ORIGINAL ARTICLE

PREVALENCE AND ASSOCIATED FACTORS OF DISRESPECTFUL AND ABUSIVE CARE DURING CHILDBIRTH AMONG WOMEN WHO GAVE BIRTH IN HEALTH FACILITIES IN HAWASSA CITY, SOUTHERN ETHIOPIA

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ABSTRACT

Background: *There is growing evidence that shows phenomena of disrespect and abuse during childbirth occur globally even though the degree and severity are different across countries. The problem is getting attention in recent years especially in developing countries like Ethiopia. However, there is a paucity of studies assessing the magnitude of disrespectful and abusive care during childbirth.*

Objective: *This study was undertaken to determine the prevalence and associated factors of disrespectful and abusive care during childbirth in health facilities of Hawassa city, Southern Ethiopia.*

Method: *A facility-based cross-sectional study was conducted in Hawassa city from February 8 - April 27, 2018. A total of 577 mothers from both public and private health facilities were included. Domains of disrespect and abuse that were assessed were; physical abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care and poor rapport between women and providers. Binary logistic regression model was used to examine the relationship between exposure and outcome variables. Adjusted odds ratio (AOR) with 95% confidence intervals (CI) was used to determine the association between dependent and independent variables.*

Result: *Overall 46.9% [95% CI: 42.8-51]of mothers reported experiencing disrespect and abusive care during childbirth in health facilities. The adjusted odds of disrespectful and abusive care among births in public health facilities were 12.9 times higher than birth in private facilities [AOR=12.94 (95% CI: 5.87, 28.50)],mothers who had total delivery four and above had 4.7 times increased odds of encountering disrespect and abusive care [AOR=4.67 95% CI: 1.69, 12.89)].In contrast to mothers who had spontaneous vaginal delivery; mothers who had instrumental delivery had 2.6 times increased chance of encountering disrespect and abusive care [AOR =2.63 (95% CI: 1.05, 6.59)]. Mothers attended by female health providers were 1.75 times more likely to be disrespected and abused than mothers whose delivery was attended by male providers [AOR= 1.75 CI: (1.14, 2.71)].*

Conclusion: *The prevalence of disrespectful and abusive care during labor and delivery was high in Hawassa city health facilities. Factors associated with disrespectful and abusive care are public health facility, instrumental delivery, parity and sex of health care provider. Therefore, national health strategies and policies should focus on combating disrespect and abuse during maternal care. It is also recommended to give intensive training focusing on respectful maternity care especially in public hospitals by involving more female health care providers.*

Keywords*:* ***disrespectful and abusive care****, Respectful Maternity Care, Facility delivery, Ethiopia*

BACKGROUND

Pregnancy and childbirth are times of extreme vulnerability and are also critical events in the life of women and families (1). Each year, more than 350,000 women die from complications during pregnancy and childbirth, with an estimated 4.3 million newborns born dead or die shortly after birth(2).The Ethiopian Demographic Health Survey (EDHS) 2016, reported a maternal mortality ratio of 412 per 100,000 live births (3).

Even though there are substantial improvements in skilled maternity services in the world, there is still a significant gap in the quality of maternity care which

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is evidenced by neglectful, abusive, and disrespectful care(4).To achieve the target set in the Sustainable Development Goals (SDG) which is a global reduction of the maternal mortality ratio to less than 70 per 100,000 live births, there is a crucial need to promote respectful, evidence-based maternal care service (5, 6).

World Health Organization (WHO) states compassionate and Respectful Maternal Care (RMC) as the right every woman has to attain the highest standard of health. This includes the right to dignity, compassionate, and RMC to all childbearing women throughout pregnancy, childbirth, and the postnatal period. Globally, many women experience disrespect and abuse care while giving birth in health facilities (7).

Caring, empathetic, supportive, trustworthy, respectful, and empowering are among the identity that would describe the ideal skilled birth attendant. However, many women and adolescent girls do not receive the care that matches these terms(8).The promotion of RMC goes relatively beyond direct clinical quality improvement but also women's relationships and interactions with care providers (8, 9).D&A is "interactions or facility conditions that seem to be humiliating or undignified and those interactions or conditions that are experienced as or intended to be humiliating or undignifying" (10).Disrespectful and abusive is currently renamed as mistreatment and is categorized as physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health systems conditions and constraints (4).

Disrespect and abuse during maternity care service is not only the concern of mothers nowadays but is becoming a serious community concern(1). Disrespectful and abusive care during labor and delivery not only violates the rights of women and the unborn child to get RMC but also can affect their rights to life, their rights to health, their bodily integrity, and freedom from discrimination(7, 11, 12).It could lead to psychological humiliation, grievance and unspoken suffering. It will also have a negative effect on women's decisions to seek care for delivery services (4, 11, 13). Institutional delivery in which little attention has been given to the care and respect could be why many women avoid giving birth in health facilities and their perceptions would have the most influence in their decisions to use health facilities in the future(14, 15). The quality of care offered at maternity facilities not only affects pregnant women emotionally and physically but also has an impact on the long-term health and survival of mothers and neonates (2).

Factors majorly contributing to disrespect and abuse during facility-based childbirth include; health system factors, provider-level factors and personal factors like normalizing of abuse, individual knowledge on the right to health care service, level of education, socio-demographic factors and obstetric factors(16-19).

