ ወቅታዊ ሁኔታ ማለትም አለባበስ ወይንም የንጽህና ሁኔታ ወይንም በምሰሩት ሥራ ምክንያት በጤና በለሙያዉ ተሰድበዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q205A5b	Do you think that all patients are treated equally in the facility? በዚህ የጤና ተቋም ሁሉም እናቶች እኩል ይታከማሉ ብለዉ ያስባሉ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q205A5c	Have you heard about women discriminated because she was HIV positive? አገልግሎት ባገኘሽባቸዉ የጤና ተቋም ዉስጥ የኤች.አይ.ቪ በሽታ ስላለባቸዉ ማድሎና ማገላል የደረሰባቸዉን እናቶች ሰምተሽ ታዉቂያለሽ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q205A5d	Have you heard of women discriminated because she was physically disabled? አገልግሎት ባገኘሽባቸዉ የጤና ተቋም ዉስጥ የአካል ጉዳት ስላለባቸዉ ማድሎና ማገላል የደረሰባቸዉን እናቶች ሰምተሽ ታዉቂያለሽ?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q205A5e	If No for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አይደለም ከሆነ ላጋጠመዎት ክብር የለሌዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል የጤና ተቋም ለዋጥኩ=2

		ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
Article6 Every woman has the right to healthcare and to the highest attainable level of health.		
Q206A6a	Have you been left alone for a long time? የሥነ-ተዋልዶ ጤና አገልግሎት ለማግኛት የጤና ተቋም ሄደዉ ለረጅም ጊዜ ለብቻዎ ተቀምጠዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
Q206A6b	Have you been kept for a long time in the health facility before receiving any service? የሥነ-ተዋልዶ ጤና አገልግሎት ለማግኛት የጤና ተቋም ሄደዉ ለረጅም ጊዜ አገልግሎቱን ሳያገኙ ተቀምጠዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
	If No for question above, what decision did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አይደለም ከሆነ ላጋጠመዎት ክብር የለሌዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Informed to manager=0 Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል/የመንግሥት የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
Article 7 Some health facilities have been known to detain or prevent women from leaving with their babies, because they cannot pay their bills.		
Q207A7a	Did you detained or prevent from living with your baby because you cannot pay their bills. የሥነ-ተዋልዶ ጤና አገልግሎት ክፍያ መክፈል ስላልቻሉ ልጅትን ከርሶ ለይተዋል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
	If yes for question above, what decision	Informed to manager=0

	did you make for the non-respectful care you faced during facility based maternal care? ከላይ ለተጠየቁት ጥያቄዎች ለአንዱ እንኳን አዎ ከሆነ ላጋጠመዎት ክብር የለሌዉ የሥነ-ተዋልዶ ጤና አገልግሎት ምን ወሰኑ?	Shift to another government facility =1 Shift to private facility=2 I have postponed using the facility=3 Others= explain=4 ለአስተዳደሩ ነገርኩት=0 ወደ ሌላ የመንግሥት የጤና ተቋም ለዋጥኩ=1 ወደ ግል የጤና ተቋም ለዋጥኩ=2 ለተወሰኔ ጊዜ የጤና ተቋም መጠቀም አቆምኩ=3 ሌላ ይገለጽ=4
	Did you have a complicated health problem due to abuse or physical harm during facility based maternal care? በጤና ተቋሙ ዉስጥ የሥነ- ተዋልዶ ጤና በሚያገኙበት ጊዜ በደረሰቦት ክብር ለሌሌዉ የስነ-ተዋልዶ ጤና አገልግሎት ምክንያት ያጋጠሞት ዉስብስብ የጤና ችግር ነበር?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2
7000	በጠቃላይ በጤና ተቋሙ ዉስጥ የስነ-ተዋልዶ ጤና አገልግሎት በክብር ያገኙ ይመስሎታል?	Yes=0 NO=1 Not rember=2 አዎ=0 አይደለም=1 አላስታወስም=2

Annex 3 In- depth Interview Guide for women who experienced D and A – in overall provider client relationship

Q1. Could you kindly describe your experience during childbirth at the facility (Name)? Please explain to us what happened Probes; labor history (when and how it started, travel to the facility, admission procedures, waiting time, management before delivery, management during delivery, and after delivery.

Q2. Describe the most notable event during the stay in the facility during your last childbirth?

Q3. Please narrate to us your experience of unfriendly and insensitive treatment during your last childbirth.

Q4. How did the incident/s of unfriendly and insensitive treatment that you experienced during your last childbirth in the facility affect you and your immediate relatives?

Probe for physical, emotional/psychological, financial implications, how the incidents/incidents affected family and relatives/friends

Factors that contribute to disrespect and abuse in health facilities

Q5. In your own opinion, what factors contribute to providers being unfriendly and inhuman treatment in health facilities?

Probe for Infrastructure, human resource- deployment, motivation, staff attitude, staff training, supplies/ commodities, leadership and management, information management, referral system, community factors

Dealing with disrespect and abuse in health facilities

Q6. When you felt that the treatment you received from the facility was improper during your lasts childbirth, what did you do/or plan to do and why?