While many interventions were aimed, the quality of relationships with caregivers during maternity care has received less attention (17).There are few researches conducted on disrespect and abuse of women during childbirth in Ethiopia and no research at all was conducted specifically in Hawassa city. Having a good understanding of the prevalence and factors associated with disrespect and abuse is, therefore, critical for developing interventions and encouraging clients' future facility utilization. Therefore,

this study aimed to assess the prevalence and factors associated with disrespect and abuse during facility-based childbirth in Hawassa City, Southern Ethiopia.

METHOD

Study setting: The study was conducted in four randomly selected public health facilities and two randomly selected private health facilities of Hawassa city, Ethiopia. Hawassa is the capital city of the Sidama Regional State. According to the regional health bureau data (2016/2017), there were 14,921 skilled institutional deliveries in Hawassa city health institutions. The city has sixteen health facilities of those eleven were public and five were private health facilities.

Study design and period: A facility-based cross-sectional study was conducted in public and private health facilities found in Hawassa city from February 8 - April 27, 2018.

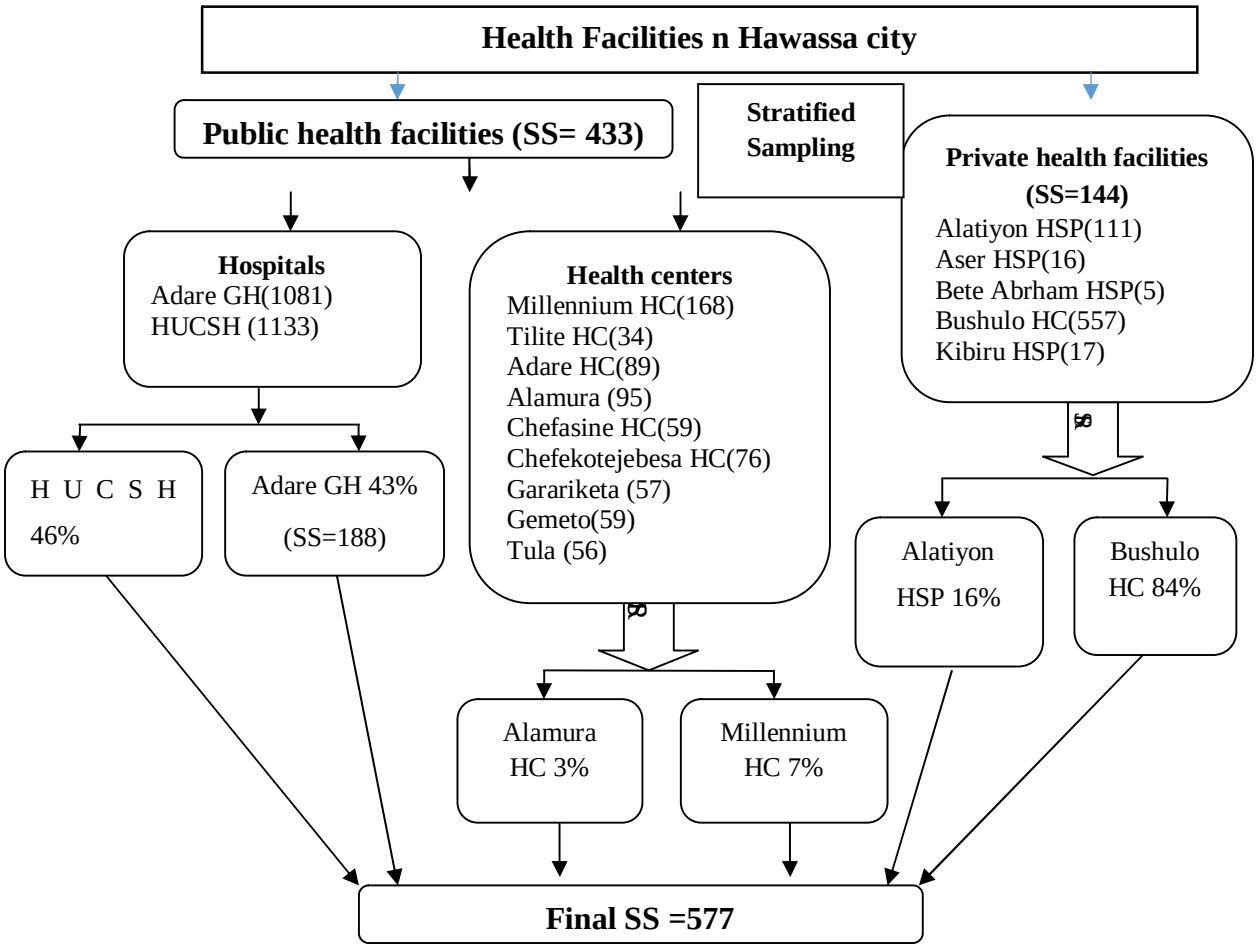
Source population: All mothers who gave birth in the health facilities of Hawassa city administration were the source population of the study.

Study population: All mothers who gave birth in the selected study facilities and who are ready for exit in a postnatal room were recruited to the study.

Inclusion criteria: All mothers who have given birth in the selected study facilities and are ready for exit in a postnatal room in health facilities of Hawassa city administration.

Sample size determination: The required sample size for the first objective of the study was determined using the single-population proportion formula with the assumption of 78.6% prevalence of disrespect and abuse(20), 95% confidence level, and 5% marginal error. The estimated sample size after considering 10% non-response rate and 1.5 design effect was 426.The sample size for the second objective was calculated using EPiInfo version 7 software. The calculation was separately made for three potential predictors; mode of delivery (Spontaneous vaginal delivery (SVD)/Instrumental delivery), number of ANC visits (<4visits/≥4visits), and delivery place (public/private health facility)..The expected proportions for the aforementioned factors were extracted from a study conducted in Bahirdar, Ethiopia (21).Ultimately the highest sample size of 577 was obtained for a factor associated with ANC visits. This sample size was reached using 80% power, 95% confidence level, 1.5 design effect, 10 % non-response rate, AOR of 1.97, and percent of disrespect and abuse among unexposed of 61%.

Sampling techniques: Health facilities were initially stratified into public and private health facilities. Then health facilities were selected using the lottery method from a list of all (public and private) health facilities found in the city administration. All primary, secondary and tertiary level public health institutions found in the city were considered for the study. Three months of delivery performance (in the preceding year within a similar month of the data collection period) of the respective health facilities were assessed. Based on the assessment, the total sample size was proportionally allocated to the selected health facilities. Finally; a systematic sampling technique was applied to include every fifth mother from private and every seventh mother from public health facilities exiting from the postnatal room after being discharged.



***Key**: SS= Sample Size SRS= Simple Random Sampling HC= Health Center GH= General Hospital and HSP= Hospital*

***Figure 1:** Schematic presentation of sampling procedure in the selection of health facilities in Hawassa City*

Data collection: Data were collected using an interviewer-administered structured questionnaire after soughing verbal consent from all eligible mothers before the interview. The questionnaire was first developed in English and then translated into Amharic for data collection. Seven data collectors and two supervisors who are BSc. degree holder midwives and nurses recruited from health facilities other than the study site participated in the data collection process. Levels of disrespect and abusive care during childbirth were measured using the 15-itemrespectful maternity care scale validated in the Ethiopian context(22).The domains of disrespectful and abusive care assessed were physical abuse, verbal abuse, stigma and discrimination and poor rapport between women and providers. Other relevant variables (socio-demographic variables, obstetric characteristics, sex of service providers and type of health facility where the delivery was conducted) were added to the data collection tool as additional information.

Operational definitions:

- **Overall Disrespect and Abuse:** If mothers answer "Yes" to at least three or more questions among the fifteen items; she was considered as disrespected and abused at the time of labor and delivery. Value three indicates the mean score of the response of the mothers.

- For a specific category of disrespect and abuse with more than one verification criterion, a woman was labeled "disrespected and abused" in that category if she respond "Yes" to at least one of the verification criteria during childbirth.

Data quality assurance: Data collectors and supervisors were trained for one day on issues such as the techniques of approaching and introducing themselves to the respondents, data collection and how to ask questions in a neutral manner. Supervisors were also trained on how to check the completeness and consistencies of questionnaires to ensure the quality of the data. A pre-test was carried out on 28 mothers who gave birth at Leku Primary Hospital and Adare Health Center then after any unclear questions were checked and corrected based on the result. Double data entry of questionnaire in EpiInfo was also performed on 28 samples to reassure the quality of the data.

Data analysis and interpretation: The data were coded and entered into EpiInfo version 7 and exported to SPSS version 23 software for analysis. The outcome measurement was dichotomized into responses of "Yes" or "No" to identify reported events of D&A. Fifteen questions classified under different domains of disrespectful and abusive care were asked and the mean score was used to assess the overall prevalence of disrespected and abused among mothers. Additionally to identify the domain of each category of disrespectful and abusive care we computed the reported event in the respective category.

Categorical variables were summarized using frequency, and mean and standard deviation was applied to summarize continuous variables. Potential confounders were identified by running bivariable logistic regression analysis and then those independent variables that had a p-value of less than 0.25 were further taken to multivariable logistic regression analysis to control the effect of confounding. Adjusted odds ratio (AOR) with 95% confidence intervals (CI) was used to determine the association between dependent and independent variables. A p–value < 0.05 was used to declare the significance of the association between independent and dependent variables. The fitness of the model was assessed using Hosmer–Lemeshow goodness-of-fit statistics (P=0.116).

Ethical considerations: Ethical clearance was obtained from the Institutional Review Board (IRB) of Hawassa University College of Medicine and Health Science. In addition, a permission letter was secured from Hawassa city health department and from the selected health facilities. Verbal informed consent was obtained from participants after a detailed explanation of the purpose and benefit of the study right before the individual data collection.

RESULT

Socio-demographic characteristics of the respondents: A total of 548 mothers responded to the survey question making a response rate of (95.0%). The mean± SD age of the respondents was 26.8 (± 4.4) years. More than one-third (44.3%) of the respondents were in the 25-29 years age group, more than 75% of the study participants were urban dwellers and 46.9%of the study participants were followers of the Protestant religion. Most 224 (40.9%) of the respondents have attended primary education and267 (48.7%) of the respondents were housewives by occupation. In addition, almost half of the respondents (47.3%) have a family average monthly income of greater than 1001 Ethiopian Birr (Table 1).