(Explore for personal initiative in seeking redress through community involvement, facility management, legal psychological support from any institution or family members)

Community understanding of disrespect and abuse

Q7. In your own opinion, what is the community perception to care and treatment during delivery by service providers during delivery? What do majority of women here say about their experiences with services providers during child birth?

Q8. Do you think the community has a role in influencing the way service providers communicate and handle them during child birth? Why do you say so?

Q9. In your own opinion do you think that, in this community there are community level mechanisms to mitigate unfriendly and insensitive treatment in facility based births?

Future plans for fertility and delivery

Q10. Tell us your future plans regarding future child deliveries

Probe desired number of children, where they would go for delivery; reasons for choice of plans, the place of delivery, alternative to the hospital delivery.

Ask respondent if he/she wants to add anything

Plan to see the respondent again in case there are any clarifications to be made.

Annex 4 In- depth Interview Guide for women who have never experienced D and A yet

Q1.Could you kindly describe your experience during childbirth at facility (Name). Please explain to us what happened: Probes; labor history (when and how it started, travel to the facility, admission procedures, waiting time, management before delivery, management during delivery and after delivery.

Q2. Describe the most notable event during the stay in the facility during your last child birth?

Q3. Please narrate to us your experience of friendly and sensitive treatment during your last childbirth.

Q4. How did the incident/s of friendly and sensitive treatment that you experienced during your last child birth in the facility affect you and your immediate relatives?

Probe for physical, emotional/psychological, financial implications, how the incidents/incidents affected family and relatives/friends

Factors that contribute to disrespect and abuse in health facilities

Q5. In your own opinion, what factors contribute to providers being unfriendly and inhuman treatment to women during child birth in health facilities?

Probe for Infrastructure, human resource- deployment, motivation, staff attitude, staff training, supplies/ commodities, leadership and management, information management, referral system, community factors

Community understanding of disrespect and abuse

Q6. In your own opinion, what is the general community perception to care and treatment during delivery? What do majority of women here say about their experiences with services providers during child birth?

Q7. Do you think the community has a role in influencing the way service providers communicate and handle them during child birth? Why do you say so?

Q8. In your own opinion do you think that in this community there are community level mechanisms to mitigate unfriendly and insensitive treatment in facility based births?

Future plans for fertility and delivery

Q9. Tell us your future plans regarding future child deliveries

Probe desired number of children, where they would go for delivery; reasons for choice of plans, the place of delivery, alternative to the hospital delivery.

Ask respondent if he/she wants to add anything

Plan to see the respondent again in case there are any clarifications to be made.

Annex 5 Key informant interview guide for service providers

Perceptions and experiences of care during childbirth, focusing on treatment by health workers and the facility environment.

1. In your opinion, how are women in general treated by health workers in the health facilities when they come to ANC, delivery and postnatal care?

2. Could you describe for me what supportive/respectful care during childbirth means to you? a. In your opinion, is respectful care provided to women during childbirth in hospitals/health facilities? Please explain.

b. In your opinion, what would health workers need from a woman in order to provide supportive/respectful care?

c. In your opinion, what would health workers need from a woman's family and community in order to provide supportive/respectful care?

d. In your opinion, what would health workers need from their colleagues in order to provide supportive/respectful care?

e. In your opinion, what would health workers need from their supervisors in order to provide supportive/respectful care?

f. In your opinion, what would health workers need from their Hospital implementers in order to provide supportive/respectful care?

g. In your opinion, what would health workers need from Ministry of Health at national and provincial levels in order to provide supportive/respectful care?

3. Sometimes women are mistreated or poorly treated during childbirth. Have you ever seen or heard any type of mistreatment happening? [Probe: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints?]

Could you explain the situation?

a. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

If the informant is not aware of any cases of mistreatment - share examples provided by participants in in-depth interview with recently delivered women.

Interviewer: After the key informant explains the scenario, ask if there were any other times or ways that mistreated happens. If they describe another scenario, follow-up with questions 3a-3b.

Perceived factors that influence how women are treated during childbirth

4. You mentioned these types of mistreatment: *(Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that you/friend/family/clients were hit or yelled at by the health care provider].* In your opinion, what factors influenced how you/friend/family/clients were mistreated? Please explain.

a. Related to supplies (availability of medication and equipment)

b. Related to health workers (number of staff, heavy workload, lack of training, attitude and biases towards patients based on economic and educational status, tribal affiliation, number of children, etc.)

c. Related to patient load (number of patients, patient's or companion's expectation/ attitude)

d. Related to health facility (management practices, policies, infrastructure/setup and services)

e. Related to the insecurity – who controls the local community, fighting?

f. Related to health system (MoH at central or provincial level)

g. Other factors

5. In your opinion, what policies could be issued or revised to address these factors so that women are treated better during labor and childbirth from a policy maker perspective?