Table 1: Socio demographic characteristics of mother who delivered in Hawassa city health facilities, Hawassa, Ethiopia, 2018 (n=548)

Variable	Frequency (n)	Percentage (%)
Age in years		
15-19	17	3.1
20-24	137	25.0
25-29	243	44.3
30-34	120	21.9
Above 34	31	5.7
Place of Residence		
Urban	416	75.9
Rural	132	24.1
Marital status		
Single and Widowed	22	4.0
Married	526	96.0
Religion		
Orthodox	172	31.4
Catholic	61	11.1
Protestant	257	46.9
Muslim	51	9.3
Others *	7	1.3
Ethnicity		
Sidama	235	42.9
Wolaita	93	17.0
Amhara	102	18.6
Oromo	82	15.0
Others*	36	6.6
Educational level		
No formal education	113	20.6
Primary (1-8)	224	40.9
Secondary (9-12)	93	17.0
College and above	118	21.5
Occupation		
Housewife	267	48.7
Private employee	63	11.5
Government employee	104	19.0
Merchant	78	14.2
Student	36	6.6
Health care decisions		
Mother	24	4.4
Husband/partner	57	10.4
Jointly	467	85.2
Family monthly income		
<500	174	31.8
501-1000	115	21.0
>1001	259	47.3

*Other * in ethnicity include Silte, Hadiya, Kenbata, Tigre, Gamogofa, Shinasha, Kefa, Gurage and Gedio. In religion, Adventist and Hawariy at were included.*

Obstetric History of Mothers: Of the interviewed mothers, 510 (93.1%) had a history of ANC follow-up during their current pregnancy. Of those who had ANC follow-up, more than half (53.1%) had four and above ANC visits and many of the mothers 328 (64.3%) visited public health centers for ANC. Two hundred sixty-one (47.6%) of respondents delivered at least one of their babies in a health facility. Of the total respondents, 166 (30.3%) reported they faced complications during labor and delivery. Majority of reported complication was prolonged labor with 87 (15.9%) mothers. Most of the mothers 313 (57.1%) delivered through spontaneous vaginal delivery (**Table 2)**.

Prevalence of Disrespectful and Abusive care during childbirth: The overall prevalence of disrespectful and abusive care among mothers during childbirth in health facilities was 46.9 % (95% CI: (42.8-51.0)), where the major share is from general hospitals, which accounts for 124 (48.2%) (Figure 2).

Types of disrespectful and abusive care during childbirth: From the domain of physical abuse, 74 (13.5%) of women were beaten, slapped, kicked, or pinched during delivery. The other most commonly experienced form of disrespect and abuse was a poor rapport between women and the provider. Under this domain, all of the women 548 (100%) reported they were not allowed to practice cultural ritual practice in the health facilities. By excluding this variable, 241 (44%) of mothers reported disrespectful and abusive care in the domain of poor rapport between women and providers. The second domain of disrespectful and abusive care was a failure to meet professional standards of care and from this domain; the most reported form was health workers not responding to mothers' needs 162 (29.6%). Additionally, 145 (26.5%) of mothers reported they faced verbal abuse (Table 3) (Figure 3).

Women's experience of disrespectful and abusive care during childbirth: Regarding the types of disrespectful and abusive care mothers had experienced during labor and delivery; only one type of disrespectful and abusive care was experienced by all mothers followed by two types (69%) of disrespectful and abusive care (Figure4).

Factors associated with disrespectful and abusive care during child birth Bivariable logistic regression analysis were performed to assess the association of each independent variable with disrespectful and abusive care and those factors with p-value <0.25 were further taken to the multivariable regression model. In multivariable logistic regression analyses, mode of delivery, type of health facility, parity and sex of the main provider conducting delivery were significantly associated with disrespectful and abusive care.

Mothers who delivered in public health facilities were 12.94 more likely to be disrespected and abused than mothers delivered in private health facilities [AOR=12.94 95% CI: (5.87, 28.50)].Mothers who delivered four and above babieshad4.67 times increased odds of being disrespected and abused than mothers who delivered only one baby [AOR= 4.67 95% CI: (1.69, 12.89)]. Similarly, respondents who delivered through instrumental/vacuum delivery were 2.63 times more likely to be disrespected and abused than respondents who delivered through spontaneous vaginal delivery [AOR= 2.63 95% CI: (1.05, 6.59)]. In addition, mothers whose delivery was attended by female health providerswere1.75 times more likely to be disrespected and abused than mothers whose delivery was attended by male providers [AOR= 1.75 CI: (1.14, 2.71)] (Table 4).

Table 2: Obstetric characteristics of the mothers who delivered in Hawassa city health facilities, Hawassa, Ethiopia, 2018 (n=548)

Variable	Frequency (n)	Percentage (%)
ANC visit		
Yes	510	93.1
No	38	6.9
Place of ANC		
Health post	26	5.1
Public health center	328	64.3
Public referral hospital	23	4.5
Private health center	48	9.4
Private hospital	48	9.4
Private clinic	37	7.3
Number of ANC		
<4	239	46.9
≥4	271	53.1
Gravidity		
One	236	43.1
Two	191	34.9
Three	88	16.1
Four and above	33	6.0
Health facility delivery		
All	180	32.8
One	261	47.6
Two	83	15.1
Three	24	4.4
Complication duringlabor/delivery		
Yes	166	30.3
No	382	69.7
Type of complication		
Prolonged labour	87	15.9
Hemorrhage	32	5.8
Hypertensive disorder	33	6.2
Other*	14	2.4
Mode of delivery		
SVD	313	57.1
Instrumental/vacuum delivery	38	6.9
Caesarian section(C/S)	84	15.3
Episiotomy	113	20.6
Type of facility delivery was conducted		
Private hospital	21	3.8
Public general hospital	181	33.0
Public referral hospital	192	35.0
Public health center	44	8.0
Private health center	110	20.1
Sex of delivery attendant		
Male	268	48.9
Female	280	51.1
Length of Stay in the health facility		
Less than one day	252	46
One up to two days	238	43.4
Greater than two days	58	10.6

N.B: *others* in type of complication includes still birth, oligohydoamoinos, infection, fetal distress and malpresentation.*

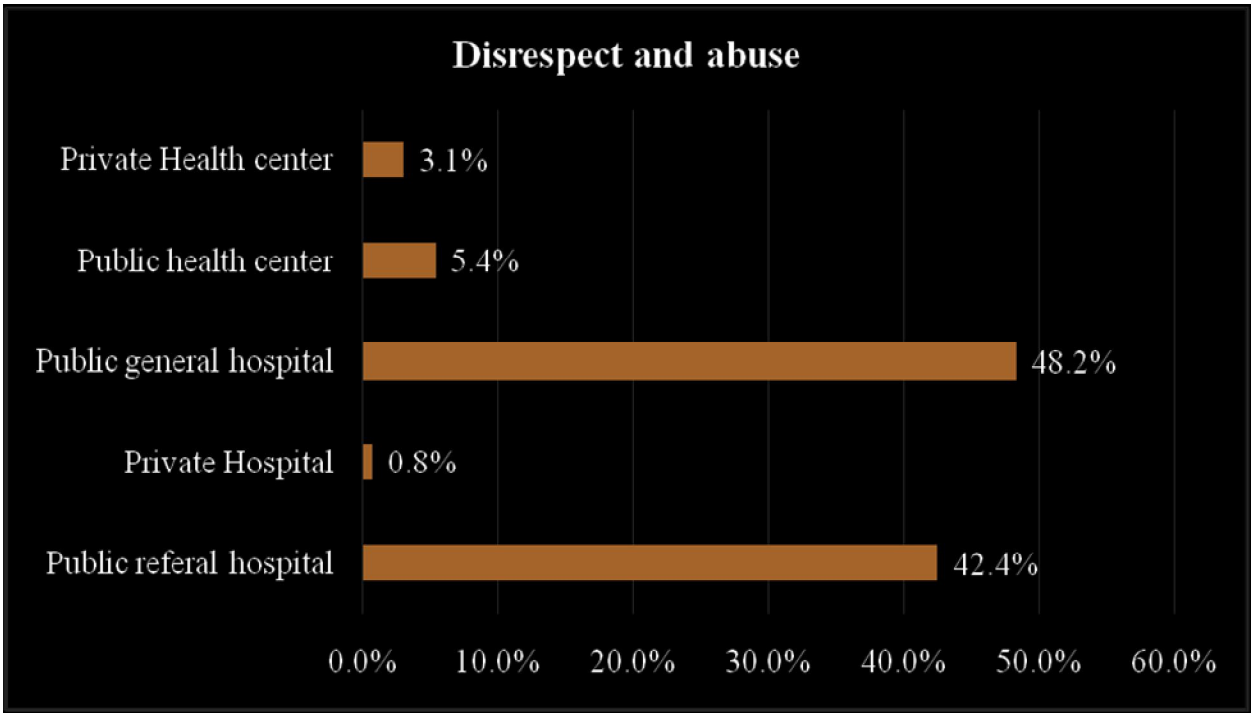


Figure 2: *Overall prevalence of disrespectful and abusive care by health facility types among mothers who delivered in Hawassa health facilities, Ethiopia, 2018 (n=257) from total sample size (N=548)*