6. In your opinion, what improvements in the HEALTH SYSTEM could be done, involving health facility managers, or MoH at the central and provincial levels, to address these factors so that women are treated better during labor and childbirth?

7. All women are entitled to care which respects their basic dignity, privacy and autonomy. How can we ensure women and communities are aware of these rights?

How staff are treated

8. In your opinion, what is the most rewarding /motivating part of health workers' work? Why?

9. In your opinion, what is the most challenging part of health workers' work? Why? [Probe: what mistreatment or harassment by clients, colleagues or supervisor do you think they experience?]

10. In your opinion, do they feel valued or appreciated in their work? Why or why not?

11. Overall, do you think that health workers' work environment is supportive? Please explain. a. What do you think could be done to make health workers' work environment more supportive?

12. Do you think the proposed Midwives and Nurses Council and the established Medical Council can improve the provision of quality respectful maternity care? If so HOW?

Wrapping up

13. Is there anything else that you would like to tell me about your work that may be helpful for understanding women's and health care providers' experiences during facility births?
14. What are you most interested in learning from our assessment of women's experiences during facility births?
15. Do you have any question for me?

Thank so much for your time and assistance. The information you shared will be kept confidential and is anonymous. We look forward to sharing the results of the study with you in the coming months.

Annex 6 Informed consent statement: for survey respondents and indepth /key informant interviews

Good morning/afternoon, my name is -- I am working with Abdulkadir Gelgelu who is completing his master's Degree in Addis Ababa University College of Developmental studies, Center for Population Studies. This study is, part of the requirements for the fulfillment of the MSc programme he is enrolled. I would like to ask you questions about some important issues in relation to quality of respectful maternal care during facility based maternal care.

Whatever information you provide will be kept strictly confidential and will not be shown to other individuals or providers. Participation in this study is voluntary, If you prefer not to respond to all questions or to some of the questions it is your right and your decision will not be affected in any way the services you are receiving at the hospital/clinic/health center and you don't forced to answer any question if you don't, and you can stop the interview at any time. However, I hope that you will actively participate in this survey since your views are important. The study may require 10-15 minutes. So please give me only some minutes to complete my questions. At this time, do you want to ask me anything about the survey?

May I begin the interview now?

1 = Yes 2 = No

Annex 7 Amharic Informed consent statement: for survey respondents and indepth /key informant interviews

እንደምን አደሩ / ዋሉ ስሜ -- I በአዲስ አበባ ዩኒቨርሲቲ የልማት ጥናት ኮሌጅ ፣ የሕዝብ ጥናት ማዕከል የሁለተኛ ዲግሪያቸውን በማጠናቀቅ ላይ ከሚገኙት አቶ አብዱልቃድር ገልገሉ ጋር አብሬ እየሠራሁ ነው ። ይህ ጥናት እሱ ለተመዘገበው የሁለተኛ ድግሪ ፕሮግራም መሟላት ከሚያስፈልጉት መስፈርቶች አንዱ አካል ነው ። በተከበረው የእናቶች የሥነ-ተዋልዶ የጤና እንክብካቤ ወቅት ከሚከበሩ የእናቶች እንክብካቤ ጥራት ጋር በተያያዘ አንዳንድ አስፈላጊ ጉዳዮችን በተመለከተ ልጠይቅዎ እፈልጋለሁ ።

የሚሰጡት ማንኛውም መረጃ በጥንቃቄ በሚስጥር የሚቀመጥ ሲሆን ለሌሎች ግለሰቦች ወይም አቅራቢዎች አይታይም ። በዚህ ጥናት ውስጥ መሳተፍ በፈቃደኝነት ነው ፣ ለሁሉም ጥያቄዎች ወይም ለጥያቄዎች መልስ ላለመስጠት ከመረጡ የእርስዎ መብት ነው። እናም እርሶ የመለሱት መልስ በሆስፒታል / ክሊኒክ / ጤና ጣቢያ እና በምንም አይነት መንገድ የእርሶን መብት አይነካውም ። ካልመለሱ ማንኛውንም ጥያቄ እንዲመልሱ አይገድዱም ፣ እና ቃለመጠይቁን በማንኛውም ጊዜ ማቆም ይችላሉ። ሆኖም ግን ፣ አስተያየቶችዎ አስፈላጊ ስለሆኑ በዚህ የዳሰሳ ጥናት ውስጥ በንቃት ይሳተፋሉ ብዬ ተስፋ አደርጋለሁ ። ጥናቱ ከ10-15 ደቂቃዎችን ሊፈልግ ይችላል ። ስለዚህ ጥያቄዎቼን ለማጠናቀቅ እባክዎን የተወሰኑ ደቂቃዎችን ብቻ ይስጡ ። በዚህ ጊዜ ስለ ዳሰሳ ጥናቱ ማንኛውንም ነገር ሊጠይቁኝ ይፈልጋሉ?

ቃለመጠይቁን አሁን ልጀምር?

1 = አዎ

2 = አይ (ሴቲቱን አመስግነው ቃለመጠይቁን አጠናቅቀው