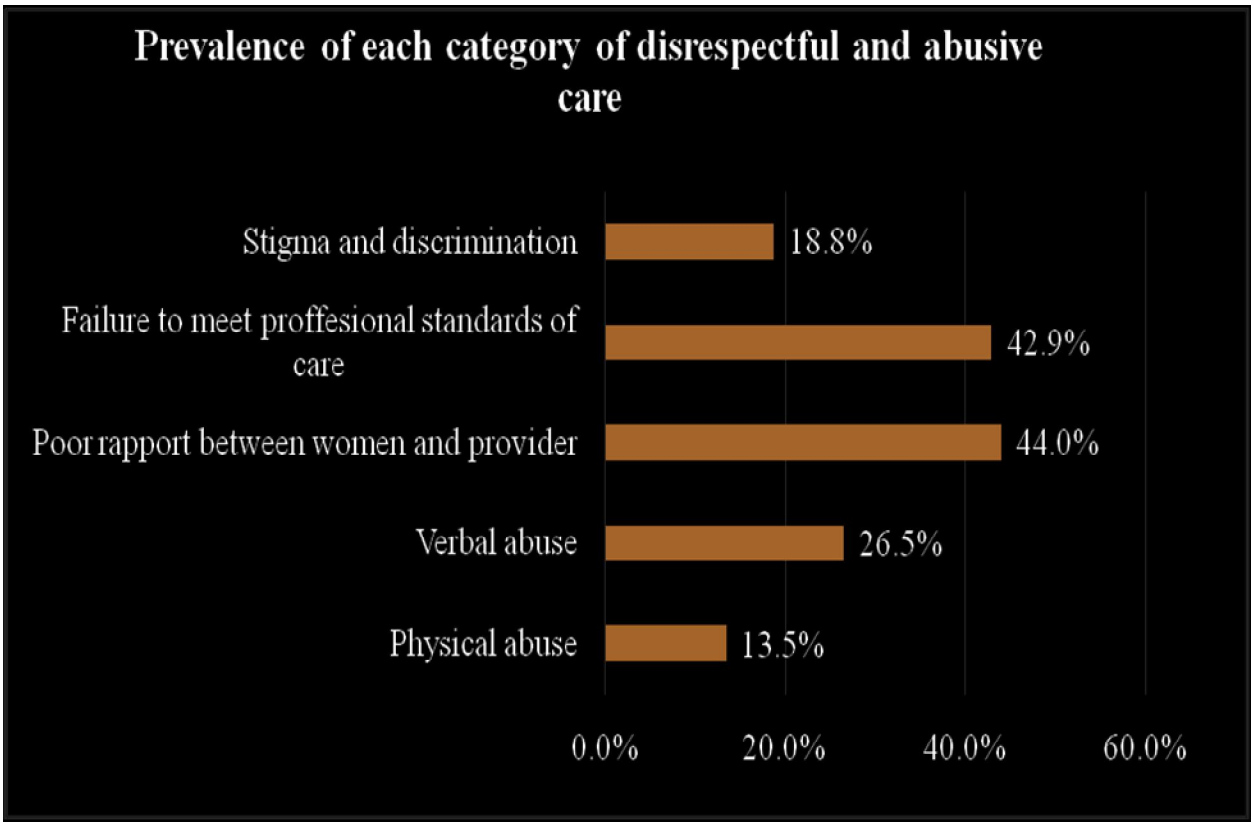


Figure 3: *Prevalence of each category of disrespectful and abusive care among respondents, Hawassa city, Ethiopia, 2018*

Table 3: Category of disrespect and abuse during facility-based childbirth, Hawassa city, Ethiopia, 2018 (n=548)

Disrespectful and abusive care dimensions	Yes n (%)	No n (%)
Physical abuse		
Health provider slapped, kicked me during for different reasons	74 (13.5)	474 (86.5)
Verbal abuse		
Health workers shouted at me because I haven't done what I was told	145 (26.5)	403 (73.5)
Stigma and discrimination		
Some of the health workers did not treat me well because of some of my personal attribute.	74 (13.5)	474 (86.5)
Health workers discriminate me and my companions due to my personal attributes.	74 (13.5)	474 (86.5)
Failure to meet professional standards of care		
Health workers talked positively about pain and relief	464 (84.7)	84 (15.3)
Health worker respond to my needs asked or not	386 (70.4)	162 (29.6)
I was kept waiting for a long time before receiving service	48 (8.8)	500 (91.2)
Service provision was delayed due to the health facilities internal problem	42 (7.7)	506 (92.3)
Poor rapport between women and provider		
Health workers care for me with a kind approach	509 (92.9)	39 (7.1)
Health workers treated me in a friendly manner	501 (91.4)	47 (8.6)
Health worker showed his/her concern and empathy	452 (82.5)	96 (17.5)
All workers treated me with respect as an individual	373 (68.1)	175 (31.9)
Health workers spoke to me in a language that I could understand	467 (85.2)	81 (14.8)
Health provider called me by my name	442 (80.7)	106 (19.3)
Health care provider allow practicing cultural rituals in the facility	0 (0)	548 (100)

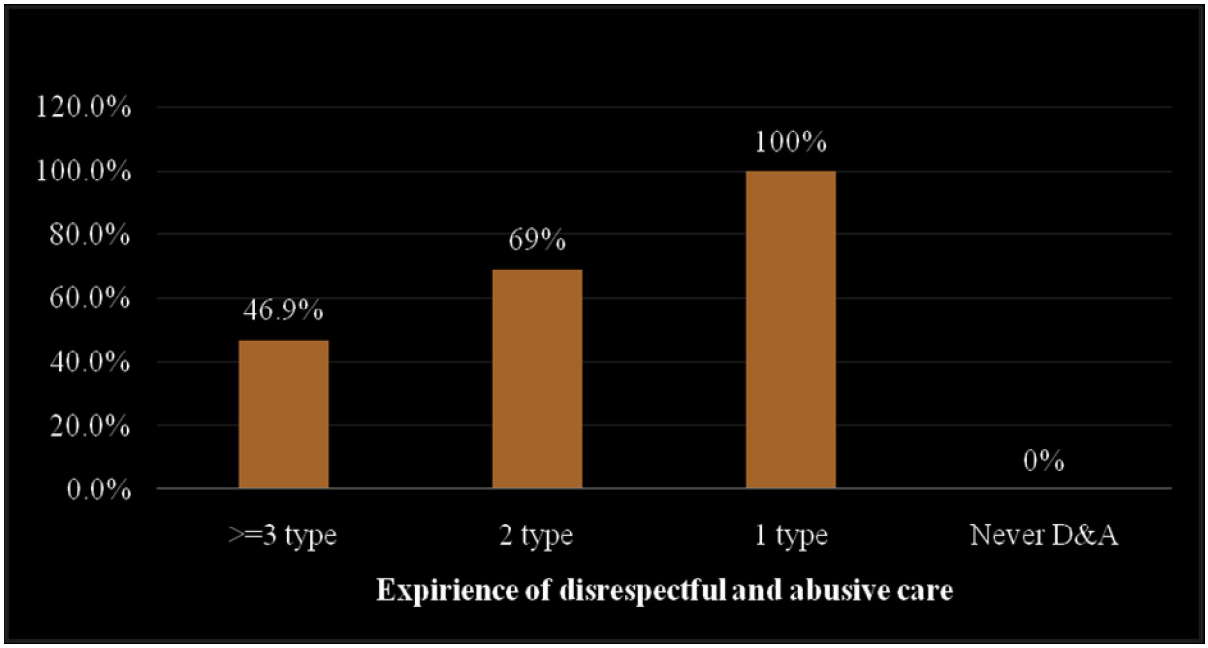


***Figure 4**: Types of disrespect and abuse experienced by the respondents, Hawassa city, Ethiopia, 2018.*

Table 4: Bivariable and multivariable logistic regression analyses of overall disrespectful and abusive care of mothers who gave birth at Hawassa city health facilities and its explanatory variables, Hawassa city, Ethiopia, 2018.

Types of variable	Disrespectful and abusive care		COR (95% CI)	AOR(95% CI)
	Yes	No		
Place of residence				
Rural	77	55	1	1
Urban	180	236	1.83 (1.23, 2.72)	0.67 (0.41, 1.09)
Marital Status				
Married	240	286	1	1
Single and widowed	17	5	4.05 (1.47, 11.14)	1.76 (0.46,6.67)
Educational status				
No formal education	63	50	1	1
Primary	100	124	0.64 (0.41, 1.01)	0.95 (0.54, 1.69)
Secondary	46	47	0.77 (0.45, 1.35)	1.78 (0.86, 3.69)
College and above	48	70	0.54 (0.32, 0.92)	1.11 (0.45, 2.71)
Occupation				
Housewife	128	139	1	1
Private employee	33	30	1.19(0.69, 2.07)	1.83 (0.83, 4.07)
Government employee	36	68	0.58(0.36,0.92)	1.19 (0.48, 2.91
Merchant	39	39	1.08(0.65, 1.79)	1.65 (0.78, 3.49)
Student	21	15	1.52 (0.75, 4.07)	2.00 (0.78, 5.13)
Decision about health care				
Her self	18	6	1	1
Jointly	199	268	0.25 (0.09, 0.63)	0.68 (0.20, 2.29)
Husband/partner	40	17	0.78 (0.26, 2.31)	1.26 (0.32, 5.03)
Number of ANC				
<4	157	120	2.24 (1.58, 3.15)	1.46 (0.96, 2.21)
≥4	100	171	1	1
Parity				
One	108	128	1	1
Two	81	110	0.87 (0.59, 1.31)	1.19 (0.72, 1.99)
Three	42	46	1.08 (0.66, 1.77)	1.44 (0.77, 2.69)
Four and above	26	7	4.40 (1.83, 10.59)	4.67 (1.69, 12.89)*
Mode of delivery				
Spontaneous vaginal delivery	152	161	1	1
Caesarian section	13	71	0.19 (0.11, 0.36)	0.47 (0.21, 1.07)
Instrumental delivery	27	11	2.6 (1.25, 5.42)	2.63 (1.05, 6.59)*
Episiotomy	65	48	1.43 (0.93, 2.21)	1.39 (0.79, 2.45)
Sex of delivery attendant				
Male	92	176	1	1
Female	165	115	2.74(1.94, 3.88)	1.75 (1.14, 2.71)*
Length of stay in the health facility				
Less than one day	131	121	1	1
One up to two days	104	134	0.71 (0.50,1.02)	1.38 (0.86, 2.21)
Greater than two days	22	36	0.56 (0.31, 1.01)	1.72 (0.78, 3.79)
Type of health facility				
Public health facilities	247	170	17.6(8.96, 34.4)	12.94 (5.87,28.50)*
Private health facilities	10	121	1	1
Family monthly Income				
< 500 Birr	113	146	1	1
501-1000 Birr	53	62	0.78 (0.49, 1.25)	1.06(0.58, 1.95)
>1001 Birr	91	83	0.77(0.48, 1.038)	1.14(0.56, 2.32)

**** P-Value <0.05***

DISCUSSION

The current study assessed the prevalence of disrespectful and abusive care and factors associated with it among women during facility-based childbirth. The analysis showeda 46.9% overall prevalence of disrespectful and abusive care during childbirth at a health facility which is one of the highest figures in the world and is consistent with different studies conducted in Sub-Saharan Africa (SSA). Two systematic reviews and meta-analyses conducted in Ethiopia and SSA reported pooled prevalence of disrespectful and abusive care during childbirth and maternity care of 49.4% and 44.09% respectively(12, 23).

On the other hand, the finding of the current study is higher than studies conducted in Tanzania which reported a 15% prevalence of disrespectful and abusive care, Kenya 20%, India 28.8%, and Bale zone (Ethiopia) 37.5% (11, 24-26).The possible explanation for the differences might be policy differences related to RMC, health facilities differences, interview time, setting of the interview, and differences in the definition of disrespectful and abusive care in the studies.

In contrary, , the finding of the current study is lower than the study conducted in Addis Ababa, Ethiopia which reported 78.6% prevalence of disrespectful and abusive care(20). A community-based study on disrespectful and abusive care conducted in Bahir dar, Ethiopia also showed a higher (67.1%) prevalence of disrespectful and abusive care than this particular research (21).This discrepancy might be due to differences in an operational definition that has been used to measure the experience of disrespectful and abusive care, study setup, and sampling technique.

One type of disrespectful and abusive care was experienced by all mothers, two types by 69% of mothers and 46.9% of the mothers experienced three or more types of disrespect and abuse during childbirth in the current pregnancy. A study conducted in Brazil found that; mothers who at least had one type of disrespectful and abusive care were 18.3% and 5.1% of the mothers encountered two types of disrespectful and abusive care(27).On the other hand, a study conducted in Southeastern Nigeria found a 98% prevalence of at least one form of disrespectful and abusive care during labor and delivery(28).These discrepancies might be explained by differences in socioeconomic status, time of data collection, health system differences, and the differences in health facilities of the countries.

Our study pointed out 26.5%verbal abuse by health workers, which is higher than the finding of research conducted in Tanzania which reported 19.48% verbal abuse. Likewise, 4.3% and 1.9%prevalence of verbal abuse was observed in studies conducted in Nigeria and Malawi respectively(28-30). In contrast, a study exploring Jordanian women's exposure to verbal abuse found that 37 % were victims of verbal abuse (31). These inconsistencies might be due to socioeconomic and socio-cultural differences in the study areas.

In the current study physical harm like slapping and kicking was experienced by 13.5% of mothers which is three times higher compared to a study conducted in Tanzania(11).Differently lower when compared to studies conducted in India and Enugu(Nigeria)30.4% and 35.7%, respectively (28).

In the current study, mothers who delivered in public health facilities were 12.94 times more likely to be disrespected and abused during childbirth as com-

pared to mothers who delivered in private health facilities. This finding was consistent with a study conducted in Bahir dar, Ethiopia (21). Similarly, according to a study conducted in Gujrat, Pakistan; the risk of reporting disrespectful and abusive care was twice in public health facilities as compared to private (32).The reason behind this association could be staffing shortages which may have led to longer wait times and neglectful and poor-quality care. Lack of infrastructures like enough room and beds which may lead to reduced privacy in the labor wards may also have contributed to increased disrespectful and abusive care in public facilities. Shortage of medications can also create stressful working environments which might predispose health care providers to behave poorly (or even abusively) towards women in public health facilities (5, 27).

We also identified that mothers who delivered four and above babies are 4.67 times more likely to be disrespected and abused than those who delivered only one baby. This finding is consistent with a study conducted in Kenya which showed that women of higher parity were three times more likely to be disrespected and abused(11).This could be due to the view of abusive practices as part of the process of ensuring the safety of the mother and baby, inadequate infrastructure (e.g. lack of beds, curtains, and drugs at the facilities), the high workload of providers and provider perception that multi-parous women already have previous birth experience.

This finding also showed that mode of delivery was associated with disrespectful and abusive care. Mothers who had instrumental delivery were 2.63 times more likely to be disrespected and abused than those mothers who had a spontaneous vaginal delivery. This finding is in line with studies conducted in Ethiopia (21, 33).This might be related to the invasiveness of the procedure and health workers' eagerness to ensure good health outcomes since they used it to shorten the second stage of labor this will be perceived as a painful experience for the mothers therefore they think that they are being disrespected and abused.

Mothers whose delivery was attended by female health care professionals were 1.75 times more likely to get disrespectful and abusive care as compared to mothers whose delivery was attended by male health care providers. This finding shows consistency with a study conducted in an Ethiopian public facility which reported male providers were observed engaging in RMC practices more frequently than female providers(34).

The interpretation of the findings of this study should consider the following limitations: In the first place; the study assessment relied on self-report, so the measurement might be prone to subjectivity. Second, since the study was conducted in a health facility compound, it will be more prone to social desirability bias. Finally, non-consent and confidentiality domains of disrespectful and abusive care were not assessed.

CONCLUSION

This particular study endeavored to provide the picture of disrespectful and abusive care that women are experiencing in Hawassa city health facilities. The study further highlighted that the prevalence of disrespectful and abusive care in Hawassa health facilities is found to be high. The factors that are associated with disrespectful and abusive care are; types of facility, mode of delivery, sex of health care providers

conducting delivery, and parity. After all, avoiding disrespectful and abusive care for women is not about luxury, it is about a human right issue as a woman has the right to the maximum attainable standard of health, which includes sympathy and respectful health care.

Based on the findings of the study; we recommend policymakers advocate the principle of respectful maternity care (RMC) to strengthen the national health strategies and policies. Sidama region health bureau and Hawassa city health department and public health facilities should address the identified significant risk factors of disrespectful and abusive care through building accountability, setting standards to evaluate and measure the extent of disrespectful and abusive care, facilitating training programs, monitoring of RMC performance, and supportive supervision providing an adequate pregnant friendly environment in the health facilities, for example, providing materials to help mothers to practice cultural ritual practice.

Finally, future research is recommended focusing majorly on what further factors influence disrespectful and abusive care using observational and mixed designs.

List of abbreviations: ANC: Antenatal Care; CRC: Caring, Respectful and Compassionate; EDHS: Ethiopian Demographic Health Survey; FMOH: Federal Ministry of Health; L&D: Labor and Delivery; MCHIP: Maternal and Child Health Integrated Program; RMC: Respectful Maternity Care; SDG: Sustainable Development Goals; SVD: Spontaneous Vaginal Delivery; SRHB; Sidama Regional Health Bureau, USAID: United State Agency for International Development; WHO: World Health Organization.

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Authors' contribution: BT designed the study, coordinated the data collection and management, analyzed the data and prepared the manuscript. AT, KM and AZ participated in the design of the study and supervised data collection and analysis of the data. All the authors critically reviewed the manuscript for intellectual content and approved the final manuscript.

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